CORONERS ACT, 1975 AS AMENDED

SOUTH  *AUSTRALIA*

FINDING OF INQUEST

An Inquest taken on behalf of our Sovereign Lady the Queen at Adelaide in the State of South Australia, on the 6th, 7th and 8th day of October 2001 and the 3rd day of January 2002, before Wayne Cromwell Chivell, a Coroner for the said State, concerning the death of Wayne Mark Thomson.

I, the said Coroner, find that, Wayne Mark Thomson aged 47 years, late of 42/469 Portrush Road, Glenside, South Australia, died at Glenside on the 14th day of February 2000 as a result of neck compression due to hanging. I find that the circumstances of the death were as follows:

1. Introduction

1.1. At about 7:00pm on Monday, 14 February 2000, two Mormon missionaries, Richard Arkins and Stephen McConkie, were driving north along Portrush Road at Glenside when they saw a man hanging by a rope tied to the second floor balcony of a block of flats on the western side of Portrush Road. (Exhibit C5a).

1.2. An ambulance was called but the man had been dead for up to an hour, according to the ambulance officer (Exhibit C6a, p1).

1.3. The police officer who attended, Constable M S Cawthorne, stated in his report that there were 'no signs of violence or intravenous drug use, at this time it would appear that the deceased died due to self-induced asphyxiation'. (Exhibit C6a, p4). Detective Senior Constable Johnson L Fry who attended the scene at about 7:25pm that evening, agreed with Mr Cawthorne's conclusions. (Exhibit C7a, p2).

1.4. The deceased was later identified by a friend as Wayne Mark Thomson of unit 42, 469 Portrush Road, Glenside. (Exhibit C1a). The police said that it appeared that Mr Thomson had no living relatives. (Exhibit C6a, p7).

1.5. It became apparent to the investigating officers that Mr Thomson had attempted to get help for his psychiatric condition, and his suicidal feelings in particular, on several occasions in the few days leading up to his death. These attempts included:

- A visit to Dr Barrow, a General Practitioner, on 11 February 2001;
- A telephone call to Eastern Assessment and Crisis Intervention Service ('EACIS') at 10:45am on 13 February 2000;
- An attendance at the Royal Adelaide Hospital ('RAH') at 12:00 noon on 13 February 2000;
- A visit from two EACIS workers at 2:30pm on 13 February 2000.

1.6. Despite these attempts, Mr Thomson received no effective treatment which may have avoided his suicide. This inquest examined how that may have occurred.

2. Medical and psychiatric history

2.1. Very little is known of Mr Thomson's history, medical or otherwise. Since the inquest, counsel assisting me contacted Dr Anthony Newcombe, consultant psychiatrist, personally. He advised that he saw Mr Thomson during 1999, the last occasion being 17 November 1999, three months before he died.

2.2. Dr Newcombe confirmed that Mr Thomson came from Sydney, and had been unable to get work. He suffered a chronic low grade depressive illness for which he was prescribed anti-depressants. He also had an anti-social personality, was unhappy about his accommodation and the fact that he had Hepatitis C, and he was angry generally and with the police in particular.

2.3. Dr Newcombe said that he made many suggestions to Mr Thomson about dealing with some of these issues, but Mr Thomson did not take them up.

2.4. Mr Thomson had been a patient at AllCare Medical Centre at Fullarton since January 1999, when he presented complaining of anxiety and depression, and had been prescribed Prozac and Valium (see the case record, Exhibit C8).

2.5. Entries in the AllCare practice casenotes include an entry on 26 April 1999 by Dr C Angas:

> 'says anxiety can be such that feels he will commit suicide but won't say it so he doesn't get committed.'
>
> (Exhibit C8)

2.6. The Royal Adelaide Hospital record (Exhibit C9a) also contains a reference to a consultation in the Department of Gastrointestinal Medicine in September 1997 on referral from a Dr Aisatullin, a General Practitioner on North Terrace, Adelaide.

