CORONER'S COURT

**OF NEW SOUTH WALES**

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| **Inquest:** | Inquest into the death of LAK |
| **Hearing dates:** | 23 – 26 May 2022<br>Date final submissions due 12 August 2022 |
| **Date of findings:** | 26 August 2022 |
| **Place of findings:** | Coroner's Court of New South Wales |
| **Findings of:** | Magistrate Carolyn Huntsman, Deputy State Coroner |
| **Catchwords:** | CORONIAL LAW – young First Nation's man; death in residential drug rehabilitation facility; forensic patient order; cultural safety in provision of health services |
| **File number:** | 2018/00276778 |
| **Representation:** | Mr Peter Aitken, Counsel Assisting, instructed by Crown Solicitors Office<br>Ms Berberian, Counsel, GROW, instructed by Spark Helmore<br>Mr Patrick Rooney, Counsel for Southern NSW Local Health District (SNSWLHD) and South West Sydney Local Health District (SWSLHD) instructed by McCabes Lawyers<br>Mr Simeon Beckett, Counsel for Dr Smith, instructed by Avant<br>Mr Timothy Abbott Solicitor for Ms AK |

**Findings:**

I make the following findings pursuant to s81 of the Coroners Act 2009 NSW:

Identity: LAK

Date: 9 September 2018

Place: GROW Community Residential Rehabilitation Centre at West Hoxton in Sydney

Cause of death: Hanging

Manner of death: Suicide

**Recommendations** Nil

**Non-publication orders:** A non-publication order pursuant to s. 75(2) of the Coroner's Act prohibiting publication of LAK's name or anything tending to identify him [and his family members].
A non-publication order was made pursuant to s74 of the Coroners Act 2009 (NSW) that there be no publication of any evidence identifying a person as having been a resident of the GROW residential rehabilitation facility.

## JUDGMENT

1 The inquest was conducted to inquire into the tragic death of a 19 year old First Nations man, LAK, who died in the grounds of the GROW Community residential rehabilitation centre at West Hoxton in Sydney on Sunday 9 September 2018.

2 As Coroner I begin these Reasons for Decision by extending my sincere condolences to LAK's mother, Ms AK, and LAK's siblings and extended family members, for their loss of a beloved family member who was so young, with his life ahead of him.

3 The evidence at the inquest established that the institutions and organisations that had the care of LAK at various times in 2018 had LAK's health and wellbeing as primary objectives of that care. The inquest examined whether there were better ways of ensuring that care was culturally safe for LAK as a First Nations man, and whether processes in place were lacking or contributed to his death.

## Issues

4 The Issues for the inquest were circulated to the parties and were as follows:

> Issue (1):
> Determination of the statutory findings required under s. 81 of the Coroners Act 2009, namely: the identity of the deceased, and the date, place, manner and cause of death.

5 In relation to the manner of death the issues were:

> Issue (2)
> The adequacy of the community management of his forensic order/mental health between March 2018 and May 2018
>
> Issue (3)
> The adequacy of the planning, management and support of LAK's transition to residential rehabilitation and in particular:
>
> > (i) How could a 'dual diagnosis' rehabilitation facility such as GROW be better supported in addressing the mental health, cultural and therapeutic needs of forensic patients and other clients who are receiving treatment from the Community Mental Health teams.
> >
> > (ii) How can Community Mental Health effectively meet these needs, including with respect to hand over and ongoing monitoring; and what are the current difficulties for community mental health in being able to provide for their clients in residential rehabilitation settings
> >
> > (iii) How can residential rehabilitation facilities be supported to accept into their programs/residences, higher risk residents such as those who are mentally ill and/or subject to forensic patient orders?
>
> Issue (4)
> Whether the self harm/suicide risk was adequately understood, monitored and addressed by the relevant staff at GROW after his move there.
>
> Issue (5)
> What prompted LAK to take his own life on 9 September 2018
>
> Issue (6)
> What was the emergency response procedure at GROW, and how did this operate/function when LAK disappeared on 9 September 2018; and have there been changes implemented since then
>
> Issue (7)
> How would the cultural needs of First Nations Peoples receiving mental health treatment be better addressed

6 Another issue raised was whether any recommendations might be considered.

**Background**

7 The information about LAK is drawn from the brief of evidence; it is important to acknowledge that LAK, the person, was a son, and brother, to family members who loved him. He was also a teenager who was only just embarking on his life journey.

8 LAK was born on 13 October 1998 to his mother MS AK and father. He identified as an Aboriginal Dunghutti man from the area of Kempsey NSW and was accepted and acknowledged by the Dunghutti Tribal Nations Ancestors, Elders and peoples. He had two brothers and two sisters. His father had unfortunately passed away when LAK was very young and he had lost his eldest sister in a car crash when he was in his teens. It was well-known that LAK was deeply grieving his sister's loss.

9 LAK initially grew up in Kempsey with his mother and siblings and they moved to various places in NSW during his childhood, including Wagga, Tumut, Cootamundra, Batlow and Junee. He described a difficult relationship with his stepfather. He spent many of his high school years in Cootamundra. He completed a six month TAFE course in 2016. He enjoyed maths and science. LAK had struggled with depression at times and was diagnosed with ADHD at the age of 13. He had been working as a sheep handler at a Junee abattoir prior to the incident with the police woman which led to the court proceedings which will be further discussed below.

10 Prior to his admission to Bega hospital, in May 2018, LAK was in a relationship with his girlfriend (Tia) of some three months' duration and had employment as a painter's assistant in the Bega area. He had plans to join the local football club and the PCYC. His brother also lived nearby in Bega. LAK had made a committed effort to try and remain alcohol and drug-free, including from prescription drugs, and was clearly taking positive and mature steps to manage his health and get his life back on track.

11 Whilst in Bega Hospital, he told Dr Lemieszek that he wished to remain drug-free and learn to play the guitar and seemed to embrace the scope for a new

stage in his life. Unfortunately his relationship with his girlfriend did not endure and they broke up while he was in hospital.

12 Dr Smith, a leading clinician and psychiatrist at the Bega Hospital at the time LAK was there, described LAK's passing as "crushing" to the staff who had cared for him at Bega Hospital and that his loss "still hurts".

13 The evidence of various witnesses who provided statements during the police investigation, and those who gave evidence at the inquest, indicated that LAK made a strong and very positive impression on those who he came into contact with.

**The Coroner's role**

14 An inquest is different from other types of Court hearing; it is neither criminal nor civil in nature and the Coroner does not make determinations of individual liability or orders that are binding on the parties (such as in civil litigation), nor determine whether a person is guilty or not of an offence (such as in criminal proceedings).

15 An inquest is not meant to be like traditional adversarial proceedings; the object is to determine the manner and cause of a person's death, with the co-operation of those involved in the process. The strict rules of evidence are not applied in an inquest. While parties to an inquest are afforded natural justice, or procedural fairness, the Coroner has a right to receive relevant evidence in whatever manner the Coroner considers appropriate and evaluate it accordingly, including in statement form and orally, by way of further clarification and testing and exploring.

16 The inquest process has often been described as one which does not set out so much to apportion individual blame but rather to expose possible shortcomings, systems faults and issues arising from the circumstances of the manner of a death, and ask how those matters might be remedied in the future.

**The evidence**

17 Prior to the inquest hearing, a thorough investigation into LAK's death was undertaken and a substantial brief of evidence was prepared which was tendered in evidence.

18 The detailed police brief of evidence included witness statements and documents compiled during the investigation. Witness statements were obtained from clinicians and medical staff, including treating psychiatrists, and included statements from – Dr Gordon Elliott, treating psychiatrist, Bega; Dr Brendan Smith, treating psychiatrist, Bega; Tracy Boulton, social worker, Bega; Stephen Young, Aboriginal Mental Health Clinician, Bega; Anita Bizzotto, nursing unit manager, Bega; Mr Patel, acting nursing unit manager, Liverpool Community Mental Health Team (CMHT); Dr Hafiz, treating psychiatrist, Liverpool CMHT; Delphine Leslie, Aboriginal Mental Health, Liverpool. Witness statements from GROW staff were obtained, including by the former CEO of GROW, Mr Butt; Tanya Orth, care services officer, GROW; Danielle Khan, care services officer, GROW; John Rampton, care services officer, GROW; and a statement from the current National manager of GROW, Mr Aaron Beatus, was obtained. The brief of evidence also included witness statements from GROW resident, SH NPO Statements were also obtained from family members including LAK's mother, Ms AK. Witnesses statements and relevant policy documents from the health services were provided (Southern NSW Local Health District (SNSWLHD) and South West Sydney Local Health District (SWSLHD) – the witnesses included Mr Paul Parker and Mr Damien Eggleton.

19 A significant number of medical records and other documents were obtained including reports prepared for the Mental Health Review Tribunal (MHRT); records of Corrective Services New South Wales, records of the New South Wales Ambulance Service; records by Justice Health; and medical records from Bega Hospital, Liverpool CMHT, and various records from GROW; and policy documents from Southern New South Wales Local Health District and Southwest Sydney Local Health District.

20 Witnesses also gave oral evidence and were questioned. Witnesses who gave evidence at the inquest included Mr SH NPO Dr Brendan Smith; Mr Patel; Ms Bolton; Mr Stephen Young; Ms Delphine Leslie; Mr Rampton; Ms Orth; Mr Beatus; Mr Parker; and Ms Edwards (expert witness and psychologist). Witnesses also gave evidence as to new policies, in relation to Aboriginal Cultural Safety and support of First Nations mentally ill clients, which are now in place at local health districts - Southern New South Wales Local Health District and Southwest Sydney Local Health District.

21 A cultural expert, Ms Vanessa Edwidge, psychologist, provided a report and also gave oral evidence to the inquest. Her evidence addressed issues of cultural safety, and culturally appropriate mental health treatment of First Nations clients. The Department of Health provided an update as to relevant policy developments in this area. Vanessa Edwidge is a Ngarabal woman, and Chair of the Australian Indigenous Psychologists Association and has worked with Aboriginal and Torres Strait peoples for much of her career. She gave evidence about the impacts of intergenerational trauma and social determinants. GROW also provided considerable information about their reformed practices and policies.

**Summary of evidence and findings**

22 I have summarised the evidence in relation to the different phases of LAK's treatment, from the time of the court proceedings and the making of the forensic order, below in these reasons for decision. As part of the summary of evidence I have made findings on the evidence, as detailed.

23 The inquest necessitated an understanding of the complexities of legal orders and their interaction with mental health care provision. Given those complexities, significant detail has been required in these Reasons for Decision. LAK's mental health management involved a complex interplay between orders of the criminal court, orders of the Mental health Review Tribunal (including breach orders) and management of his mental health - both

pursuant to those orders, and according to LAK's presentation as mentally unwell, leading to his admission to an inpatient unit.

24 Against this complex backdrop, is the reality that LAK was a teenager, in the earliest phases of mental health diagnosis and treatment, yet these early phases were occurring in the context of criminal proceedings and a forensic order.

**Court proceedings and the forensic patient order**

25 In November 2016 LAK was involved in an incident where a female police officer suffered injury and he was subsequently charged with inflict grievous bodily harm to the police officer acting in the execution of her duty. At the time of the incident LAK was mentally unwell. The District Court found him not guilty on the grounds of mental illness. The circumstances of the incident included that LAK had seen naked and was running around the paddocks and was saying that he was in the creek with God; police were called (see Police Facts sheet, tab 29; and report of Dr O'Dea tab 48). LAK is recorded to have assaulted one of the officers who responded to a call from neighbours. Dr O'Dea, psychiatrist, subsequently concluded that LAK had been suffering from a drug-induced psychosis.

26 Prior to the District Court hearing (of 22 March 2018), LAK had been released to bail on about 14 November 2017. He had spent some time in custody on remand prior to that bail determination. He had also previously been on bail in the period February 2017 to June 2017. He was also remanded in custody, from his arrest in November 2016, to his release on bail in February 2017.

27 LAK was therefore in the community, on bail, for some time before the Community Mental Health Team's involvement, which effectively crystallised with the verdict of not guilty on the grounds of mental illness on 22 March 2018, and the making by the District Court of an order pursuant to s 39 of the then in force Mental Health (Forensic Provisions) Act 1990. In general terms this order provided for LAK's conditional release into the community and for him to appear before the Mental Health Review Tribunal (MHRT) on a date to be fixed.

28 From that point on LAK was a forensic patient, under the direction of the MHRT. Consequently, Bega Hospital's decision-making about his care and treatment, and transition into the community, was under the direction of the MHRT. As detailed below this was further complicated by proceedings for breach of the forensic order. As LAK was under MHRT direction, his subsequent transition to GROW was a period of leave from Bega Hospital, rather than a formal discharge from his inpatient status, as the MHRT had not yet completed its review. The MHRT had adjourned their review of LAK's order while the Bega team explored discharge planning options, so when the bed at GROW came up there was a need to accept the placement so as not to lose the bed, and so LAK was placed on leave from Bega Hospital until the MHRT could review LAK's case. The MHRT review was scheduled for September and the Bega Hospital had discussions with staff at the MHRT about LAK being placed on leave to GROW prior to the MHRT review hearing.

29 The assault of the police officer was something that LAK reflected on, and expressed considerable remorse about, to clinicians at Bega Hospital, expressing a wish to be able to meet with and apologise to the officer. The facts of the matter as described by various people in the brief suggest that LAK was likely drug-affected as well as mentally unwell at the relevant time.

30 After the District Court forensic order of 22 March 2018, LAK was referred to the Bega Valley Community Mental Health Team for ongoing management during his period as a forensic patient. It is important to note that at no time prior to the forensic order does it appear that LAK was subject to any court order requiring involvement with the community mental health team. He was initially released to bail on a Supreme Court bail order (made on 6 February 2017) – the conditions imposed by the Supreme Court required abstinence from illicit drugs, and that LAK was required "to abide by all reasonable directions of his mother and sister with respect to his behaviour, and in particular he is to submit himself forthwith for assessment at the Connections Medical Centre Tumut". The transcript of the Supreme Court bail notes that his mother wanted him reviewed for any health condition.

31 On 14 June 2017 he was arrested for breach of bail and a detention application was made - the facts relating to that detention application are at p18 of Tab 35 of the brief. The breach alleged was that LAK had not complied with his bail (reporting and other conditions). It appears that he was on bail from 6 Feb 2017 to 14 June 2017 when his bail was revoked, and he remained in custody until 14 November 2017 when he was released on bail. He remained on bail from 14 November 2017 to the date of the making of the forensic order on 22 March 2018.

32 The bail conditions from November 2017 - when he was residing in Bega - contained conditions to abstain from drugs and alcohol but did not require LAK to be in contact with community mental health services (see page 96 behind tab 46 of brief). Dr Elliot's note of May 2017 indicates "new referral to service" - this confirms LAK had not previously engaged with Bega CMH team while residing there on bail. (p13, tab 49).

33 On 22 March 2018 the District Court forensic order was made, and as detailed above it appears that, as at that date, there was no established contact with mental health services. The order required him to attend the Mental Health Review Tribunal. Before the first review of the District Court forensic order by the MHRT, a breach order was issued by the MHRT (see below). The MHRT, by order dated 5 June 2018, adjourned the breach proceedings (breach of forensic order) making no determination on the breach. The tribunal noted that the Community Forensic Mental Health Service (CFMHS) had not yet provided their report to the tribunal.

