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Committee Secretary
Mental Health Select Committee
Parliament House
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Submission for the inquiry into the opportunities to improve mental health outcomes for Queenslanders.

Please find following details of my son's treatment and death due the treatment received at Wattle Mental Health Unit at Robina.

- Nathaniel was 17 years old when he began to take some drugs possibly acid.
- He became angry punching holes in walls.
- He started to self-harm to punish himself for his behaviour, but he was not suicidal
- One day he started smashing plates, after an argument with me he smashed a bottle and came for me and my boyfriend and then he tried to turn it on himself my boyfriend managed to pin him down and we called to police.
- Ambulance and police arrived, and he was taken that night to a mental unit at Gold Coast Hospital? and placed under a treatment authority, I had no idea what this meant at the time.
- He was then transferred to a mental health unit at Robina Hospital and was transferred to the Wattle unit at Robina hospital the next day.
- We were able to visit Nathaniel in his room at the Wattle unit the first night, the room was bleak with blank walls and no colour, it was very depressing to be in, it was the only time we were allowed into his room.
- I was asked to have a conversation with someone by a ward person, they asked if I wanted to sign up for a university research program, this happened on my first visit and many times after that, but I refused to take part in it always.
- While I was extremely emotional and not thinking straight, I believe I was made to sign something, but I am not sure what it was.
- Not long after his stay he was given the first antipsychotic drug in oral form, he was OK and a bit calmer, as it was mild, but I noticed that he became vacant.
- After a while we had a few home visits and he was fine, he was trying to avoid tobacco and caffeine as the doctors advised him to do.
- They then switched him to another oral medication, and after that they administered a depot injection of another antipsychotic medication.
- On his first visit home after the depot injection, he ran off and was found in a park with an extension cord to hang himself.

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- I was involved in a review with the doctors, this was via zoom, I could not see the people's faces that were talking. At this meeting I agreed to keep him there hesitantly, but I was concerned with the medication they were giving him, I was scared because when I hugged Nathaniel, I felt his heart beating out of his chest.
- He had another home visit just after he was given another depot injection of antipsychotic medication, at this visit he waited until I nodded off to sleep and tried to stab himself in his throat, his younger 16-year brother found him, and we called the ambulance who didn't arrive for around 30 minutes my son had to hold a towel to his throat to stop the bleeding. He was rushed to hospital and was in ICU.
- He was returned to the wattle Unit a woman that came in and said "I am sorry, I feel we have failed you; I don't think we gave you enough medication.
- There was a few home visits after this in which I was very scared, one time I was at my Aunt's house at Southport where he ran out while we were not looking, we called the police and they found him at the light rail station and returned him to the Wattle Unit, another visit I took him to Pacific fair and bought him lunch which he attempted to run off again, a security guard held him while the ambulance arrived to take him back to the hospital. After one of these outings Nathaniel told me the doctors kept asking him if the "voices" told him to do things and after they kept asking, he just gave in and said they did.
- After a few weeks they arranged another home visit, just before again they gave him a depot injection of antipsychotic medication, this medication made him pace constantly for 12 hours at home, the psychiatrist said a possible side effect of this medication was restless legs. Around 12.30am I had just nodded off to sleep on the lounge, Nathaniel ran out of the door barefoot, his brother chased him but was unable to run on the pebbles he came back to get his shoes and alert me, we all went out looking for him and called the police. It was not until the next morning when the foreman arrived on the worksite that they found him, they think he climbed to the roof and jumped off, the coroner advised he died of multiple fractures.
- During his I called "Ryan's rule" 3 times, after one of the times he still given medication without a review, a hearing was set up for 9th December which together with Nathaniel we tried to bring this forward unsuccessful. I believe the hospital should have not given my son any more drugs, they should have waited until all drugs were out of his system.
- I want changes to the mental health system, so no other children will be treated in this way and their families are not sentenced to a lifetime of grief.