3. Recent contacts with Mr Thomson

3.1. Visit to Dr Barrow, Friday 11 February 2000

Mr Thomson visited Dr Barrow on 11 February 2000 at the AllCare Medical Centre at Fullarton. Dr Barrow's notes of the consultation are as follows:

> 'On Prozac 20mg / mane 28 and 5 rps (repeats)
> Itchy skin reaction settling slowly – cause still unclear'
> (Exhibit C8)

3.2. Dr Barrow was unable to remember Mr Thomson, or what transpired at the consultation (T7). He told me what questions he would have asked Mr Thomson as part of a routine psychiatric assessment (T8). He was unable to recall the answers he received. The best that he could offer was that he could presume, from the fact that nothing is noted, that Mr Thomson presented as normal (T8). Dr Barrow accepted, and was apologetic about the fact that his notes were inadequate (T12, 15).

3.3. Another aspect of concern is that Dr Barrow gave Mr Thomson a six month prescription for Valium, without arranging for a review of his condition. This was the first time Dr Barrow had seen Mr Thomson, and he had no longitudinal view of his illness, except the information from Dr Angas' notes which I described earlier. I will also refer to this issue again later in these findings.

3.4. Telephone call to EACIS, Sunday 13 February 2000

At 10:45am on 13 February 2000, Mr Thomson telephoned EACIS and spoke to Ms Grace Veloo, a Registered Psychiatric Nurse. Ms Veloo's notes of that conversation are as follows:

> ' - feeling suicidal and unable to cope
> - seem to have 'lost' friends from AA. & Narcotics Anon
> - has called on an acquaintance to call on him but feels he's placing him at risk because of his suicidal thoughts.
> - has been abusing alcohol – can't remember the last time he had any alcohol
> - admitted to have consumed some methylated spirits this morning and described this as 'naturopathic' medicine
> - unable to assess how much

- apparently has a 'communicable disease' which he has not been able to tell anyone
- (very difficult to get info – client sounded vague and long pauses before forthcoming with info)
- willing to wait for ACIS H/V this afternoon @ 1430 hours
- has no phone – will leave door open
- strongly urged to abstain from alcohol
- he admitted to having 'pills' about the place
- advised not to ingest any substances as ACIS willing to assess & assist as necessary
- stated 'will leave it at that' and hung up

Plan: H/V earlier if possible otherwise @ 1430 hrs'

(Exhibit C10a)

3.5. Ms Veloo arranged a home visit as early as possible. In the meantime, she arranged for the police to call around. Her concerns were as follows:

> 'P/C to Police re my concern that Wayne may have ingested other substances besides methylated spirits and not inform me. Because of his slowness in answering questions and also his inability to grasp what the questions were are suggestive that he may be cognitively impaired – no slurriness of speech.
>
> Plan: Police will attend and contact ACIS'
>
> (Exhibit C10a)

3.6. A police patrol consisting of Constables Tramits and Hannaford attended Mr Thomson's unit at about 12:30pm. Mr Thomson was not there. They found the door unlocked and, upon entering, saw a 'small hydroponics cannabis setup'. (Exhibit C12, p1). Mr Tamits' statement made no reference to a rope. However, he reported to Ms Veloo, according to her note, as follows:

> 'P/C from Police: Wayne not in – door had been left unlocked. Marijuana plants found on premises and also a rope tied in a noose found on the floor. Police informed Wayne has a history with Police and apparently he's 'not a nice character' if has been drinking and abusing drugs. Police advised team to get Police escort if H/V required.
>
> Plan: H/V as arranged with Police escort.'
>
> (Exhibit C10a)

3.7. When he gave evidence, Mr Tamits said he did not remember if the rope was knotted with a noose or not, all he could recall was that it was in a 'loop' (T123). I will refer to this issue again, later.