34 It is of relevance that as well as the forensic order/conditional release order made by the District Court on 22 March 2018 requiring review by the MHRT, there was also a breach of that order before the MHRT. A breach order was issued by the MHRT on 17 May 2018 (pursuant to s68 of the Mental Health (Forensic Provisions) Act 1990). The reasons for the breach order stated that conditions of residence (his brother's house) and drug and alcohol abstinence may have been breached, given reports of positive test for cannabis on admission to Bega Hospital, and noting reports of a physical altercation with his

brother may jeopardise the residential address. The date of the breach order was 17 May 2018. On this date LAK was in Bega hospital having been scheduled and involuntarily detained on 15 May 2018.

**Mental health treatment and review while in custody**

35 LAK was in custody on remand for a period of time before the making of the forensic order (he was also on bail for some of that period). Whilst in custody there were some reviews of his mental health. LAK was reviewed by a psychiatrist in custody, after being bail refused, in June 2017 – Dr Hearps, psychiatrist, reviewed LAK on 30 June 2017 and found he was depressed. He noted some suggestion of psychotic thoughts recorded in notes during LAK's time on remand in 2016 – report of hearing voices (31/12/16) and delusional beliefs of communication with animals on (8/11/16) but that it did not appear that LAK was prescribed medication at that time. Dr Hearps observed during his assessment of LAK that he was malodorous and unkempt, with poor selfcare, and some evidence of vagueness and poverty of thought but that he did not appear to be hallucinating. Dr Hearps recorded his impression that LAK was suffering from depressed mood and queried whether he also had a psychotic disorder although there were no psychotic symptoms at the time. The plan was to commence LAK on medication, being Avanza and Olanzapine and to review him in three weeks. It is noted that this assessment was relatively soon after LAK was returned to custody and may have evidenced deterioration in his mental state in the community around the time of breach of his bail.

36 On review on 19 July 2017 it was noted that the medication (Avanza and olanzapine) were reportedly helping. On review on 24/08/17 he was noted to be depressed and worried about receiving a long gaol sentence. A later review (undated) noted LAK was stable "in remission". He saw a psychologist in gaol on 5 September 2017 and the psychologist recorded that "his mood had stabilised which he attributed to his current medication [which he reported he had been taking for three months]". He told the psychologist he had issues adjusting to Parklea but felt better in Long Bay where he felt more supported.

37 A review on 24/10/17 noted he was commenced on his medications due to blunted affect which was much the same and it was observed “possible prodromal underlying psychotic illness”.

38 Transit Screening form, for Junee on 8 November 2017, noted his medications and that he was for Wagga District Court on 10/11/17. Court documents (tab 45, page 96) indicate that bail was granted at Wagga Wagga District Court and was entered on 14 November 2017 requiring LAK to live at Bega at his brother’s address, not to enter Junee or Cootamundra and not to consume drugs or alcohol. The bail did not require engagement with any health services nor with community mental health. LAK’s brother NPO entered a security agreement as acceptable person for the bail undertaking on 14 November 2017. He appears from the records provided to have been released to bail from Junee Correctional Centre on 14 November 2017 but there was no indication whether he was released with a supply of the medication that he had been prescribed in custody.

39 As detailed below LAK does not appear to have sought the assistance of the community mental health team in Bega during the period that he resided there (from November 2017 to the making of the forensic order in March 2018).

**Contact with mental health services after the making of the forensic order**

40 After the forensic order was made on 22 March 2018 LAK was reviewed by the Community Forensic Mental Health Service in June 2018 (this was primarily for the purpose of the MHRT review, and was scheduled in the context of upcoming MHRT hearing). In this period, LAK was otherwise under care of Bega Valley Mental Health Team (Bega CMHT) after the forensic order was made. The Bega CMHT, as detailed below, were making attempts to contact LAK in April and May 2018, and made personal contact in April and May 2018.

41 From the Bega team's notes (see behind tab 49,) LAK was first referred to them after the making of the forensic order, and it appears that even though LAK had been residing on bail in Bega he was not in contact with the Bega team prior to the making of the forensic order. It is therefore probable that he had not been

receiving any medication since his release on bail. He did receive mental health review while in custody (he was in custody, on remand, in the period 14 June 2017 to his release on bail in November 2017; and the notes from that time in custody indicate that LAK had a mental health review in September 2017 which recorded that he was stable on medication).

42 It appears from the Bega CMT notes that the Community Forensic Mental Health Service contacted them by phone (Sarah Wells):

> "advising requirements and processes of forensic order. To contact with a time for Risk Assessment . Requested that Dr Elliot's forensic psychiatric appointment before their risk assessment" (page 1 tab 49).

43 Notes indicate an appointment with Dr Elliot was booked for 15 May, and with Community Forensic Mental Health Service scheduled to undertake a risk assessment on 6 June, and the MHRT hearing was scheduled (see p2, tab 49). On 29 June, the date of the first review hearing, the MHRT adjourned LAK's matter for further review to 21 September 2018.

44 The role of the Community Forensic Mental Health Service (CFMHS), amongst other matters, is to provide reviews and assessments for the MHRT review process (See tab 40 , p 18 page 14 of MHRT Guidelines :

> "forensic patients on a conditional release order who have a major mental illness are to be reviewed by CFMHS prior to every tribunal review"

45 The role of CFMHS at this point was doing an assessment/review for LAK as a forensic patient in the community and for provision of report to the MHRT at the scheduled MHRT review (the CFMHS review was conducted and their report is in the brief of evidence for the inquest). The role of the CFMHS, in relation to LAK, at that time, was not an active treatment provision role.

46 The MHRT adjourned their review, and a further review by CFMHS was required before the adjourned review date, this appears to have been scheduled for a time in September when LAK was in GROW.

47 No CFMHS review would be required, on reading of the guidelines, when LAK was put on leave from the hospital. (LAK was not discharged to GROW by MHRT - MHRT review was adjourned - he was given leave from Bega Hospital and his status remained that of an inpatient, of Bega Hospital MHU, on leave to GROW, pending tribunal review hearing being arranged.)

**Transition to Bega Community Mental Health team care and supervision**

48 The forensic order was made on 22 March 2018 and Bega CMT undertook a home visit on 23 April and 11 May (p5, tab 49). However as detailed below they were attempting to contact LAK before that date. They were first made aware of the need to supervise LAK when contacted by CFMHS about the forensic order.

49 The report prepared by Chris Groninger, Clinical Nurse Consultant, Bega CMHT (an annexure to Mr Young's statement), sets out a history of the following: being alerted to the forensic order of the Court on 29 March 2018, receiving documents on 3 April, assigning a case manager on 4 April, attempting a home visit on 11 April (LAK was not home) and arranging for an assessment on 18 April which LAK did not attend, phone calls and then a successful home visit on 23 April when an assessment was performed in the presence of Mr Young. A time and date were set to complete that assessment (10 May, attended but LAK was at work), with a psychiatrist appointment for 15 May (which LAK attended with Dr Elliot). Dr Elliot's note indicates "new referral to service" (p13, tab 49) - this confirms that LAK was not previously engaged with Bega team while residing there on bail.

50 On 11 April 2018, Mr Stephen Young, Aboriginal Mental Health Drug and Alcohol clinical leader based at Bega CMHT, received a phone call from Ms Keogh Drug and Alcohol service, Bega CMHT, who noted she had received a referral for LAK on 3 April but did not have any psychiatric assessments or pharmaceutical treatment plan/chart (brief page tab 10 p 2). At that time there was concern that LAK may have relapsed into substance use (cannabis) as he had been in Bega for 2-3 weeks without supervision by Bega Valley Mental

Health Drug and Alcohol service, before the Justice Health referral came through (see statement of Young, tab 10).

51 Mr Young then spent two weeks trying to make contact with LAK via home visits; he was told that LAK was at work. LAK was eventually seen by Mr Young and Ms Keogh on 23 April in a home visit. At the time LAK was noted to be wearing work clothes consistent with being a painter's labourer. LAK advised that he was not taking drugs and wanted to seek forgiveness from the police officer he had assaulted and get a traineeship with the PCYC. He expressed frustration with the forensic order. A mental health assessment was to be conducted. Mr Young described LAK as engaging well with Ms Keogh. (Young statement tab 10)

52 On 11 May 2018 LAK was again seen in a home visit by Ms Keogh, along with Mr Young, where a mental health assessment was conducted (Young, tab 10, p 3). It was noticed that LAK had suffered a deterioration in his mental health, appearing slightly agitated, guarded, with restricted affect and he became suspicious during the assessment. A consultation with psychiatrist Dr Elliot was organised and Mr Young also rang LAK's girlfriend who advised that LAK had been displaying odd bizarre behaviours, making gun signals with his hands and talking to himself and running in front of cars. Mr Young felt that a Form 1 scheduling was indicated. On 15 May 2018 LAK was assessed and scheduled by Dr Elliot to the Bega Hospital Mental Health Unit ("MHU") (see statement of Bizzotto tab 11).

53 Progress notes on admission indicate urine drug screen positive for cannabis (p16, tab 49). Of note, in the GROW material there is a reference to LAK saying that his last consumption of cannabis was on 15 May. This may indicate that LAK's decline in his mental health may have been associated with resumption of cannabis consumption.

**Treatment in Mental health Unit and mental health unit team follow up while on leave to GROW**

54 For the duration of his stay at Bega Hospital LAK was treated by Dr Brendan Smith, psychiatrist (see statement Dr Smith tab 8). Dr Smith concluded that LAK was psychotic, either as a result of drug-induced psychosis or as part of a relapse of his underlying schizophrenia.

55 Dr Smith noted at that time, that LAK's insight was low and he required admission and treatment, both from the context of risk of harm to others and also risk of harm to self, given expression of suicidal thoughts in the past and LAK's current psychotic state.

56 On 17 May 2018 LAK was visited in hospital in the MHU by Mr Young, and again on 21 May, where he presented as much improved.

57 A progress note from 23 May made by Stephen Young (page 57 tab 10) revealed that various crisis accommodation options for LAK when discharged were being explored. On 25 May a multidisciplinary team interview with LAK was held, with two doctors present (p 60 tab 10).

58 LAK initially struggled with his involuntary detention in Bega MHU, but later made significant progress and was allowed staged leave periods (periods off the ward, where he could access the grounds and/or the community). He had periodic recurrences of suicidal ideation mostly precipitated by periods of stress or relationship strain, but there was an overall trend of declining suicidal ideation which appeared to be related to response to medication, drug abstinence and LAK's improving insight into his mental illness including increased insight into the potential for a better, stabler, healthier future.

59 The staff considered that LAK's trajectory could be significantly improved if his drug issues were properly addressed, and mainstream drug and alcohol rehabilitation options were explored, especially as LAK did not like his confinement at the hospital. Oolong House was considered suitable as it was an Aboriginal-specific service located in Nowra. Another service considered

was GROW, a rehabilitation facility in Liverpool, which dealt with people with mental illness and was considered able to link in with local indigenous services.

60 A review of the clinical notes reveals that the team at the Bega MHU had a preference for regional residential rehabilitation units, rather than a big city centre, given LAK's potential vulnerabilities. There were restrictions on some regional centres because of the place restrictions in his forensic order.

61 Within the confines of his Forensic Order, the Bega MHU/SNSWLHD treating team, in particular VMO Psychiatrist Dr Smith, Social Worker Ms Bolton and ACL Mr Young, worked on developing a plan for LAK to be placed in a suitable rehabilitation facility so that he was no longer detained in a locked mental health unit. Significant efforts were made as follows.

62 Ms Bolton (social worker) initially contacted Oolong House at Nowra, which is run by Katungul Aboriginal Corporation and offers culturally appropriate residential rehabilitation therapeutic programs for Aboriginal and Torres Strait people.

63 Ms Bolton also made enquiries with Watershed, a drug and alcohol program in Wollongong and the Kedesh Rehabilitation Centre in Mona Vale. Other facilities, including GROW Community Residential Rehabilitation Centre at West Hoxton were also contacted. VMO Psychiatrist Dr Smith noted that Oolong House was considered suitable for LAK to attend, and that GROW was determined to be another suitable option given their program being oriented towards individuals with mental illness, and their ability to link with local indigenous services. Dr Smith noted that GROW was able to assess LAK several weeks earlier than Oolong House. Following GROW's assessment, LAK was accepted into their residential rehabilitation program. LAK had by then been an inpatient of the MHIU for almost 3 months, and the clinical notes record that he was very keen to leave the MHU.

64 The records, and evidence at the inquest, clearly indicate the treating team considered that Oolong House was advantageous from the point of view of

being culturally safe and appropriate. The Bega team maintained the intention that that if he went to GROW, LAK would be assessed for placement at Oolong House while at GROW, as there was the potentialfor him to transfer programs if he were later accepted into Oolong House and preferred to be there rather than at GROW.

65 From June 2018 LAK was showing a good response to his antipsychotic medication (statement of Bizzotto tab 11). Ms Bolton (social worker) was allocated to working on the accommodation transfer plan.

66 By June 2018 LAK's health had substantially improved. On 8 June 2018, Dr Smith filed a notice of intent to seek conditional release for LAK with the Mental Health Review Tribunal. He wrote:

> Our intention at this time is to find [a] placement for LAK at an appropriate therapeutic environment, whether this is a rehabilitation (drug/alcohol) setting or supported accommodation in the community. These options continue to be explored […].

67 On 13 June 2018 Dr Smith prepared a report for the MHRT noting an improvement in LAK's presentation and suggesting Drug and Alcohol rehabilitation and indigenous specific housing needs:

> A drug and alcohol program that takes into account and targets his specific needs could be highly beneficial for [LAK's] medium and longer-term outcome. […] Our service is currently looking into Indigenous-specific supported housing options that may be suitable longer-term options for LAK to settle into and to allow him to establish himself in society in a healthy fashion.

68 It appears from Dr Ahmed's statement that she provided a second opinion supporting the overall plan for treatment and care, in June 2018, but did not otherwise have much of a role in his care.

69 By 13 June 2018 LAK wanted to leave the unit and Dr Smith thought he was ready for some leave. He noted the discharge options: “looking at Triple Care Farm +/- supported accommodation options following on from this”.

70 On 20 June 2018 Mr Young visited LAK to discuss accommodation and noted a real improvement in his understanding and insight into his illness (p 73 tab 17).

71 By 4 July social worker Ms Bolton is recorded in the progress notes making enquiries about various rehabilitation options in the community. On 5 July the Katungal Aboriginal Corporation Drug and Alcohol team had offered to help with a reference to Oolong House, however this appears to have stalled at the Katungal end, for reasons that are not important, by 11 July. By that date Ms Bolton was making direct attempts to contact Oolong House, leaving messages for staff on 12 and 16 and 17 July and sending a fax request on 12 July

72 On 12 July 2018, Dr Smith prepared LAK’s staged leave management plan. It included stages of leave, early warning signs and coping strategies to manage those early warning signs. Dr Smith’s team had attempted to directly contact LAK’s mother and brother on numerous occasions to tell them about the leave plan.

73 On 13 July 2018, Dr Smith accompanied LAK on his first episode of escorted leave, together with social worker Tracey Bolton and RN Mark Bichard.

74 On 16 July Ms Bolton also made enquiries with GROW that indicated that there may be a bed available, but they would have to confirm. On 17 July Oolong House offered LAK an assessment date of 28 August, with up to two weeks after that for the result of the assessment, and whether or not LAK would be accepted, to be known.