3.8. <u>Visit to Royal Adelaide Hospital, Sunday 13 February 2000</u>

After his telephone call to EACIS, Mr Thomson went to the Royal Adelaide Hospital

where he was seen by Dr Jeeraj Gogia at 12:10pm. Presumably, Mr Thomson was at the Royal Adelaide Hospital when the police called at his flat.

3.9. Mr Thomson first presented at the Royal Adelaide Hospital at 12:05pm, and the Triage Nurse wrote on the Emergency Department record (part of Exhibit C9a) that the presenting complaint was 'suicidal'.

3.10. However, by the time Dr Gogia saw him, he found no suicidal ideation. Instead, Dr Gogia thought Mr Thomson was in a 'situational crisis' because he had lost his keys and had become 'very anxious' (Exhibit C9a). In a letter to Dr Chynoweth, Dr Gogia said:

> 'He claims to have three plants of marijuana and some prescription psychotropic medication on the premises which he is worried about. He currently uses 1 cone of marijuana daily, claims to drink heavily and is a support pension. On further questioning, Mr Thomson revealed he has Hepatitis C and is anxious regarding the risk of hepatocellular carcinoma and 'other' internal sequelae. Furthermore he has no friends or family in Adelaide and has little support to fall back on when he becomes anxious as he is today.'
>
> (Exhibit C9a)

When he gave oral evidence, Dr Gogia described Mr Thomson as 'slightly anxious' (T18), rather than 'very anxious', the words he used in his letter of referral to the General Practitioner (Exhibit C9a).

3.11. Dr Gogia discharged Mr Thomson with the letter to the General Practitioner. He said that if he thought Mr Thomson had been suicidal, he could have called a Psychiatric Registrar to assess him (T23, 27). He gave Mr Thomson an ACIS card so he could call them himself if the need arose. He did not know that Mr Thomson had already done so.

3.12. It is surprising that Dr Gogia reached such a clear view that Mr Thomson was not suicidal when, only six minutes earlier, Mr Thomson had apparently told the Triage Nurse that he was suicidal.

3.13. Dr Gogia did not know that Mr Thomson had also already told Ms Veloo at EACIS that he was suicidal, and that she was so worried about him that she sent the police around to check on him.

3.14. Even allowing for this lack of knowledge, however, it is still surprising that Dr Gogia dismissed the Triage Nurse's note as 'mistaken', without a more detailed exploration of Mr Thomson's mental state, or calling in the Psychiatric Registrar.

3.15. Although he did not specifically record his findings in the casenotes, Dr Gogia said he conducted a mental state examination of Mr Thomson in accordance with his undergraduate training. Surprisingly, he was able to recall from memory Mr Thomson's responses (T19-21). His conclusions were as follows:

> 'A. My mental state examination essentially, I thought that Mr Thomson had presented with a situational crisis. He claimed to have Hepatitis C which was causing him significant difficulties, with regards to the likelihood of having hepatocellular cancer from that.
>
> Q. Is that a recognised complication of Hepatitis C.
>
> A. Yes, it's not an unrealistic fear for someone with Hepatitis C and he had the situational crisis going on with his lost keys and his marijuana and his medications, which he had every right to be anxious about and which he was.' (T21)

3.16. Dr Gogia accepted the criticism that his notes should have recorded the symptoms he elicited from Mr Thomson during his mental state examination, so that others reading the file might be able to get a better picture of the history of Mr Thomson's illness (T36). His notes were inadequate for that purpose, and do not support his contention that he conducted a proper mental state examination, and that the results were as he described.

3.17. <u>EACIS home visit, Sunday 13 February 2000</u>

Two EACIS workers, Mr Andrew Trumble a Senior Social Worker, and Ms Grace Veloo, a Registered Psychiatric Nurse, attended Mr Thomson's unit at about 2:30pm on 13 February 2000. As arranged, they were accompanied by the same police officers who had attended earlier, Constables Tamits and Hannaford. Mr Trumble explained that the purpose of their visit was to assess Mr Thomson's mental state, and then make decisions on the basis of that assessment (T40).