75 Dr Smith’s opinion was that LAK should be granted unescorted leave as soon as possible:

> in the spirit of preparing LAK for the experience of a D+A rehab admission, as well as allowing him to demonstrate his readiness for this type of program with a lower level of supervision.

76 In oral evidence Dr Smith recounted his conclusion that LAK was ready for extended leave from Bega MHIU:

> … He was really in a stable state for a number of weeks leading up to rehab. He had a number of periods of unescorted and escorted leave – all instances went very well.

77 Dr Smith discussed unescorted leave with Dr Ahmed (the unit director/delegate for Dr Bhandari), who agreed and approved unescorted leave for LAK. Dr Smith observed that LAK was "very pleased". Dr Smith's plan at this stage included:

> Liaison with CMHT [Community Mental Health Team] in the area of GROW in order to refer [patient] and seek a community treatment plan for the possible purposes of a forensic CTO as part of his community treatment.

78 On 18 July Mr Young discussed accommodation again with LAK. It was considered desirable to try and have accommodation close to his mother and his girlfriend, possibly Oolong House (p 76 tab 10). LAK was interested in exploring rehabilitation options (p 78). On 23 July the Oolong house intake was chased up (p 79). By 30 July GROW was also being considered (p 81).

79 On 18 July 2018, Dr Smith reviewed LAK with Dr Xu, and a social worker and a nurse. They discussed options for community services, including Oolong House, GROW Facility and CCC Farm. Dr Smith noted:

> The Oolong house assessment is planned for 28/8/18. It would take a further 2/52 to process the assessment. Oolong house is analogous to boarding school. SW will browse Oolong website with LAK later today.

80 On 3 August 2018, Dr Smith and Dr Lemieszek conducted a review with LAK, with Ms Bolton (social worker) also present. At this meeting they explained the concept behind rehabilitation to LAK. LAK expressed some impatience about spending 3 months on the ward, and they reassured him that they were working on getting him into a rehabilitation facility as soon as possible. Dr Lemieszek

was at this stage liaising with GROW to ensure that LAK was on their waiting list.

81 On 2 August LAK had asked student worker Ms Coen about progress with the Oolong House referral. Ms Coen contacted Oolong who confirmed that a phone assessment was booked for 28 August, with notification of the outcome 2-3 weeks later. A progress note made by Ms Bolton dated 3 August identifies that a number of follow-ups with GROW had occurred, seeking the scheduling of an assessment. A note made by Ms Coen on 8 August confirmed that a phone assessment for LAK at GROW was scheduled for 10 August, although GROW's own notes (tab 53 p 110) suggest that the application was approved pending receipt of criminal history records. Ms Coen also made enquiries with Flourish at Tumut for outreach support if LAK returned to Gundagai.

82 On 9 August 2018, Dr Smith attended a multi-disciplinary team meeting regarding LAK. The plan from this meeting was, in part:

> GROW phone appt Friday 10/8 at 11.30am
>
> OOLONG appt for an assessment 28/8 at 2.30pm …

83 On 10 August 2018, LAK was accepted into GROW's drug and alcohol rehabilitation program. Dr Smith noted on review that LAK was "very pleased and happy with the outcome of his assessment." A progress note made on 13 August confirmed that GROW had accepted a referral for LAK and that a bed was available.

84 Clinical Nurse Consultant at Bega (Anita Bizzotto (tab 11) reports that by August 2018 LAK was very keen on the Drug and Alcohol rehabilitation option. He was to go on leave and then have a MHRT review after a month, and he would be transferred to the Liverpool CMHT for care. Progress notes record LAK enquiring about the progress of the GROW referral in August.

85 At a multidisciplinary team meeting on 14 August 2018 Mr Young reiterated his concerns that GROW lacked appropriate provision for cultural and spiritual wellbeing (Young, p 83). At this Multi-Disciplinary team (MDT) meeting on

baLAK the MDT ultimately decided that GROW was appropriate for LAK in the circumstances. Mr Young completed a file note in which he has recorded that at the MDT he reiterated his concerns for GROW services lacking Aboriginal culturally appropriate provisions for Aboriginal cultural and spiritual well-being specifically, further identified that Aboriginal strong spirit is a connection to land, origin, Elders and community, and that if this is not recognised and incorporated into discharge planning LAK will ultimately suffer cultural unwellness.

86 On 15 August 2018, Ms Bolton received a call from a staff member at the MHRT regarding the recommended plan that LAK be provided extended leave from the MHIU at Bega Hospital (i.e. not be formally discharged) to attend a trial period at GROW. Ms Bolton told the MHRT staff member that should LAK attend GROW, her team would refer LAK to the local Community Mental Health Team at Liverpool and ask for their support in linking him in with community based Aboriginal supports and/or programs to ensure that all aspects of his care including his connection to his Aboriginal culture and community were catered for.

87 On 15 August 2018 social worker Ms Bolton's progress note records a conversation with the MHRT staff member, noting the recommended plan for extended leave, a trial of rehabilitation, with a hearing (at MHRT) in one month. The note also records the proposal for support to be offered by the Liverpool Community Mental Health team, while GROW will require 7 days of medication and will arrange an appointment with their doctor, and that the Liverpool team will be asked to ensure that connection to LAK's Aboriginal culture and community was part of his care.

88 On 16 August 2018, Dr Smith and Ms Bolton worked on the plan for LAK to attend GROW. Aside from confirming that a bed would be held for LAK, they also ensured that GROW would support LAK's upcoming assessment with Oolong House. They confirmed that "GROW will assist LAK to be linked in with Aboriginal supports and programs to ensure that the cultural and spiritual requirements for recovery are considered and supported".

89 On 16 August 2018, Dr Smith and Ms Bolton spoke with the Liverpool Community Mental Health Team (CMHT). They requested that an Aboriginal case manager be allocated and were advised that "case manager Dell would provide at a minimum regular liaison with LAK". They also enquired about Aboriginal support services or programs in the community and were advised that Dell "would be able to make appropriate referrals".

90 Approval for the plan, including engagement of an Aboriginal Case Manager at Liverpool CMHT, was received on 17 August 2018. The plan included the following:

- To be seen by his case manager at least twice per week in the first two weeks of his stay at GROW and seen by his case manager at least once per week going forward. …

- LAK is to be referred to Flourish in Gundagai in case he does move to his mother's so that there are supports in place when he arrives.

- Continue the referral process with Oolong Aboriginal Co-Operation drug addiction treatment centre in Nowra NSW (as a backup option for residential drug and alcohol rehabilitation that is indigenous-specific)

91 Bed availability at GROW was confirmed on 16 August. On 17 August LAK was told that the Mental health Unit at Bega would continue to support him during his initial period in rehabilitation and would be in weekly contact. On 20 August 2018, LAK was transferred to GROW.

92 Dr Smith has indicated that ultimately GROW was able to assess LAK earlier than Oolong, but it was intended that Oolong would still be pursued for a placement. The notes suggest that LAK was happy to be accepted by GROW. He was granted unescorted leave (time outside of the MHU without an escort/supervision) on an almost daily basis between 10 and 20 August 2018, and this is recorded as going well. He was then transferred to GROW, on

extended hospital leave. The intention, with MHRT approval, was for LAK to be there on leave from the MHU, for about a month prior to his next MHRT review.

93 The clinical notes/records confirm that LAK himself was pleased that he had been accepted by GROW. LAK was motivated to beat his addiction and to continue to improve his mental health, in preparation for becoming a father.

94 An Oolong House intake assessment for LAK was booked for 29 August 2018. On 6 August 2018, LAK was accepted into GROW. A referral was made to the Liverpool Community Mental Health Team (CMHT) on 17 August 2018. LAK was transported to GROW on 20 August 2018. He remained a patient of SNSWLHD / Bega Hospital, who was technically on “extended leave”.

95 It appears that LAK did not undergo the telephone assessment with Oolong House on 29 August 2018 (despite Ms Bolton’s efforts in arranging for her Social Work Student, Ms Veronica Coen, to contact Grow to ensure that LAK was supported in relation to that call). Ms Coen has recorded that a call to Oolong House confirmed that the assessment was not done but that because LAK's clinical team preferred the option for him to attend Oolong House, she wished to re-refer. An email was sent to Oolong House confirming the above.

96 It is recorded by Ms Coen on 6 September 2018 that LAK stated he that he wanted to stay at GROW because he is "*happy with the programs, work, free time and has connected with the people there*". When Ms Coen asked LAK whether he felt that his cultural needs were being met, he re-affirmed his preference to stay at GROW.

**Transfer to Liverpool CMHT and ongoing Bega team involvement**

97 Dr Nadir Hafiz, psychiatrist, who was employed by NSW Health as a VMO psychiatrist at the Liverpool CMHT at the time, has clarified that whilst the MHRT had addressed correspondence to her on 6 September confirming the upcoming MHRT review on 21 September, the doctor allocated by that team at Liverpool to LAK would be dependent on staff availability at the time. In this

case Dr Khanbai, psychiatrist, had been allocated, with a consultation with LAK scheduled for 14 September 2018.

98 A progress note from 16 August, noted that a referral had been made to the Liverpool CMH Team and that an Aboriginal case manager had been requested. The Community Forensic Mental Health Team had been advised and would be organising to undertake their pre Tribunal hearing assessment when LAK arrived.

99 On 17 August LAK's care was transferred to the Liverpool CMHT, (according to Ms Bizzotto tab 11). This date is backed up by a note referred to by Aboriginal Mental Health worker Delphine Leslie (tab 16). She gave evidence at the inquest confirming her awareness that Terry Campion was regularly seeing LAK and that she considered him a very experienced and able mental health case manager. Delphine was located in a community organisation and had a number of support roles to provide to clients; she was not located within the mental health team – this is further discussed below.

100 Ms Leslie says that she was told of the referral by Mr Patel from the Liverpool CMHT on 20 August. She says she would have been expected to make contact with LAK "once he had settled in" and when it could be arranged. She expected that LAK's newly allocated case manager (Terry Campion) would provide her with further information before she went to meet with LAK.

101 Mr Patel, Registered Nurse, from Liverpool CMHT, says he received the referral from Dr Smith on 20 August and assigned the matter to the case manager, Terry Campion, a clinical nurse specialist, the same day (statement tab 14; see also Vol 5 tab 52 p 12). Mr Patel did not have direct contact with LAK before his death. GROW records (tab 53 p 11) show LAK arriving on 20 August.

102 The Aboriginal Mental Health Worker at Liverpool CMHT, Ms Leslie, apparently was notified about LAK by Mr Patel on 20 August, however from her statement it appears that she was also waiting on a briefing from the allocated case manager, Mr Campion, before going to see LAK.

103 On 24 August Mr Campion rang GROW and subsequently spoke to LAK who said he was doing ok and agreed to a visit on 31 August. Psychiatrist Dr Khanbai was booked in for a 60 minute assessment on 14 September (Vol 5 tab 52 p 13). On 28 August Mr Campion again rang and tried to speak to LAK but he couldn't come to the phone. No acute mental health issues were reported, and LAK had had a good weekend, going up to the Blue Mountains.

104 On 31 August Mr Campion met with LAK at GROW (Vol 5 tab 52 p15) and spent some 45 minutes with him. LAK's initially flat affect loosened up during the interview. Mr Campion apparently encouraged LAK that there were positive outcomes for those who had been unwell and used psychotropic drugs if they stayed away from illicit drugs. LAK was able to discuss safety aspects of his care without appearing overtly uncomfortable. He denied thoughts of self harm. LAK rated his current mood as 8/10 and said it had been as low as 7/10. He spoke of his loss of his sister as the trigger for his previous drug-taking. A further meeting and care plan was scheduled for 4 September.

105 On 4 September Mr Campion visited LAK in GROW in the company of Dr Reid and Sarah from the Community Forensic Mental Health team (the CFMHT would have been reviewing LAK for the purpose of the MHRT hearing). The assessment recorded was that LAK was "currently stable on medication and psycho-social supports".

106 On 5 September 2018 Ms Leslie, had a conversation with the case manager Mr Campion, in which she was advised that LAK was 19 years of age, a forensic patient subject to a Forensic Community Treatment order (at the time he was on leave from Bega MHU) and was advised that LAK suffered from schizophrenia and depression and was grieving his sister's death, and that he had been at GROW for two weeks. She says that the next day (Thursday) she was not able to attend having already been booked to visit clients, the Monday she had rostered off and she understood from Terry that he had visited LAK twice and that he seemed ok and that there was no sense of urgency, so she organised to go and see LAK on Tuesday 11 September.

107 Ms Leslie stated that given the isolation of LAK from his family and his Aboriginal needs, she would not consider GROW to be the most appropriate facility, however she was also aware that there are limited places or facilities available. She said that there should be more funding for places for Aboriginal people.

108 By letter dated 6 September 2018, the MHRT wrote to Dr Nadir Hafiz, Liverpool CMHT, to advise that LAK's next Forensic Community Treatment Order review by the Tribunal was listed for 21 September 2018 at Bega Hospital and via Video link. A psychiatrist report and recently completed risk assessment were to be available.

109 The same letter was sent to Mr Campion. Documents including case manager reports, psychiatrist reports, recent drug screen results, progress notes, any recent correspondence/ reports by Community Forensic Mental Health Service and any recently completed risk assessment were requested to be available. In addition, the Case Manager and Psychiatrist were requested to appear in person.

110 The same letter was sent to LAK. He was advised that he could have legal representation or non-legal representation (support person).

111 On a number of occasions whilst LAK was at GROW, Dr Smith contacted either Mr Campion, or LAK himself, for an update on LAK’s mental health and his general state of mind.

112 A medical officer review was scheduled for 14 September 2018 and an antipsychotic injection was due to be given on 17 September 2018.

**The continuing involvement of the Bega Team**

113 Records indicated Dr Smith’s continuing involvement after LAK’s transfer to GROW

114 On 23 August 2018, Dr Smith spoke on the phone with GROW staff and LAK. Staff informed him that LAK had settled in well. Dr Smith encouraged LAK to engage with GROW and the upcoming assessment for Oolong House:

> reminded him of his Oolong House referral, which was ongoing and for which he had an assessment coming up next week for. I stated that he should continue to engage in treatment at GROW and that once assessed by Oolong, if they accepted him, he could consider this as another option (it would likely be more suitable, as it is a shorter program and indigenous-specific).

115 LAK denied any thoughts of self-harm, harming others, suicide or homicide during the call

116 On 24 August 2018, Dr Smith spoke on the phone with Terry Campion, LAK's CMHT assigned case manager, for an update on his contact with LAK. Dr Smith provided Mr Campion with a brief handover and reminded him that LAK would need a psychiatry review.

117 On 31 August 2018, Dr Smith spoke on the phone again with GROW staff and LAK. Staff stated that LAK was fitting in well with their rehabilitation program. LAK told Dr Smith that he was enjoying the program at GROW and denied thoughts of self- harm. Dr Smith became aware that LAK's scheduled Oolong House assessment had not taken place that past week. In his plan, Dr Smith wrote that Tracey Bolton would chase up Oolong regarding the assessment. He also planned to contact LAK in a week's time.

118 On 6 September 2018, Veronica Coen (a social work student) called GROW and spoke to LAK. When Ms Coen asked if LAK felt his cultural needs were being met at GROW, LAK "reaffirmed his preference to stay at GROW." GROW (brief Tab 9 p 17/18). The note records that a place at Oolong was still being pursued as the clinical team preferred it and it was a shorter stay (the placement in Oolong was four months, the placement in GROW was 12 months). Following this call, Ms Coen called Oolong to confirm that the assessment had not been done. In her note she said that "Writer explained LAK's clinical team prefer Oolong option and wish to re-refer." Ms Coen then spoke to Dr Smith, who said

that he would discuss with LAKthe benefits of the shorter program at Oolong House.

119 On 7 September 2018, Dr Smith attempted to call GROW to speak to LAK. The line was engaged on multiple attempts. When he got through, LAK was unable to talk as he was participating in structured activities. Dr Smith left a message that he would contact LAK later the following week.

**Social stressors other than his forensic status**

120 During LAK's stay at Bega MHU a number of notes record his concerns about his relationship with his girlfriend and what he thought was her pregnancy with their child. They include the following:

- 19/5 wants to tell the love story about her p 417
- g/f abandoned him p 55
- 19/6 advises his g/f is now pregnant p 113
- 21/6 unrealistically has plans to live with g/f mother p 577
- 23/6 stressed out by pregnancy, wants to be there for her (visited by her the previous day p 579)
- saw photo of her on FB out drinking. Stressed out by concerns about baby p 583 (note p 585 refers to her as his "ex")
- 16/7 concerned Forensic Order may prevent him seeing his baby p685
- 19/7 gets phone call that g/f doesn't love him any more (in the days previously he had kissed a fellow patient); says he has learned that his partner has also been unfaithful p705

- 20/7 discloses previous suicide attempt prior to admission, mostly related to conflict with his mother. Depressed about g/f's infidelity p715 Page 716 suicidal ideation of hanging by rope and a tree but no intent (Dr Shu Wen Xu). Whether Dr Smith was made aware of this will be canvassed with him, noting that another psychiatry registrar, Dr Lemieszek, has said in his statement that LAK denied any suicidal thoughts to him during the time he was involved in LAK's care (tab 13).

- 21/7 reports ongoing thoughts of guilt re g/f

- 22/7 distressed by text from his ex g/f and is doubting that the baby is his: pps 728-729; 731

- 6/8 bumps into ex g/f's mother (presumably while he is on leave) and asks if she is pregnant and is told yes. Appears distracted afterwards p228

121 It is noted that while at GROW he was reported to be happy about an ultrasound result for the pregnancy.

122 While at GROW he reportedly became romantically interested in another resident who reportedly rejected his advances. This is detailed below.

**LAK's stay at GROW**

123 GROW is a community-based organisation which describes itself as having a core purpose to help, support and facilitate residents to recover from mental illness and drug and alcohol addiction through a program of mutual help, peer support, personal development, self-actualisation and recovery. Group therapy sessions are supported by residential workers.

124 It is acknowledged that there are a limited number of organisations in NSW that provide residential rehabilitation services, and the competition for beds, and the importance and significance of these services to individuals with mental health and drug and alcohol problems, is known to many in the community.

125 In respect to GROW I refer to the submissions of the legal Counsel for GROW which describe the facility:

> GROW-A dual diagnosis community-based organisation
>
> In the context of the issues for consideration in this inquest it is important to highlight some of the following central features and characteristics of GROW which underpin the various submissions in relation to LAK's time at the West Hoxton facility:
>
> GROW is a dual diagnosis community-based organisation with the core purpose to help, support and facilitate residents to recover from mental illness and drug and alcohol addiction solely through mutual help, peer support and personal development.
>
> GROW is built around residents living together in a secluded and peaceful rural environment to provide structure and routine to regain a sense of control.
>
> A formal referral is required for residents to attend GROW. That referral is usually made from various sources particularly from hospitals and health professionals.
>
> The main focus at GROW is for residents to partake in group therapy session where they are supported by and learn from others in recovery, although these sessions are facilitated by Residential Program Workers (**PRW**) and senior residents.
>
> As the GROW program is centred around peer and community support, staff are not mental health clinicians or medically trained. However, generally speaking, the PRWs at GROW have either completed or are completing Bachelor's or masters level qualifications in the fields of psychology, social work and community justice, in addition to holding further education Diplomas and Certificates in fields such as community service and mental health.
>
> GROW is accredited under the National Standards for Mental Health Services 2010. Most recently in 2021 GROW underwent a new accreditation audit whereby all of GROW's policies and procedures including those at the West Hoxton facility were reviewed and approved.

126 The first 4 weeks at GROW involves a live-in assessment. The criteria for acceptance includes being over 18, on Centrelink or able to self-fund, suffer from a mental health problem and/or drug and alcohol addiction, and have completed detoxification. An intake assessment is also conducted. In this case LAK's intake assessment appears to have been conducted on 10 August 2018 (see tab 53 p 12) based on the information recorded on the first page of the

Intake Form. That date appears to tally with the progress notes of Bega MHU. The GROW records also show a series of documents starting with a "Treatment Outcomes Data Collection Form" dated 21 August 2018 (tab 53 p 16), which appears to have included a brief addiction questionnaire, health questionnaire and a Kessler 10 assessment.

127 The 21 August material also includes a questionnaire described as a suicide screener. Each of these questionnaires is labelled at its foot as "Induction pack", which would appear to indicate that all these documents were completed on 21 August. Whilst the answers that LAK gave appear to be reasonably positive in terms of his outlook (including that he had not had recent thoughts of killing himself), at the point in that document where he is asked about thoughts of suicide, LAK appears to have preferred not to answer a number of questions (the box marked 'prefer not to say' is ticked). At the end of the assessment the interviewer has recorded to refer the client to a 'safety plan'.

128 The induction document also suggests the staff member request permission to organise a specialist mental health assessment as soon as possible, consistent with the rating of moderate risk level. At the end of the document the section setting out what action was then taken has been left incomplete (tab 53 p 28).

129 Although the document is dated 21 August, the case notes from GROW suggest that the induction was completed on 20 August. The author of that case note is recorded as "John/Maria".

130 Mr John Hampton told the inquest about processes at GROW including the then use of the suicide screening tool (that tool is no longer used).

131 Whilst the screening tool is no longer is use, it was applicable at the time LAK resided at GROW, and Counsel for GROW concedes in written submissions that it was clear that questions were not answered responsively by LAK also, but submits that the screening tool was somewhat confusing.

132 The relevant answers appear at question 8 as set out below:

8. Have things been so bad lately that you have thought about killing yourself?
- ☑ Yes
- ☑ No
- ☐ Don't wish to say
- ☐ Did not ask

**If YES is selected at Question 8 the below shadowed questions are to be responded to.**

a. How often do you have thoughts of suicide?
- ☐ Daily
- ☐ Weekly
- ☐ Monthly
- ☑ Don't wish to say
- ☐ Did not ask

b. How long have you been having these thoughts?
- ☐ In the last 2 months
- ☐ 2–6 months ago
- ☐ 6-12 months ago
- ☐ 1-2 years ago
- ☐ More than 2 years ago
- ☑ Don't wish to say
- ☐ Did not ask

c. How intense are these thoughts when they are most severe?
- ☐ Very intense
- ☐ Intense
- ☐ Somewhat intense
- ☐ Not at all Intense
- ☑ Don't wish to say
- ☐ Did not ask

133 The answers provided to questions 8(a)-(c) by LAK are not responsive to the main question in 8 where LAK had ticked "No" to the question whether things had been so bad lately that he had thought about killing himself. The questionnaire only required those sub questions to be answered if the answer to 8 was "yes".

134 However the answers provided should still have prompted further review on the design of the form – it required review if there was an answer of concern. The evidence at the inquest was that there are now a number of changed procedures which would trigger such review by mental health clinicians for any at risk indicators.

135 The case notes do not reveal whether the GROW-associated psychologist at the time, Mr Vijay Kumar, visited LAK during his time at GROW, and witnesses at the inquest did not believe he had done so.

136 On 2 September the GROW records show that LAK had a visit from one of his brothers. It appears likely that the visit of a psychiatrist to LAK at GROW recalled by a staff member was most likely a visit by Mr Campion, CMHT case manager, probably on 5 September.

137 Ms AK, mother of LAK, has recently completed a statement where she sets out her recollection that, following LAK's death, she was at GROW collecting his belongings and spoke to a female staff member who alleged that LAK had been told on 6 September that his girlfriend had aborted the baby. Other evidence appeared to conflict with this having occurred, especially the evidence about the ultrasound, and other evidence of Mr Young at the inquest.

138 A file note made by Mr Patel, from Liverpool CMHT, on 10 September (Vol 5 tab 52 p 23) shows he had a phone conversation with someone called Niki from GROW. Niki reported that Sunday at GROW is an unstructured day. She said that LAK had recently found out the gender of his child (a son) from his girlfriend and was happy with this, however there was some family conflict between him and his [sic] mother in law (this appears to be a reference to his girlfriend's mother). The note says that according to Niki, LAK was coming out of his shell but was feeling down yesterday (9 September). The note suggests that LAK had seen GROW's psychiatrist weekly (this may have been a reference to the CMHT case worker) but had not yet seen the psychologist.

139 Earlier that week the Liverpool CMHT case manager, Mr Campion had seen LAK and reported to Dr Smith on 7 September that LAK seemed mentally well and he had no concerns, although he was somewhat restricted in affect. Dr Smith indicated that LAK would be shy with new people. It does not appear from the material that LAK was evaluated after 5 or 6 September by a clinician or trained health professional, although Dr Smith made several attempts to call LAK on Friday the 7th and eventually briefly spoke to him, but LAK said he was unable to talk, as he was in a structured program. Dr Smith said he'd call back the following week.

140 A GROW residential support worker entry from 6 September suggests there were no concerns with LAK; entries for 7th and 8th September suggest that LAK seemed to avoid interaction with staff but interacted well with residents; on 8 September he responded but didn't seem to want to have a conversation with staff. On Sunday 9 September 2018 LAK died. The cause of his death did not appear to be in issue in these proceedings, however findings are required to be made about the circumstances of his death, and so will be briefly explored in these Reasons for Decision.

**What happened on 9 September 2018?**

141 A resident of GROW, SH NPO told police of his friendship with LAK. He said that on 9 September 2018 he was approached by LAK who asked whether he could get into the maintenance shed. SH asked LAK what he wanted, as at the time they were all knocking down trees and weeds, and LAK stated "I need some rope". SH asked what he wanted it for, and LAK said "to get the bushes out". SH would not give LAK access to the shed. (At the time SH had the access key as he was acting as the team leader and the key was the responsibility given to him by staff within the facility). Straight after LAK spoke to him SH walked to the staff office and spoke to a staff member reporting what LAK had said. He returned and saw LAK walking around the building appearing to be looking for something. SH recalled seeing a box trailer with general rubbish in it, and it also contained two milk crates. The trailer was a place to put general rubbish from around the grounds. SH NPO believed he could recall a rope wrapped around the steel cage of the trailer.

142 SH reported for lunch and he and other residents realised that LAK was not there. People went looking for LAK and began searching the grounds of GROW. It was within five minutes that SH was told by another resident that LAK had hung himself. SH ran to the location and saw LAK already lying on the ground and Dane and a worker by the name of John were giving CPR to LAK. Shortly after ambulance and police arrived. At the inquest SH NPO gave evidence consistent with his statement, and also talked about his grief at what happened to LAK.

143 Statements in the police brief indicate that a paramedic, Mr Lukin, received a call on the 9 September 2018 at 12:57pm to attend a reported hanging, and he went to the GROW community. He and another ambulance officer walked to the back of the property, where LAK was located, having to walk through the bush to get to that location. On arrival he saw a male person providing CPR and could see a rope hanging from a nearby tree. There were other people standing nearby and it appeared the male doing CPR had been doing so for a while. Paramedics took over and worked to resuscitate LAK for about 20 minutes, declaring him deceased at 13.38 pm.

144 The evidence of Ms Orth is that when Mr NPO told her that LAK had asked for a rope, this was 10 minutes before lunch. As she had concerns she went and spoke to Mr Rampton who told her he had spoken to LAK earlier that day and LAK had stated "there's nothing anyone can do to fix it". Ms Orth said she discussed with Mr Rampton that they should try to find LAK, and at 12.28 the first lunch bell rang and they waited to see if LAK came to lunch. When the second bell rang at 12.30 Mr Rampton left to look for LAK. Ms Orth went to search, around 10 minutes into lunch time, and she details how residents started to search also and how they located LAK shortly after. Ms Orth was concerned by LAK's appearance that he may be deceased; Mr Rampton commenced CPR; Ms Orth ran to get face shields and the ambulance arrived soon after she returned with the face shield (to be used for mouth to mouth). She observed ambulance officers giving CPR and using a defibrillator.

145 The evidence indicates that residents and staff went to look for LAK when they noticed him missing at lunch time. LAK had been seen not long before that walking around the grounds. He had appeared to SH Lamber to be down in mood. John Rampton originally drove a vehicle up a dirt road to look for LAK, and on returning was alerted by a resident that LAK had been found. Ms Orth also telephoned him. On his way to the location John dialled 000 – he arrived to see some residents and Ms Orth standing near LAK who had been cut down. He asked whether CPR was commenced, and started to do CPR, continuing this under instruction of triple 000 – he was also assisted by Dane. ambulance arrived and took over. It appears quick action was taken to try to locate LAK,

and also to take him down. CPR was quickly commenced by John Rampton and CPR was maintained until the paramedics arrived and took over. LAK was unfortunately unable to be revived and was pronounced dead at the scene.

146 The evidence supports a conclusion that LAK placed one end of a rope around his neck and the other end around a tree (two metres above) and also stepped up on two milk crates which he placed there. The evidence supports a conclusion that his actions were deliberate. Although LAK was located soon after these actions were taken, because staff and residents were looking for him, he was unable to be revived.

**Cultural safety and Cultural needs**

147 Expert evidence was received from a psychologist, Vanesa Edwige, who is a Ngarabal woman, Chair of the Australian Indigenous Psychologists Association and who has worked with Aboriginal and Torres Strait peoples for much of her career, and understands the impacts of intergenerational trauma.

148 Ms Edwige was asked to address a number of questions in her report, dealing with cultural and risk issues for LAK and the handover process to the CMHT and to GROW. Relevantly, Ms Edwige considered that a culturally safe place for LAK to be, would have other Aboriginal or First Nations residents and/or supports, and be a place that met his cultural needs; that culturally validated tools should be used to assess risk as part of the induction process, with the formality of the Kessler 10 questions being unsuited in her view to help establish rapport and getting an insight into the person's feelings and thoughts; and that an interdisciplinary complex case conference including suitable representatives would have been a preferred method of disseminating information about LAK amongst the services which were to take over his care after he was on leave from Bega hospital.

149 Ms Edwige identified a number of challenges involved in providing suitable care and treatment in the context of a Western medical approach, this is further discussed below.

## Findings

150 In detailing the evidence above, I have made a number of findings as to what occurred with the forensic order, treatment in the community and at GROW, and the circumstances of LAK's death. The above detail records those findings of fact. My findings on the issues, and formal findings of the inquest, follow. The findings on the issues will reflect the detailed summary and findings already made in these Reasons for Decision.