3.18. Mr Trumble described Mr Thomson's attitude as a 'bit withdrawn' when they arrived, although he was 'quite well-dressed' (T40). The unit was very untidy with items strewn all over the floor, which usually suggests a person 'in some distress' (T41). Mr Thomson did not appear intoxicated, in contrast to his demeanour during the earlier telephone call with Ms Veloo (T42). He told them he had seen a psychiatrist in the past but did not wish to continue doing so because 'it gets me nowhere' (T44).

3.19. Both Mr Trumble and Ms Veloo saw the rope on the floor near the bedroom. Like Constable Tamits, Mr Trumble said he saw a 'loop' (T78), but Ms Veloo was in no doubt it was tied in a noose (T136).

3.20. Both workers used the word 'dismissive', to describe Mr Thomson's attitude when they asked him questions about his earlier telephone call, and whether he was still feeling suicidal (T42, 138). Both workers said that his presentation was entirely different from the telephone call to Ms Veloo, but they were unable to explain the change (T47, 141).

3.21. Both workers said that, in their opinion, Mr Thomson was not psychotic (T46, 133), nor did he appear to be suffering a psychiatric illness as defined in the Diagnostic and Statistical Manual of Mental Disorders (DSM IV).

3.22. When they returned to their office, Mr Trumble and Ms Veloo wrote up the 'Psychiatric Triage Schedule', Form UR9.8 (part of Exhibit C10a). As to the 'Presenting Problem', Mr Trumble wrote:

> 'Feeling suicidal and unable to cope. Rang ACIS this am saying he had made a noose and had pills lying around and had consumed unspecified amounts of alcohol including methylated spirits. Felling that he was going nowhere, had no career path and was having anxiety attacks and bad nightmares as a result of a car accident he had recently witnessed. When asked about his financial situation he sated he was not too concerned as he was anticipating an inheritance at a later stage'.
> (Exhibit C10a)

3.23. In the sections marked 'Past Psychiatric History', 'Past Medical History' and 'Family Psychiatric History', Mr Trumble wrote 'nil known'. It is unclear whether Mr Thomson was questioned about these matters. However, the workers were aware that he was taking antidepressant medication, which should have given them a clue that he had seen a doctor at some stage (T53). As I have already mentioned, they also knew that he had seen a psychiatrist. Mr Trumble wrote 'multiple GPs' in the section marked for the patient's General Practitioner.

3.24. In a section of UR9.8 headed 'Safety', on page 4, three sets of questions are set out as an aid to clinical assessment. At the end of each question is a box, and the form asks the worker to 'Please tick all relevant boxes'. Under 'General Factors', Mr Trumble ticked only two, namely 'History of alcohol abuse' and 'Abuse of illicit or prescription drugs', but not 'History of psychiatric illness' or 'Recent history of

separation, relationship breakdown or major loss'. Under 'Questions relating more specifically to suicidal risk', he has ticked 'Has experienced suicidal thoughts' and 'Has made plans to kill self' and added 'in the past but denied current plans at conclusion of interview'. He did not tick 'No future life plans' because, he explained, Mr Thomson did have plans in that he was anticipating an inheritance (T55). He did not tick 'No immediate social support' either.

3.25. Mr Trumble said he was not aware that Mr Thomson had been to the Royal Adelaide Hospital that morning (T48). However, it is clear that the EACIS workers were aware of that fact. Mr Trumble made a note of this in the UR9.8 form, and that Mr Thomson told them he 'did not wait to be assessed'. Mr Trumble was unable to explain this inconsistency (T77), nor could either worker explain why they did not contact the Royal Adelaide Hospital to find out what had transpired.

3.26. The 'working diagnosis' made by the EACIS workers was '(1) Depression – Reactive, (2) Longstanding suicidal ideation'. Their assessment was that he 'responded positively to counselling and referral suggestions and did not appear at risk of further suicidal ideation or action.' They referred him to:

1 The Drug and Alcohol Services Council for alcohol and marijuana counselling;
2 Community Health centre for counselling;
3 Men's Contact and Resource Centre for issues regarding isolation and loneliness;
4 EACIS to advise them of 'follow through' with the above referrals;
5 EACIS to review him again in 48 hours;
6 His General Practitioner to review his anti-depressants.

(Exhibit C10a)

3.27. Mr Trumble said that he informed the police officers that Mr Thomson was capable of dealing with the issue of his marijuana plants (T47), so the two EACIS workers left him with the police. The police officers issued Mr Thomson with an infringement notice, during which process they described his demeanour as 'calm', 'in control of the situation', and he did not appear 'agitated, nervous or present himself as a person at risk of suicide'. (Exhibit C12, p2).

3.28. Mr Trumble agreed that the presence of the police may have interfered with his ability to assess Mr Thomson, in the sense that it may have made him more guarded and defensive. This poses a difficult problem. Obviously, the presence of the police was

justified, and they acted appropriately throughout, but their presence would have been counter-therapeutic (T62-64).

4. Issues arising at inquest

4.1. I received two written reports and heard oral evidence from Professor R D Goldney, Professor of Psychiatry at the University of Adelaide and Director of The Adelaide Clinic. Professor Goldney has wide experience of both the public and private mental health systems, and is an acknowledged expert in the area of suicide prevention.

4.2. Dr Barrow's treatment

I have already observed that Dr Barrow acknowledged when he gave evidence that his notes were inadequate. Professor Goldney confirmed this (T93).

4.3. Professor Goldney was also critical of the fact that Dr Barrow provided Mr Thomson with a 6-month prescription for anti-depressants at their first consultation. He described such practice as 'at the very least, unwise' (T94). He said that although such long prescriptions were acceptable for long-standing patients with very stable conditions, this was not the case with Mr Thomson. Although the medication was not lethal, Dr Barrow should have gained a better understanding of Mr Thomson's illness before giving him a 6-month prescription.

4.4. Dr Gogia's treatment

Professor Goldney said that there were gaps in terms of an appropriate degree of inquiry performed by Dr Gogia into Mr Thomson's condition. For example, Mr Thomson's concerns in relation to liver cancer and the medication in his flat may have been evidence of delusional thinking which could have been explored further. He said:

> 'But there were signposts, so to speak, that I think and experienced psychiatric clinical would take as warning points or signposts to … ask further questions about. Whether or not Mr Thomson's thinking was delusional, what were his thoughts about the hepatitis C. Were they reasonable thoughts about what could happen from the physical point of view or were they delusional thinking. And sometimes when a person has a severe depressive condition they can have delusions of somatical bodily delusions which may not be based on reality in terms of their physical health. So there were question marks there in that assessment, I think.' (T97)

4.5. Further, Professor Goldney said that it was 'illogical' that Mr Thomson would have displayed suicidal thoughts to the triage nurse, and yet 5 minutes later Dr Gogia

concluded that there was no suicidal ideation (T97). Clearly, Mr Thomson's thoughts were fluctuating, and a more searching assessment by an experienced clinician might have uncovered better information.

4.6. In fairness to Dr Gogia, Professor Goldney pointed out that he was a surgical trainee who was placed in a position where he needed to assess a difficult psychiatric clinical picture without the appropriate expertise. He said:

> 'I think in some ways it is unfair for people such as him to have to assess patients such as this. It is not appropriate. I mean if you've got a surgical problem you don't go to the casualty department and get assessed by a psychiatric registrar or a psychiatric intern. I mean you get assessed by somebody who is meant to have some expertise. And so I think Dr Gogia - I accept what he says and I think probably his training sort of leads him down that direction and in that sense it is very good because you don't want to have a surgeon who is going to vacillate too much, I mean you might die with your surgical problem before a decision is made. Whereas psychiatry is a bit different.' (T99, 100)