## Submissions of parties on the issues

151 Counsel Assisting made very detailed and thorough submissions on the issues identified, and these were circulated to all parties with a timetable for response. In general terms, Counsel for Dr Smith, and Counsel for the local area health services for Bega and Liverpool, (Southern NSW Local Health District (SNSWLHD) and South Western Sydney Local Health District (SWSLHD) supported the submissions of Counsel Assisting, with additional observations and submissions made. LAK's family also provided submissions on the issues of most concern to members of LAK's family – these are referred to below. All submissions, made by all parties, were carefully considered in making the findings as set out below.

## The position of LAK's family on the issues

152 The position of LAK's family was set out in written submissions provided after the inquest. A moving statement was also read by Ms AK, mother of LAK, at the close of the inquest – this statement made clear that LAK was very loved by family and friends and is dearly missed.

153 In written submissions the family expressed the view that there were many shortcomings in the management of LAK, both at the GROW facility and prior to him entering that facility, and their view is that this contributed to his mental state and infliction of self-harm. The family noted that the Mental Health unit at Bega hospital was considered by Ms Edwards to not be the best place to ensure LAK's cultural safety. In addition the family submit that Mr Young had expressed

concerns that LAK's detention in the high dependency unit (at Bega) might have an adverse impact on his well-being. Mr Young recommended placement in a culturally appropriate facility, being Oolong House. The family noted that there was no place available and so he was referred to GROW. The family submit, relying on Ms Edwards's opinion, that without cultural supports and connections, GROW would not have met LAK's medical or psychological needs, nor resulted in the clinical identification of his deteriorating mental health leading to his suicide.

154 The family also submit that there was a lack of adequate care on transfer from Bega to the GROW facility. The family note the care plan developed by Dr Smith, and despite that care plan, after LAK's transfer to GROW on 20 August 2018, no scheduled appointment with a psychiatrist from the Liverpool Community Health Mental Health Service occurred, the first appointment being scheduled for 14 September 2018, after LAK's death. The family note that whilst there was referral to Aboriginal Mental Health worker, Ms Leslie, her first scheduled appointment was after LAK had passed away. It is further submitted that the rope which LAK utilised should not have been so accessible.

155 The family supports the recommendations contained in Vanessa Edwige's report (paragraph 70 on page 19).

156 In making the findings on each of the issues, as set out below, I have carefully considered the family's position.

157 Whilst I give weight to the family's concerns in relation to the Mental Health Unit at Bega hospital, I note that the limitations of that environment were recognised by the Bega treating team – this was a reason why they worked so hard, as detailed above, and below, to transition LAK out of the Mental Health Unit. There are limited options for acute care of mentally unwell persons, when such persons are seen to be at risk of harm to self or others. In such circumstances, acute inpatient mental health units are of the first step in treatment, if a bed is available. LAK presented as needing inpatient treatment when he was assessed by Dr Elliott. Further, there would be a heightened sense of

responsibility for LAK, and also for the safety of the community, given that he was subject to a forensic mental health order. The ongoing stay in the MHU was in part occasioned by the fact that LAK's forensic order was subject to review by the MHRT and he could only be formally discharged by the MHRT, and not the Bega treating team. This is one of the reasons that ultimately he left the MHU by way of a period of leave, not by formal discharge.

158 In relation to the family's position on the contact of the Liverpool Community Mental Health Team with LAK, this is carefully considered below. In relation to Ms Leslie it is noted, as discussed below, that she was aware that Mr Campion, experienced mental health caseworker, was in touch with LAK during this early period of residency at GROW. She did not perceive an urgency to the situation for this reason, and given her significant caseload at the time and her limited availability, her position may not have been unreasonable, as discussed below. The issue of resourcing, and addressing, First Nations cultural safety in provision of mental health services, is further discussed and examined in the findings set out below.

**Issue 2: The adequacy of the community management of LAK's forensic order/mental health between March 2018 and May 2018**

159 This issue received limited attention at the inquest hearing, as it became clear that any delay in the implementation of community management from March 2018 was largely as a result of the administrative transition, after the finding made at the special hearing on 22 March 2018, including notification by the relevant authorities to the Bega Valley Community Mental Health Service ("BVCMHS"). Prior to the forensic order being made by the District Court, and after LAK's release to bail in November 2017, Community Mental Health engagement was not a requirement of his bail, as detailed above.

160 LAK first came to the attention of the BVCMHS through a referral to its Drug and Alcohol Service by the Mental Health Review Tribunal ("MHRT"), received by mental health clinician and case manager Ms Jaquelyn Keogh received on 3 April 2018. That referral apparently did not include any previous or current psychiatric assessments or current medication chart. The Mental Health

Review Tribunal had in turn requested relevant material from the Wagga Wagga Court Registry on 26 March 2018, which had responded the same day with what material it had to hand.

161 Ms Keogh asked Mr Stephen Young, the BVCMHS Aboriginal Mental Health Drug and Alcohol Clinical Leader, to accompany her on a visit to LAK, to assist in providing a culturally safe provision of service. They attended LAK's home together on 11 April but he wasn't home. They tried to see him over the next 2 weeks; the follow up attempts to see LAK in April are set out above in these Reasons for Decision and he was seen by Ms Keogh and Mr Young on 23 April and 10 May.

162 Th appointment with Dr Elliot psychiatrist was scheduled on 15 May, and Dr Elliot reviewed LAK - Later that same day Dr Elliott received further information from LAK's girlfriend which suggested to Dr Elliott that he had "underestimated the degree [LAK] was unwell this morning". A schedule was completed by Dr Elliott and the same day CMO Dr Tormey agreed with that opinion. LAK was admitted into the Bega Hospital Mental Health Unit ("Bega MHU") as an involuntary patient. LAK was initially reported as agitated and threatening to escape but later settled.

163 In all the circumstances, I am satisfied that the Bega CMHT was actively trying to contact LAK and was not able to establish contact on some occasions due to LAK being unavailable. I also note that during those initial contacts LAK appeared to be going well, and the deterioration observed on 15 May appears to have occurred rather suddenly.

164 It is unfortunate at the time of LAK's release on bail there appears to have been no identification that mental health support might be required to minimise LAK's risk. The reason for this is unclear however there is no indication that the courts were advised of any mental health information until the time of the making of the forensic patient order. This might be because it appears that there was no diagnosis or treatment of LAK until his period on remand, and until the material was obtained for the District Court proceedings. This reflects the reality that

LAK was a teenager who had not yet been fully assessed and treated for his mental health.

165 I am not of the view that there was inappropriate management of LAK in the community by the Bega CMHT, rather I am of the view that the evidence supports the conclusion that members of that team actively engaged with LAK and tried to care for him, and acted in his best interests. I am also of the view that appropriate regard was had to supporting his cultural needs and cultural safety through the active engagement of Mr Young, in the first contacts by the Bega Team, and this engagement by Mr Young continued after those first contacts, throughout LAK's admission to Bega MHU, despite Mr Young's very busy role. Mr Young was in Dr Smith's view "geographically stretched", and resource stretched, in trying to provide for all his clients, yet he was very active in supporting LAK, as was Dr Smith.

166 The comments of the expert psychologist, Vanessa Edwige, at paragraphs [13]-[14] of her report, are also noted, suggesting that the delay between the assessment on 23 April and 10 May, might be due to the complexities and challenges facing clinicians in rural/regional community health settings

**Issue 3: The adequacy of the planning, management and support of LAK's transition to residential rehabilitation**

167 As detailed above, Bega MHU faced a difficult challenge. LAK had been involuntarily detained for about six weeks when there was sufficient improvement to start considering alternatives to in-patient care. The situation was complicated by LAK's status as a forensic patient - he was subject to MHRT oversight, and so could not be discharged without MHRT review. That review was scheduled for September 2018. In addition, LAK had been identified as being in need of drug and alcohol rehabilitation, to help him avoid future deterioration leading to involuntary scheduling and/or possible social conflict, and to promote his mental health. The link between illicit drug use and the criminal charge which led to his forensic order was a matter which required consideration, and clinicians necessarily needed to plan for management of risk

of illicit drug use (and consequent potential for mental health deterioration) as part of LAK's mental health treatment and recovery.

168 Because rehabilitation places are in limited supply, when a bed became available there was a need to take up the place, or the offer would lapse with no guarantee of a rehabilitation bed being available when LAK was later able to be discharged by the MHRT – the MHRT review could not be brought forward. This situation of scarcity of rehabilitation places, and inability to obtain the MHRT review on short notice, meant that LAK's entry into rehabilitation had to be as an in-patient of Bega Hospital who was on leave. The existing conditions in the MHRT adjournment period allowed for leave at the discretion of the medical superintendent and therefore leave to GROW was within permissible leave options pending the upcoming MHRT review.

169 It was considered by the Bega MHU that it was in LAK's best interests to be out of detention, and out of the MHU, and it was LAK's understandable wish to leave the MHU. Mr Young was most concerned that LAK go to a culturally appropriate rehabilitation facility and in the 14 August 2018 meeting reiterated that concern.

170 I am satisfied on the evidence overall in this matter, including the evidence of Ms Bolton and Dr Smith, as supported by contemporaneous notes in the Bega MHU clinical files, that the Bega MHU team shared Mr Young's view that a culturally appropriate facility was the best option, and it remained, as at 6 September 2018, an option that the team still actively pursued, via placement at Oolong House. However, as a matter of practicality, so long as that option was not immediately available, the team had to make a difficult decision whether to grant him leave to GROW or whether to keep LAK in detention. This decision was being made at a time when their clinical views were that he should no longer be involuntarily detained in a MHU given the improvement in his mental health. The evidence supports the conclusion that it was appropriate for LAK to be transferred to a less restrictive form of care, such as residential rehabilitation, where he could appropriately continue his mental health recovery and which might also benefit him in the long term.

171 The evidence established that Dr Smith's plan for LAK's transition did focus on the culturally important aspects of LAK's care, his clinical notes support this finding, as does Dr Smith's oral evidence at the inquest – Dr Smith spend some six hours making various phone calls at the time of LAK's transfer to GROW to ensure community team follow up as well as Aboriginal cultural support. It was Dr Smith's expectation that an Aboriginal mental health worker would be able to engage with LAK in a timely manner, and would arrange for LAK to link with Aboriginal community supports in the area where GROW was located, and that the case manager would be seeing LAK initially twice weekly. Regrettably, the timeliness of that overall engagement did not occur as planned. In particular, the opportunity for a timely cultural engagement with LAK was missed, through a combination of very considerable resource pressures on Ms Leslie as the only available Aboriginal mental health worker at the time, (and she was not located with the CMHT but was located in a separate organisation and had considerable additional commitments). Ms Leslie had an understandable reassurance, through Mr Campion, that LAK appeared well at GROW, and saw no urgency, and she made an appointment to see LAK at GROW, as detailed above. I find that no criticism is warranted or justified given the evidence.

172 There was a belief that LAK was well, stable and looking forward to moving into and adjusting to life at GROW. It appears from the evidence of a fellow resident, SH (and whose full name is protected by a non-publication order), that LAK was also under a belief that he would remain at GROW for twelve months, when the Bega MHU team were still pursuing a much shorter stay at Oolong. It appears that the idea of a 12 month stay was oppressive for LAK, and this is understandable for a 19 year old.

173 It is also likely that LAK's potential vulnerability was not fully appreciated at the time. This is explored further below.

**Issue 3(i) - How could a 'dual diagnosis' rehabilitation facility such as GROW be better supported in addressing the mental health, cultural and therapeutic**

**needs of forensic patients and other clients who are receiving treatment from the Community Mental Health teams?**

174 Exploration of this issue at the inquest hearing principally involved input from Aaron Beatus, GROW's current National Manager, and Mr Patrick Parker, Director Community Mental Health and Partnerships, South Western Sydney Local Health District ("SWSLHD"). That evidence was supplemented by evidence from Delphine Leslie, Aboriginal Mental Health Worker from the SWSLHD.

175 Putting to one side the initiatives that GROW has already implemented, examination of this issue included: (i) what community-based resources are presently available in the area(s) close to GROW facilities; (ii) what SWSLHD resources are available; (iii) whether exchange of information could be improved between GROW and an involved Community Mental Health team; and (iv) whether mental health assessments conducted by GROW could be improved in culturally-specific ways.

176 Another area that arose was the extent to which training in culturally-specific needs of Aboriginal people could be offered to GROW staff via programs run through the SWSLHD, or whether the online components of that training were Health Education and Training Institute ("HETI") based only, which prevented external access.

177 Mr Parker's statement dated 20 May 2022, which became an exhibit at hearing, was supplemented by oral evidence. He clarified that an individual who would be best placed to talk to GROW, in the future, from SWSLHD, about the needs of an Aboriginal resident (who was also subject to SWSLHD Community Mental Health supervision) was the Care Navigator, a senior Aboriginal Mental Health Clinician. The role of this clinician is to support clinical teams in the development of culturally informed mental health and social and emotional wellbeing assessment and treatment approaches. Unfortunately, the position is presently unfilled but it is funded and intended to be filled.

178 Mr Beatus identified that only two people identifying as Aboriginal had passed through GROW since he had started there.

179 Mr Parker also identified that additional funding has been received this past financial year for an Aboriginal Mental Health and Emotional Wellbeing Peer Support Worker, and the SSWSLHD now has 19 full time equivalent Aboriginal mental health staff. This not only included the above positions but a position of an Aboriginal Mental Health Co-ordinator, whose position description (annexure B to Mr Parker's statement) appears to identify a role which would conceivably include liaison with an organisation such as GROW and who co-ordinates the Aboriginal Mental Health Training Program.

180 Similar increased numbers of positions for full-time Aboriginal mental health workers in the Southern NSW Local Health District ("SNSWLHD") were identified in the statement of Damien Eggleton, District Director Mental Health Alcohol and Other Drugs, SNSWLHD, at paragraph [11] , increased from one full time position and four trainees, to 11.6 full time positions.

181 Counsel Assisting submitted that the Coroner may wish to encourage dialogue between Mr Parker and GROW about other training resources that might be available or in a modified form, for GROW staff, although noted that the inquest did not receive any evidence about whether funding arrangements or policies might practically operate to inhibit that process. Given that limitation, Counsel Assisting submitted the Coroner may wish to consider a recommendation in terms simply encouraging GROW and SWSLHD to liaise with each other to identify possible education opportunities for GROW staff in Aboriginal cultural safety and awareness training.

182 As to community-based resources, the evidence from Ms Leslie was that there is very little in the way of presently available Elders or uncles or aunts who might be able to perform a community-based role in visits to GROW. However, Mr Beatus identified in his evidence that one new initiative for Aboriginal residents of GROW is to transport them to meetings and activities run by the

Marrin Weejali Aboriginal Corporation Drug and Alcohol service based near Picton.

183 Another matter that was explored was the extent to which the progress of an Aboriginal resident at GROW (who was also under Community Mental Health Team supervision), as recorded in GROW progress notes and assessments, might be made available to SWSLHD Community Mental Health representatives such as a case manager and an Aboriginal Mental Health Worker. This would have to be subject to the consent of the resident/SWSLHD client to such information sharing. In his oral evidence, Mr Beatus was happy to embrace such a concept, if it meant that a resident's mental health and progress at GROW was able to be monitored via sharing of notes and assessments as well as by case manager visits.

**Issue 3(ii) - How can Community Mental Health effectively meet these needs, including with respect to hand over and ongoing monitoring; and what are the current difficulties for community mental health in being able to provide for their clients in residential rehabilitation settings?**

184 This issue raises three discrete questions concerning (i) transition, namely ongoing monitoring by the Liverpool CMHT, (ii) handover, namely from Bega MHU to Liverpool CMHT, and (iii) the difficulties for a CMHT where the client is resident in a rehabilitation setting.

185 From the evidence at the hearing, it appears that the difficulties facing the Liverpool CMHT not only involved travelling to GROW to meet LAK, but also included not being aware of the result of LAK's initial suicide screening assessment at GROW. This was potentially important as his disinclination to answer some questions may have prompted an earlier arrangement by Mr Campion to see him. Without Mr Campion being available to give evidence to assist this inquest, it is difficult to be more certain about this aspect.

186 One difficulty was that Ms Leslie was the only available Aboriginal Mental Health worker at that time, which no doubt placed a real strain on her ability to meet with LAK earlier in time, while the case manager was in early contact. The evidence suggests that LAK should have been seen in the first week after his

transition to GROW, by both the case manager and Ms Leslie, to help fulfil his cultural needs, give him reassurance. It was an expectation of the Bega MHU team that this would occur at least via the case manager, as per Dr Smith's notes, twice weekly in the first two weeks.

187 Transition is important, in terms of engagement with LAK, the time of transition from a secure, highly-monitored environment, where an individual may have developed a rapport with the clinicians, to a much more unstructured and unsupervised environment, is a time of vulnerability and potential risk – during the inquests clinicians agreed in their oral evidence that this was so.

188 Transition periods create difficulties in monitoring any mental state changes. The evidence at the inquest of increased resourcing of Aboriginal Mental Health workers in SWSLHD, both in numbers and in co-ordination, clearly will assist to meet this challenge.

189 The importance of handover cannot be understated, given the transition of care issues identified above. In this case, Dr Smith had very clear and culturally focused plans for handover and review, as evidenced by his notes and his intention to continue to pursue the Oolong House option even after placement at GROW.

190 Mr Campion did have 2 telephone contacts with LAK before his face to face visit on 31 August. LAK apparently presented as well but initially flat in affect, rating his mood as 8/10, in that 31 August meeting with Mr Campion. It is unclear whether his being a young Aboriginal male, away from family and community, was well understood. Certainly, there appears to have been nothing raised by Mr Campion subsequently, to Ms Leslie, which concerned her, based on her recollection. This aspect of vulnerability was emphasised by the Court's appointed expert psychologist, Vanessa Edwige, in her report and in her evidence.

191 In particular, Ms Edwige identified (at paragraph [28] of her report) the risk factors and the potential protective factors for Aboriginal and Torres Strait

Islander people, the cultural safety issues where no-one of Aboriginal background was with LAK at GROW (paragraph [39]), and in her oral evidence reinforced the need to recognise the vulnerability of a young man who would be subject both to the effects of intergenerational trauma and also his own lived trauma.

192 Ultimately, Ms Edwige set out at paragraph [51] of her report, her opinion that an interdisciplinary complex case meeting would have been a preferred method to disseminate information among stakeholders. From her oral evidence it appears that what Ms Edwige envisaged as best practice would have included not only clinicians from the two transitioning teams but also family and a GROW representative, and would have included an Aboriginal mental health worker.

193 This concept (of a complex case meeting) was not rejected by Mr Parker, who understandably identified the practical difficulties with co-ordinating everyone, but also accepted that the increasing use of Zoom, MS Teams and other forms of video link-up had certainly improved the prospects of such meetings taking place. The idea that LAK's matter, when considered with the benefit of hindsight, could be regarded as a complex case did not appear to be strongly resisted, but at the same time it was frankly acknowledged that there are complexities with many patients/clients in the community mental health setting.

194 What emerges from Ms Edwige's evidence is a concern that the complexity of an Aboriginal mental health client's case is inherent in the matters that she set out in her report, over and above the complexities that may be encountered with other, non-Aboriginal, mental health clients on a regular basis. In short, it requires that additional attention be given to it as a critical factor in the handover process.

195 An increasing awareness among non-Aboriginal clinicians about the critical importance of understanding the cultural, spiritual, social and emotional wellbeing needs of an Aboriginal client, both through education and policy, is vital and the initiatives set out at paragraphs [15]-[18] of Mr Parker's statement

would appear to be important changes that have been introduced or implemented, some or all since LAK's death, in the SWSLHD.

196 Both the Local Health Districts involved in this matter have set in train initiatives directed at promoting an understanding and awareness of these complexities, and I find that this is an important step in the pathway to better clinical outcomes for Aboriginal and Torres Strait Islander mental health patients/clients. In circumstances where the handover remains a critical area of care, involving as it does transition from a team familiar with a client to a team unfamiliar with the client (and the client with the team), focus of attention on cultural needs and cultural safety, in this step of the process of care, should be given a high priority.

**Issue 3(iii) - How can residential rehabilitation facilities be supported to accept into their programs/residences, higher risk residents such as those who are mentally ill and/or subject to forensic patient orders?**

197 At the hearing Mr Young spoke eloquently of his involvement with LAK and concerns about the need for culturally appropriate supports for a young Aboriginal male such as LAK, particularly where he was away from family and community. It was clear to those present at the hearing that Mr Young had been committed to pursuing LAK's best interests.

198 The expert Ms Edwige acknowledged the work that Mr Young had done, in her report at paragraphs [29]-[30].

199 The evidence from GROW was to the effect that it can no longer accept patients subject to forensic orders or community treatment orders (CTO), given the limitations around clinical care that GROW has. While it is clear from the evidence that organisations like GROW are both desperately needed and vital, it is also clear that they do not and cannot function (particularly given limited funding) as some sort of community equivalent of a mental health unit. However GROW does still accept other residents under the care of a CMHT (when not subject to an order).

200 What is apparent from the evidence is that, largely through the efforts of Mr Beatus with the support of his organisation, significant improvements have been made to practice at GROW, with a view to being better equipped to accept and support mentally ill residents, including those with CMHT engagement.

201 The following changes made at GROW, and concessions made in oral evidence by Mr Beatus deserve listing, as they also identify what the corresponding shortcomings may have been at the time that LAK was accepted into GROW.

- All GROW's forms have been "revisited" in the past four years;

- A similar suicide screener is still used at intake, however if a resident is assessed as a moderate or high risk then Mr Beatus must be informed and he would make sure the case worker was also informed. Mr Beatus is required to notify the psychologist Mr Kumar of moderate and high risk assessment results;

- Viraj Kumar (the visiting psychologist) is also informed of a resident's assessed risk but is not shown the screening document. Mr Beatus agreed that this showing the document to the psychologist was a good idea and he would look at providing that information in the future;

- If a resident is assessed as high risk, GROW notifies COMHET, seeking assistance as soon as possible;

- All staff are trained specifically on the G06 (suicide screener) form;

- Lack of answers by the resident on the form (including preferring not to answer a question) are now seen as a red flag;

- If a resident is assessed as high risk GROW places them on a safety contract which means they have to be observed every 30 minutes (staff have to tick a box to confirm they have seen the resident; staff carry

computer tablets to enable field observations to be made and recorded), and if the risk remains high an ambulance is contacted to attend;

- There is no automatic alert system to flag that an observation has been missed, but the case files are audited internally every 3 months;

- There is a big gap in the hospital system for residents who may express suicidal ideation; his experience was that emergency departments may be reluctant to admit them;

- If escalation is required to inform Mr Beatus of an at risk resident, staff know to contact him (presumably via email). Any case notes would be attached to the email;

- When asked - if a box hadn't been checked in a suicide screening assessment, then how would Mr Beatus know the follow up had been actioned - he stated that "Everything goes into the progress notes". It appears it is a GROW requirement to make a note in the progress notes of the issue and its escalation;

- Any resident is able to see Mr Kumar, the psychologist;

- GROW performs a monthly audit/check for safety risks, and this includes an audit of all the grounds;

- When Mr Beatus started at GROW he made sure that it is now a staff member, and not a resident, who has the keys to the maintenance shed;

- Managers are currently going through cultural diversity training and this will then be "passed on" to all staff;

- He'd be happy to accept help from the SWSLHD with diversity training;

- The Hoxton Park GROW facility now has an Aboriginal residential program worker on staff, and hopes to hire another Aboriginal staff member;

- GROW has formed co-operative arrangements with the Aboriginal Medical Service (based in Redfern) and the Marrin Weejali Aboriginal Corporation Drug and Alcohol Service;

- GROW now engage with the AMS and Marrin Weejali before an Aboriginal or Torres Strait Islander resident arrives;

- GROW takes residents to these external services (AMS and Marrin Weejali) so they can participate in therapeutic and support services provided by those organisations which are culturally specific;

- GROW doesn't use the K10 (Kessler 10 screening toll) any more but it would be willing to use the K5 (or K6) if that is more culturally acceptable (it is noted that the scoring of the K5 is explained in Exhibit 6);

- GROW now maintains staff training records;

- GROW recognises country, and performs welcome to country at physical meetings, but not in their literature. Mr Beatus would be happy to review this;

- GROW would need more funding to accept forensic patients;

- All staff receive first aid training;

- GROW now has a defibrillator onsite, extra resuscitation masks have been obtained and staff all now wear a lanyard which enables them to make an emergency notification to the head office;

- LAK's death was the only suicide to occur at GROW;

- Progress notes for residents are a lot more thorough now than they were in 2018;

- GROW is accredited under the Mental Health Services National Standard;

- An external audit is conducted annually of GROW (it was not clarified whether this is a financial audit or a case file audit or both);

- GROW would lose funding if it doesn't meet KPIs; and

- GROW is planning to open other facilities in Victoria and the Northern Territory, and consequently is keen to learn as much as it can about culturally safe practices.

In addition to these processes:

(i) Presently all intake/phone assessment documents are sent to all staff before the resident arrives which highlight the resident's mental health status, past records, associated risks, background, nationality, medication charts etc.

(ii) Currently staff undergo extensive training on suicide screeners and the protocols around completing these. Staff training records are kept on file. Any high-risk suicide screeners are sent to the National Manager immediately for review and the resident is then put on a safety contract and closely monitored. External supports are called if required.

(iii) Currently all GROW managerial staff have undergone detailed Inclusion Training specifically around working with Aboriginal and Torres Strait Islanders. All training records are kept on file. The training will, in the future, be rolled out to all Grow staff.

**Issue 4- Whether the self-harm/suicide risk was adequately understood, monitored and addressed by the relevant staff at GROW after LAK's move there**

202 I agree with the submission of Counsel Assisting, that the evidence discloses that LAK was not prepared to answer some questions in the suicide screening assessment which applied at intake at GROW at that time - this should have raised a concern and a referral to his CMHT caseworker, and at the least a pro-active attempt to speak with Mr Campion and bring it to his attention. That no record of what action was taken, if any, is made on the relevant induction forms, means we cannot know whether such follow up occurred but it appears that it may not have. This lack of follow up from the screening tool was an issue needing addressing – and the changes made at GROW appear to have done so (evidence of Mr Beatus at inquest hearing).

203 In response GROW submits that the answers on the form were confusing (this is discussed above) and but also submits that the Suicide Screener was only a very preliminary screening tool utilised by non-clinicians at GROW, at the early stage of LAK's presentation to the facility.

204 The evidence establishes that both immediately prior, and during his time at GROW, suicide risk assessments was undertaken by qualified mental health clinicians including by Dr Brendan Smith (psychiatrist) and also the forensic mental health clinicians. Mr Campion was also aware of LAK's mental health state and any risk issues. GROW also submitted that there was a lack of clarity as to the meaning of the answers given by LAK given some confusion in the completion of the form. Whilst that might be so, the answers that were given should have prompted further review of LAK and any risk he may present.

205 In response to Counsel Assisting's submission that the answers on the suicide screening risk assessment tool were a lost opportunity to address risk of self harm that LAK may present, GROW submitted that during his time at GROW LAK was receiving regular and ongoing clinical support and risk screening and monitoring from the various agencies. It was submitted that these reviews and assessments superseded the Suicide Screener performed at GROW and were

undertaken by qualified clinicians. In particular, the submissions refer to the following evidence:

> On 20 August 2018, prior to his arrival at GROW:
> A Mental Health Inpatient Unit Risk Re-Assessment was conducted by RN Waterford who recorded risks of suicide, self-harm, harm to others and vulnerability as "Not a foreseeable risk"; and
> The Mental Health Inpatient Unit Leave Plan completed by Dr Smith recordedlow risk of suicide/self-harm.
>
> LAK arrived at GROW in the afternoon of 20 August 2018. Induction was completedafter LAK attended GROW Group. It is recorded that LAK was settling to the program unpacking and assigned to resident 2169 as his shadow..
>
> On 24 August 2018:
> Mr Campion spoke with LAK. It is recorded that LAK stated that he was doing ok and agreed for Mr Campion to visit him at GROW on 31 August at 11am. Assessment by Mr Campion noted that LAK sounded stable during the conversation. Mr Campion also spoke with Dr Smith to provide an update. A 1-hour consultation with the new psychiatrist Dr Khanbai arranged for 14 September at 1400 hours.
>
> On 28 August 2018, Mr Campion rang GROW to speak to LAK. LAK ultimately spoke to Mr Campion during which he advised that he had a good weekend. LAK stated that they went up to the Blue Mountains over the weekend. No acute mental health issues were reported or recorded by Mr Campion.
>
> On 31 August 2018:
> Dr Smith consulted with LAK as part of his weekly contact and monitoring. Dr Smith specifically considered LAK's risk profile and whether it had changed as a result of his time at GROW. Following his consultation, Dr Smith prepared a report for the Tribunal of the same date in which he recordedinter alia the following:
>
> > "LAK was accepted to the GROW residential rehabilitation on 10th August for ongoing treatment of his drug and alcohol addiction. We believe that this is a very appropriate placement forLAK at this time. We believe that he is suitable to be placed in this lesser restrictive environment at this time. Over the last month priorto his transfer, LAK was able to engage in escorted leave with staff on a nearly daily basis and was having unescorted leave off of the unit prior to his transfer to GROW, which occurred on 20th August. Since the above date, LAK has settled in well to GROW. He has had review by his community case manager and weekly phone contact with myself with a view to ensuring a stable ongoing mentalstate. As of today, LAK has

> been adapting well to the new environment of GROW. He has begun to engage well in their rehabilitation program and is becoming more comfortable with the staff and other residents there. There is no evidence of any deterioration in his mental state, nor any evidence that his risk profile has increased. He has not expressed any intent to abscond or disengage from the rehabilitation admission at any point thus far.

Mr Campion visited LAK at GROW. The consultation took 45 minutes. LAK considered his lowest mood at GROW as 7/10 and mood at consultation as 8/10. LAK was able to discuss the safety aspects of his care without appearing overly uncomfortable**.** LAK specifically denied TOSH or TOHTO (Threat of self-harm and threat of harm to others). Next review at GROW was to be 4 September 2018 with a Care plan to be developed with him. Appointment with Dr Khanbai 1400 hours on 14 September was confirmed.

On 4 September 2018, Mr Campion attended GROW with Dr Paul Reid (Forensic Psychiatrist) and Ms Sarah Wells (Forensic Psychologist) from the Forensic Mental Health Services. It was a 45-minute consultation. It is recorded that LAK tolerated the interview quite well. It was recorded that LAK was being compliant with medication, supported by GROW, Bega Hospital MH inpatient, Liverpool Community Mental Health Services, NSW Forensic Mental Health Services as well as his family to some extent. LAK denied any current psychotic symptoms and that "his story" showed very little deviation from his interview with his CCC last week. It was recorded that LAK was currently stable on medication.

On 5 September 2018, Dr Smith as LAK's treating clinician for a forensic patient completed a Forensic Patient Review Notice of Intent in support of LAK's treating team's request for the Tribunal to consider his conditional release. The Notice recorded amongst various matters, the following:

> "Details of order sought: We are seeking conditional release. We believe that LAK is ready to be placed in the community. He has been engaging well in residential drug and alcohol treatment on trial… his current risk factors are low, he is engaging well in the community mental health treatment and would be very manageable with a community treatment order in place."

On 7 September 2018, Dr Smith attempted to contact LAK. Dr Smith contacted Mr Campion. Discussed that if LAK's behaviour had plateaued there was some benefit in ceasing the Epilim. It was agreed that there was little clinical benefit to Mr Campion to set up blood test for Epilim levels at this time. Forensic CTO on 21 September was confirmed with care plan with LAK to be developed. Mr Campion was to follow up with LAK, facilitate LAK's attendance at Gladesville for the hearing and to update "Niki" at GROW. Referral sent to Delphine Leslie -Aboriginal Mental Health Worker (Vol 5, Tab 52, p2 .

206 In summary GROW submits that given the extent of external clinical and professional support and monitoring that LAK received during his time at GROW (referring essentially to the clinical reviews by Dr Smith and Mr Campion), the Suicide Screener had a limited role in LAK's management at GROW.

207 GROW submits that the evidence supports a conclusion that the deterioration in LAK's mental state was acute and sudden, and related to a personal issue with another resident which arose on 9 September. It is submitted that conclusion arises from the daily records of GROW which did not report any mental health issues of concern, and the evidence of SH, who knew LAK well as he spent a lot of time with him.

208 Counsel Assisting also submits that it was not apparent from the evidence that LAK's mood deteriorated over time: it is not evident from the progress notes, although they do note his lack of interaction with staff. SH, a resident of GROW at the time, gave evidence that LAK engaged well with the other residents, had a good sense of humour and got on well with people. SH stated he really liked LAK and they got on well. SH told the inquest that LAK only appeared down on the last day, which prompted SH to ask a staff member, Mr Rampton, to speak to LAK.

209 While the inquest hearing did not have the benefit of hearing from all the senior staff at GROW at the time, it did hear from Ms Orth. She accepted that LAK had been quiet and did not engage much with staff.

210 I find that prior to the day of his death, there were no indicators of deterioration in LAK's mental health and mood over the time he was in GROW, for the reasons above detailed – the evidence does not support a finding of such deterioration. Therefore neither GROW staff, nor clinical staff of the CMHT or Dr Smith, had any warning signs that a self harm risk was present or increased.

211 The evidence indicated that it is unlikely that staff actively understood and appreciated that LAK may have been more vulnerable to the risk of suicide, by virtue of his risk factors including his lived trauma and intergenerational trauma, in combination with the absence of protective factors. It was also apparent from the Report on Major Incident (Exhibit 3F) prepared after LAK's death, that contact with LAK's mother Ms AK may have elicited information about potential risk factors that she disclosed to the investigator, namely that LAK had previously attempted suicide after rejection by a female he had been emotionally interested in.

212 The evidence indicates that Mr Campion had been to interview LAK and make his own, clinically trained, assessment after the suicide screening by GROW. It could not therefore be said that steps were not taken to clinically evaluate LAK's emotional state, but it must also be recognised that LAK did not know Mr Campion and unsurprisingly appears to have been reserved at that first and second meeting. That Dr Smith had continued to involve himself by phone calls to check on LAK was an important further clinical intervention.

213 I note the changes made by GROW to the induction of residents, and record keeping by more detailed progress notes, in addition to increased methods of of monitoring and assessing and supporting residents at risk, are all improvements made after LAK's death. Those improvements are set out above.

**ISSUE 5 - What prompted LAK to take his own life on 9 September 2018?**

214 It is never really possible to know another person's state of mind and intentions, nor to construct these from the known surrounding circumstances. One cannot really know what caused LAK to take his own life.

215 On the available evidence, LAK appeared to be 'down' on the day of his death, but not prior, and only appeared to be focused on active planning late in the morning when he asked about finding some rope.

216 In searching for a possible explanation, there can be immediate environmental precipitants, and there is also a wider social and cultural background as identified by Ms Edwige. Environmental factors may act as triggers and be causative of an apparently impulsive act, but the background matters underscore why a person in LAK's position may be more vulnerable to going through with the act, rather than finding ways to resist that impulse.

217 As to environmental precipitants, there were two possible triggers. The first, articulated in the statement of LAK's mother, Ms AK, was a suggestion that LAK may have been told by his ex-girlfriend's mother, as recently as on 9 September 2018, that his girlfriend had chosen to have an abortion. The potential significance of that suggestion cannot be understated, as it is clear from the progress notes that LAK believed the child was his and was looking forward to the prospect of fatherhood. The information, however, was second hand, in that it was Ms AK's recollection that she was told this by a female worker at GROW some weeks after LAK's death; there is no suggestion that LAK ever told this directly to his mother and no other evidence that he said something like that to someone at GROW.

218 Further, that this was said to LAK was not borne out by the progress notes from GROW or from the recollection of one of the senior workers at GROW at the time, Ms Orth. Ms Orth's recollection was to the contrary. She recalled that about a week or so before LAK's death, another female worker, Maria, reported to her in LAK's presence that he had just had good news, that he was going to have a son. This was in the context of receiving news of the ultrasound results. Ms Orth remembered that there was a celebration. A contemporaneous note dated 23 August records that LAK had asked staff if he could "call his ex partner because she had an ultrasound today to find out the sex of the baby".

219 Ms Orth appeared to have a good recall of events. She said that important news would be recorded in the notes, whether positive or negative. It is entirely consistent with that progress note that LAK would subsequently learn of the baby's sex following the ultrasound, and Mr Young confirmed in evidence that the ex-partner had given birth to a son who he thought resembled LAK.

220 On the evidence the information about an abortion may be an instance of someone providing to Ms AK incorrect or mistaken information. That the assertion (of the worker to Ms AK) may have been mistaken is reinforced by a note found in the Liverpool CMHT notes, made by Mr Patel on 10 September 2018. It records that he spoke to a 'Niki' from GROW, who advised that LAK had recently found out the gender of his baby (a son) and was happy with this, but there was conflict with the girlfriend's mother. Further, it notes that LAK "was feeling down yesterday" (the day of his death). On all the evidence I am not persuaded that LAK was told about an abortion.

221 There is another explanation for any distress LAK was experiencing – the evidence that on the morning of his death, LAK had given a note or notes to a female resident which it was understood expressed affection for her, but that the resident had indicated in some way that the affection or interest was not reciprocated (this evidence was given by Ms Orth). Given the timing of that interaction by the female resident, with the timing of LAK suddenly appearing 'down', as observed by the resident SH, this seems to be a far more likely precipitant for LAK. LAK reportedly said that day to Mr Rampton that there was nothing he could help him with. The evidence indicates that relationships between residents were against GROW rules, so that may well have been a reason LAK would not discuss how he felt with Mr Rampton.

222 In all the circumstances, the evidence about being rejected by another resident that day, could constitute an environmental precipitant for LAK to feel down and decide to take his own life. If this was so, his death could be seen to be the result of an impulsive act, but on a background of vulnerability. The need to recognise that vulnerability, and tom ensure the cultural safety of First Nations persons receiving mental health treatment, has been demonstrated by the evidence in this inquest.

**Issue 6 - What was the emergency response procedure at GROW, and how did this operate/function when LAK disappeared on 9 September 2018; and have there been changes implemented since then?**

223 It was clear that the emergency procedure at GROW was somewhat chaotic, in terms of having a settled process for someone to call an ambulance (Ms Orth did not initially call one although Mr Rampton did so). Improvements have been made to processes, including provision of extra masks, a defibrillator and emergency contact lanyards that staff wear, together with monthly risk checks.

224 There was on the evidence no basis for finding that the emergency actions taken, or not taken, contributed to the death of LAK.

225 That a rope may have been available to LAK is a matter of concern. The monthly risk checks now conducted at GROW are an important safeguard. GROW is a farm type setting, and it was the case at the time that all sharps were secured in a locked shed, however the rope appears to have been located by LAK on a trailer/utility used to collect rubbish at this time when weeds were being cleared. The evidence of Mr Beatus indicates such a rope would now be identified as a risk and stored away.

**ISSUE 7 - How would the cultural needs of First Nations Peoples receiving mental health treatment be better addressed?**

226 This question raises a related issue, namely whether the relevant organisations involved in LAK's care were aware that LAK had cultural needs that required addressing.

227 The material produced by Bega Hospital evidences that the staff of the MHU were acutely aware that LAK had significant cultural needs that were required to be addressed. So much is evident from the progress note recording the plan for handover to Liverpool CMHT . It included:

- GROW and Liverpool CMHT were to organise referrals for LAK to Aboriginal supports in his new community;

- Bega MHU had requested an Aboriginal Case Manager and had been advised that “Dell” (Ms Leslie) would be available to “provide regular liaisons with LAK at GROW”;

- LAK was to be referred to Flourish at Gundagai in case he moved there (the application form notes a requirement for “Aboriginal supports”) ; and

- The placement at Oolong was to continue to be pursued, notwithstanding LAK’s placement at GROW.

228 It was also clear from Dr Smith’s oral evidence that he understood that LAK had cultural needs and that he expected the plan would address those. As noted earlier in these Reasons for Decision, the placement at Oolong was still pursued by the team – this is evident from subsequent Bega MHU progress notes, and the notes made on 6 September by student social worker Ms Coen , who recorded that she spoke to LAK that day by phone and “asked if he felt his cultural needs were being met. LAK reaffirmed his preference to stay at GROW”. Ms Coen then rang Oolong House and explained that they wished to re-refer; subsequently she spoke to Dr Smith who said he would ring LAK and explain the benefits of a shorter stay at Oolong.

229 There have been significant changes, set out earlier in these reasons for decision, introduced by the relevant Local Health Districts, and the engagement that GROW now has with the AMS and Marrin Weejali, and its employment of an Aboriginal residential program worker. These changes go a considerable way to addressing the issue of meeting cultural needs, but additional and regular engagement with an Aboriginal Mental Health Worker and engagement with other Aboriginal community-based organisations and Elders would act as significant further supports.

230 It is noted that the Department of Health policies being implemented by the Area Health Services are for Aboriginal Mental Health workers to be embedded within mainstream services and mental health teams – this can accelerate cultural change within an organisation and more quickly improve the cultural

awareness possessed by non Indigenous clinicians. The current policies to improve cultural safety in delivery of mental health services, and staffing changes made to improve service provision to First Nations clients of Area Health Services were detailed in statements and evidence provided by Mr Parker and Mr Eggleton.

231 In relation to those with the dual diagnosis of substance abuse and mental health issues, an effective way to ensure that cultural needs are addressed would be the availability of more residential rehabilitation facilities, like Oolong House, provided by First Nations organisations for First Nations clients. This is a resource/funding-based issue which is beyond the scope of this inquest to address.

232 It is important to identify that the recommendations of the Special Commission of Inquiry into crystal methamphetamine and other amphetamine-type stimulants, at recommendations 58 and 63, specifically identified a funding need for health services with local specialist drug treatment services that are culturally respectful, culturally competent and culturally safe, and for Aboriginal-controlled health services meeting the needs of clients affected by drug use. I refer also to the related recommendations, numbers 62, 64 and 65. I note the response to the recommendations of the Inquiry and still under consideration by government.

233 I find it relevant to extract from Ms Edwige's report in detail. Ms Edwige states in relation to cultural safety:

> 'Cultural safety has been defined by the Australian Health Practitioner regulationAgency as follows; Cultural safety is determined by Aboriginal and Torres Straitislander individuals, families and communities.
>
> > Culturally safe practice is the ongoing critical reflection of health practitioner knowledge, skills, attitudes, practicing behaviours and power differentials in delivering safe, accessible and responsive healthcare free of racism.
>
> To ensure culturally safe and respectful practice, health practitioners must;

1) Acknowledge colonization and systemic racism, social, cultural, behavioural andeconomic factors which impact individual and community health.;
2) Acknowledge and address individual racism, their own biases, assumptions stereotypes and prejudices and provide care that is holistic, free of bias and racism;
3) Recognize the importance of self-determined decision making, partnership andcollaboration in health care which is driven by the individual, family and community;

4) Foster a safe working environment through leadership to support the rights anddignity of Aboriginal and Torres Strait Islander people and colleagues.

This approach to cultural safety in health care service provision aligns with a holisticconceptualization of health and wellbeing as outlined above, and the central place ofculture and self-determination both in individual and community wellbeing'.

Mr. Young's medium to long term planning for Mr. LAK's discharge was in my opinion in line with Aboriginal concepts of social and emotional wellbeing and the principles for promoting optimal outcomes. Concerns were raised by Mr. Young pertaining to the impact on Mr. LAK's social and emotional wellbeing of being detained in the high dependency unit and the impact this restricted environment washaving on his social and emotional well-being.

> 'The Aboriginal concept of health is holistic, encompassing mental health and physical, cultural and spiritual health. Land is central to wellbeing. This holistic concept does not merely refer to the "whole body" but in fact is steeped in the harmonized inter-relations which constitute cultural well-being. These inter-relating factors van be categorized largely as spiritual, environmental, ideological, political, social, economic, mental and physical. Crucially, it must be understood that when theharmony of these inter-relations is disrupted, Aboriginal ill health will persist'. *(Edwige, V and Gray, P (2021) Significance of culture to wellbeing, healing and rehabilitation. Bugmy Bar Book Project.*
> *https://www.publicdefenders.nsw.gov.au/Documents/significance-of-culture-2021.pdf)*

> 'The SEWB model acknowledges the multiple and interrelated social, cultural, historical and political determinants of Indigenous mental health and wellbeing. Thedeterminants impact individuals differently at different transition points across the life course. They include risk factors associated with marginalization, exclusion, forced removal from Family and Country, assimilation, racism and discrimination. These determinants also include protective factors such as active engagement in cultural practices related to Country and community self-determination associated with a sense of connection to Country and kin for individual and collective identity. These unique cultural protective factors are a source of strength and resilience for Indigenous communities. Programs and services that strengthen Indigenous self-determination and governance, support traditional cultural practices, and enhancethese protective factors are crucial to Indigenous SEWB'.

( *Edwige, V and Gray, P (2021) Significance of culture to wellbeing, healing and rehabilitation. Bugmy Bar Book Project. https://www.publicdefenders.nsw.gov.au/Documents/significance-of-culture-2021.pdf)*

234 Ms Ewidge also observed:

> Mr. Young, in my opinion sought to refer Mr. LAK to a culturally appropriate drug and alcohol rehabilitation centre being Oolong House. Mr. young expressed concerns that GROW drug and alcohol rehabilitation service was not culturally appropriate.
>
> It is my opinion, that Mr. Young made significant efforts to ensure that Mr. LAK's cultural needs were being met and that his rehabilitation plan was in line with our concept of social and emotional wellbeing. As the Aboriginal Clinical Lead, Mr. Young's opinions and recommendations should have been acknowledged and efforts to implement his plans to ensure cultural safety should have been considered. Mr. Young in my opinion, was the cultural expert in this team and his advice and opinions warranted thoughtful respect and acknowledgement…..
>
> …. In my opinion there needs to be a paradigm shift from 'working on Aboriginal and Torres Strait islander people to working with Aboriginal and Torres Strait Islander people and that the ethnocentric 'expertise' of mainstream mental health services can no longer negate Aboriginal and Torres Strait Islander concepts of social and emotional wellbeing and healing that have assisted us maintaining resilience and survival across widespread adverse life events over several generations'. *(Dudgeon. P, Milroy, H and Walker, R (2014) Walking Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice. Telethon Institute for Child Health Research)*

235 Ms Edwige recommended:

> Culturally appropriate Aboriginal community controlled treatment and healing programs and facilities be considered as a primary referral source for Aboriginal clients to ensure culturally appropriate healing practices are maintained to build resilience, enhance positive cultural identities and maintain connectedness to community. 'The Bringing Them Home report (1997) emphasised the need for culturally appropriate services and programs to address the social and emotional wellbeing of Aboriginal and Torres Strait Islander people. Since then, there has beensignificant research into the ways in which connection to culture and involvement incultural activities has the capacity to promote resilience and promote healing: Protective attributes – some of which (such as the continuing strength of kinship systems and the maintenance of connection to spiritual traditions, ancestry, country and community) can be seen to being unique to Indigenous people – have enabled many people to transcend painful and personal histories. Healing refers to recovery from the psychological and physical impacts of trauma and explains healing as a spiritual process that

> includes addictions recovery, therapeutic change and cultural renewal. Healing is holistic and involves physical, social, emotional, mental, environmental and spiritual wellbeing. Programs which incorporate these elements build strength in identity, enhance cultural resilience and aid in the recovery from past traumas in a culturally safe way'*. (Human Rights Commission (1997) Bringing Them Home Report Chapter 11 The Effects | Bringing Them Home (humanrights.gov.au)*

236 I have extracted from Ms Edwige's report because of its relevance to the issues raised in this inquest. I note that the legal representatives for LAK's family endorsed her recommendations in the written submissions they provided.

237 I agree with Ms Ewidge's opinion that Mr Young made significant efforts to ensure that Mr. Atkinson's cultural needs were being met and that his rehabilitation plan was in line with First Nations' concept of social and emotional wellbeing. I do note that Dr Smith appeared to respect and value Mr Young's role in supporting LAK. That Dr Smith would listen and engage with cultural concerns was noted by My Young in his evidence at the inquest. Dr Smith observed that Mr Young was geographically stretched – resourcing was and continues to be an issue. The evidence from the Department of Health during the inquest indicates significant steps are being made to better staff LHDs with First Nations health workers and to promote cultural safety. It is early days in the process but I must find that progress has been made, and there is a demonstrated commitment to better resource health services, and some additional resources have already been provided.

238 There is a need for resourcing of drug and alcohol rehabilitation centres to be promoted, as greater access to culturally safe rehabilitation centres could then be provided to First Nations peoples.

239 Ms Edwide's report also notes the impact upon LAK of being detained in the high dependency unit of Bega Hospital – that this may have been detrimental to his well being. I find that the treating team at Bega Hospital, including Dr Smith, were appropriately concerned about this, and faced a complex situation in formulating a discharge plan, so LAK could leave the unit, because LAK was a forensic patient. I find that the Bega team in seeking to discharge LAK to a

community rehabilitation unit were motivated to act in LAK's best interests and do what was best for his recovery and well being.

240 In relation to LAK being in the MHU this arose from an assessment that he was unwell and needing treatment, and he also then faced the issue of breach proceedings for the breach of his forensic patient order.

**Determination of the statutory findings required under s. 81 of the Coroners Act 2009, namely: the identity of the deceased, and the date, place, manner and cause of death**

241 I make the following formal findings pursuant to s81 of the Act.

**Identity**

242 The identity of the deceased is LAK. I note the evidence in the brief of confirmation of identity by fingerprints, and I also note he was identified at the time by GROW residents who knew LAK.

**Place and time of death**

243 LAK died between the hours of 12.00pm and 12.54pm on 9 September 2018 at GROW residential facility in Hoxton Park NSW.

244 In relation to the time LAK's death occurred, I note the evidence that ambulance officers declared life extinct at 1.38pm, and Ms Orth's statement identifying that SH reported to her that LAK was asking about a rope, at 12.20pm. From SH's evidence it appears that he made the report as soon as he could.

**Cause of death**

245 Having regard to all the evidence as to events on the day of death, and the findings at autopsy as recorded in the report of the forensic pathologist, I find the cause of death is hanging. I note that the injuries observed by the forensic pathologist were consistent with hanging and with the ligature (rope) found to have been used in the hanging. I note there were no inconsistent or suspicious

injuries. I also note that no illicit drugs, prescription drugs of abuse or alcohol were found on toxicological examination.

**Manner Of Death**

246 I have considered the history of mental health symptoms and prior suicidal ideation which is in evidence. I have considered the evidence that LAK was reportedly 'down' in his mood on the day of his death, and that he asked for a rope.

247 I note the circumstances included that LAK was found with the rope around his neck, and the rope was anchored to a tree approximately two metres above the ground. There were two stacked milk crates next to the tree. Emergency services were contacted, Mr Rampton commenced CPR as soon as he could, and CPR instructions were given over the phone by emergency services, and when ambulance officers arrived they continued CPR, but LAK was unable to be revived. Police reported no suspicious circumstances and no evidence of foul play, and the pathologist noted no inconsistent or suspicious injuries.

248 Whilst there is no suicide note or other evidence of specific suicidal intention, the evidence as to LAK's actions, in the act of hanging himself, support the conclusion that it was an intentional act.

249 I also note the suggestions arising from the clinical notes that LAK was vulnerable to downturn in mood where there were problems in his personal relationships (one of these is recorded during the Bega admission where he was distressed at reported behaviour by his girlfriend). I note also the evidence that he may have been distressed on the day of his death by a rejection by a female resident. It is consistent with other evidence that this perceived rejection may have given him a downturn in his mood which may have influenced his actions.

250 The clinical notes record that he found being subject to a forensic order to be frustrating. It must be acknowledged that LAK was a teenager, away from family and community, and in mental health recovery. In addition, it would have been

difficult for a young person, to come to terms with the requirement of 12 months of residing in a residential rehabilitation facility (the co-resident SH gave evidence that this troubled LAK). There were therefore several potential stressors, that may have impacted his mood on the day. He had a background of having previously experienced suicidal thoughts (as detailed in clinical assessments and notes). Given all these factors I am satisfied that the deliberate actions of hanging were taken by LAK with the intention to end his own life.

251 I am satisfied on the evidence, for reasons detailed, that it is established on the balance of probabilities, that the manner of death was suicide.

**Possible recommendations under s. 82 Coroners Act 2009**

252 The following suggested recommendations are proposed by Counsel Assisting:

To both SWSLHD and GROW:

- That SWSLHD and GROW liaise with each other to identify possible education opportunities for GROW staff in Aboriginal cultural safety and awareness.

To GROW:

- To formalise an internal policy requiring that relevant GROW staff familiarise themselves with a resident's medical and related records, including mental health status and associated risk and protective factors, on each resident's admission (subject to obtaining the relevant resident's written consent for such access);

- To formalise an internal policy setting out the requirements for completion of the suicide screening assessment, including recording the result in the resident's progress notes, notifying the manager in writing immediately of any result which is assessed as 'high risk', and setting out the monitoring and further notification requirements including

observations and escalation to COMHET or NSW ambulance as required/indicated;

- Subject to resident consent, to permit GROW's visiting psychologist to have access to the results of and copies of suicide screening assessments and progress notes for a resident consulting with that psychologist;

- To liaise with the relevant Local Health District ("LHD") and to formulate a GROW policy permitting, with resident consent, the sharing of information in suicide screening assessments and resident progress notes with a case manager and other mental health workers from the LHD's Community Mental Health Team who are also involved in that resident's care; and

- To formalise a policy offering guidance to GROW staff on understanding the cultural needs, cultural safety and social and emotional wellbeing of an Aboriginal or Torres Strait Islander resident and the protective and risk factors that they may have.

253 Noting the evidence in this inquest as to changes made since LAK's death, by the LHDs and GROW, then I am not of the view that I should make the recommendations suggested by Counsel Assisting. I note the evidence of Mr Parker and Mr Eggleton as to an increased focus on provision of cultural safety, and greater resourcing, in mental health service provision to First Nations clients/consumers.

254 I also note the reform of processes at GROW since the death of LAK which will significantly increase that facility's ability to provide for residents of First Nations background – the commitment GROW has made to transporting First Nations residents to specialist First Nations services, for treatment and support, is a crucial improvement. The improvements to screening processes for new residents and risk minimisation processes for residents, is also a significant reform of processes which will allow GROW to better identify and manage risks

of self harm for their residents, who will continue to include those with mental health vulnerabilities. The evidence indicates that change has already been made by GROW, in accordance with proposed recommendations, as set out earlier in these Reasons for Decision.

255 I note that GROW does not object to the proposed recommendation by Counsel Assisting, but has observed that the changes made since LAK's death are significant. I am of the view given those changes, and the evidence of continuing commitment to improvement by GROW evidenced in this inquest, that a specific recommendation is not required. As to liaising for education opportunities, I encourage this be pursued informally, but given the lack of examination in this inquest of how this would work, I decline to make a recommendation.

256 I am also of the view that the evidence in this inquest, from the area health services, as detailed above, indicates significant commitment towards increasing the number of Aboriginal staff members in mental health teams, and increasing cultural safety for First Nations Peoples in delivery of mental health services. Noting the demonstrated changes (increased staff numbers and specific policies to promote change) which have occurred since LAK's death, and noting the commitment to such improvements which was in evidence in this inquest, then no formal recommendations for change by the area health services, or to policies of the Department of Health, are made.

257 However, there is an inescapable conclusion arising from this inquest that there is need to consider provision of First Nations residential rehabilitation centres, for culturally safe treatment of those needing support with substance abuse as well as mental health treatment. I also observe that the lack of options to access such services in regional areas appears also to arise from the reality that the Bega team had difficulty locating regional services for LAK, although this was clearly the Bega treating teams' preference. For all of these reasons, I will make recommendation 1 as set out below.

**Recommendation 1**

258 That the Minister for Health forward these Reasons for Decision to those in government who are responsible for considering the government response to the Special Commission of Inquiry into Crystal Methamphetamine and other Amphetamine-type Stimulants (the ICE inquiry) – to further inform the consideration of the recommendations of the ICE Inquiry, and specifically recommendations 58 and 63 of that Inquiry:.

> Recommendation 58 That the NSW Government partner with Aboriginal communities and Aboriginal community controlled health services to urgently develop and to significantly increase the availability of local specialist drug treatment services that are culturally respectful, culturally competent and culturally safe to meet the unique needs of Aboriginal people.
>
> Recommendation 63 That the NSW Government provide new specific funding and support to primary care Aboriginal community-controlled health services to build service capacity and staff skills to meet the needs of clients and communities affected by drug use.

259 I also observe the findings of this inquest are relevant to recommendations 59, 64 and 65 of the ICE Inquiry:

> Recommendation 59 That in implementing Recommendation 2 from the 2018 report of the *NSW Parliamentary Inquiry into the provision of drug rehabilitation services in regional, rural and remote NSW*, which recommends in part that the NSW Government significantly increase funding to drug and alcohol-related health services, the NSW Government ensure that the provision of specific services for Aboriginal people meets the unique needs of Aboriginal people.
>
> Recommendation 64 That the NSW Government enhance existing strategies to increase and retain the number of Aboriginal people working in agencies and organisations that provide support and treatment to Aboriginal people affected by AOD [alcohol and other drugs], including by implementing the following:
> • scholarships for Aboriginal Health Workers to train in AOD treatment
> • Recommendation 11 of the *2017 NSW Parliamentary Inquiry into the provision of drug rehabilitation services in regional, rural and remote NSW*, that 'the NSW Government investigate the efficacy of establishing a scheme to establish a full-time local Aboriginal trainee position alongside every skilled position recruited in areas with a significant Aboriginal population'.
>
> Recommendation 65 That the NSW Government ensure that staff of all agencies provide services and care to Aboriginal people that are culturally respectful, culturally competent and culturally safe.

260 In making recommendation 1, I note that the recommendations of the ICE Inquiry are under consideration by government, and those recommendations go to address some of the matters raised in this inquest – and for these reasons I make no further recommendations.

**Observation**

261 It is a conclusion arising from the evidence that two aspects of LAK's situation may have felt overwhelming for LAK, as a teenager, at the beginning of life as a young adult, and one who was in the early stages of diagnosis and treatment for mental health issues. The first aspect was being subject to the restrictions of a forensic patient order, with its complexities and duration uncertainties. This would always be difficult for a person, but those difficulties could only have been intensified by LAK's status at a teenager in initial stages of mental health diagnosis and treatment. The second was that LAK clearly found the concept of a 12 month residential rehabilitation program daunting (this arises from Shane's evidence). The combined effect of the forensic order and the prospect of lengthy residential rehabilitation may have caused LAK to perhaps feel he had little choice or control over his future.

262 I cannot and do not criticise the operation of a forensic patient order – such orders are to address the safety of the community as well as the safety of the person subject to the order, and it cannot be overlooked that a person (the police officer) was harmed by NPO during a psychotic episode, and this led to the making of the order.

263 However, in an inquest examining the circumstances of LAK's death, it is evident that there were constraints on his choices and opportunities imposed by the circumstances of the order and also by his mental health and drug rehabilitation needs. It is possible that such constraints may have also contributed to his mood.

## A note about the non-publication order

264 During the inquest an interim non-publication order in accordance with s 75(2) of the Act was made prohibiting publication of LAK's name anything tending to identify him [and his family members]. The family of LAK, during the inquest hearing, indicated their position that they did not seek for the non-publication order to continue. However I note the provisions of s75(5) and s75(6) of the Act:

> 75(5) If a finding is made in an inquest to the effect that the death of a person was self-inflicted, a report of the proceedings (or any part of the proceedings) must not be published after the finding unless (and to the extent that) the coroner holding the inquest makes an order permitting the publication of the report.
> 75 (6) A coroner may make an order under subsection (5) only if the coroner is of the opinion that it is desirable in the public interest to permit a report of the proceedings (or part of the proceedings) of the inquest to be published.

265 Given Recommendation (1) of this inquest may cause these Reasons for Decision to be considered by government, as part of its consideration of response to the recommendations of the ICE Inquiry, this may involve potentially wider publication of the Reasons for Decision. Given this potential wider publication, I am of the view (considering the provisions of s75(5) and (6) above) *that the non-publication order is required*. Accordingly, the published version of these Reasons for Decision will anonymise LAK's name and those of his family members..

## In Closing

266 I acknowledge and express my gratitude to Counsel Assisting, Mr Peter Aitken, and the instructing solicitor from Crown Solicitors Office, Mr Paul Armstrong, for their assistance both before and during the inquest. I also thank the investigating Police Officers, and in particular the Officer in Charge, Constable Rachel Chetwertak, for her work in the Police investigation and compiling the evidence for the inquest.

267 On behalf of the Coroners Court of New South Wales, I offer my sincere and respectful condolences to LAK's family.

268 I close this inquest.

Magistrate Carolyn Huntsman

Deputy State Coroner

Coroners Court of New South Wales