4.7. <u>EACIS treatment</u>

Professor Goldney said that Ms Veloo's actions following her telephone conversation with Mr Thomson on the morning of 13 February 2000 as 'exemplary'. He said:

> 'But probably within the constraints of what one could do there, it sounds great. Very concerned, call the police, we'll be there at 2.30, I don't think you could ask for a better service really than that.' (T104)

4.8. However, he was critical of the level of assessment carried out by the two workers during the afternoon visit. He pointed out that with evidence of delusional thinking such as referring to methylated spirits as naturopathic medicine, the reference to putting his friends at risk because of his suicidal thoughts, their knowledge that Mr Thomson had also been to the Royal Adelaide Hospital that morning, the presence of the noose, the issues were not explored sufficiently. He said:

> 'Well I think it's extraordinary that they haven't been followed through in terms of even ticking of those boxes, because you don't very often get a person who has actually got the rope there and if you do, to not really document everything about suicidal behaviour. It seems to me to be quite a grave omission.' (T106)

4.9. Having made their assessment, Professor Goldney was also critical of the multiple referrals made by the EACIS team, describing it as a 'shotgun approach before knowing what's really wrong' (T105).

4.10. Conclusions

In summary, Professor Goldney said that Mr Thomson did not receive adequate treatment from any of the three services from which he sought help in the three days before his death. He said:

> 'At this point it is pertinent to note that Mr Thomson does not appear to have had the potential benefit of assessment by a medical person with expertise in psychiatry. It is important to state that to an experienced psychiatrist there are a number of clinical pointers that have been documented which would raise specific concerns. For example, not only is there the history of poor social supports; suicidal ideation; the presence of a noose; and alcohol, marijuana and narcotic abuse; but there is also reference to Hepatitis C; fear of "hepato-cellular carcinoma and 'other' internal sequelae"; and there is the suggestion that Mr Thomson's thoughts could influence friends. Such information along with the "guarded" nature of his responses during the assessment, make it mandatory to consider seriously the possibility of a psychotic condition. It is not clear that that was fully appreciated by the ACIS workers. Indeed, it may well be unfair to expect a social worker and a community nurse to be familiar with such detailed assessment requirements.
>
> In summary, it is evident that Mr Thomson saw three different services in the three days prior to his death. It is possible that he received adequate assessment, but if that was the case, such assessment was certainly not adequately documented. Indeed, on the basis of the documents provided it is impossible to reach any conclusion other than that Mr Thomson's assessment and management was inadequate.
>
> It is of concern that Mr Thomson did not have the potential benefit of a medically trained person with at least some psychiatric experience, as there were a number of indicators which would lead an experienced psychiatrist to be particularly concerned about his overall predicament. I very much doubt whether that was appreciated by the persons who assessed him.'
>
> (Exhibit C11a, p7)

4.11. I accept Professor Goldney's analysis and adopt his conclusions.

5. Recommendations

5.1. At the request of Ms Cliff, counsel for Royal Adelaide Hospital and EACIS, I heard evidence from Mr G R Calder, an EACIS Team Leader. Mr Calder told me about certain changes and reviews which have occurred since, but not necessarily as a consequence of Mr Thomson's death.

5.2. Firstly, and perhaps most significantly, since 24 February 2000, a Mental Health Nurse is present in the Royal Adelaide Hospital Emergency Department 24 hours per day, seven days per week (T81). Since then, any person who presents at the Triage desk with a mental health issue would be initially assessed by the Mental Health

Nurse, unless there are more urgent medical issues to be dealt with. This assessment is then discussed with the Psychiatric Registrar who 'takes the next step of the assessment and makes the final decision on management' (T81). He commented:

> 'So the advantages are certainly through the expertise of the staff the mental health nurse having the training and background in psychiatry to perform the tasks, and to identify the problems, and the liaison is much, much more efficient now than it was previously, both in referring out of the department but certainly when people require admission to a psychiatric facility the liaison is much smoother.' (T82, 83)

5.3. Secondly, EACIS has introduced a system of casenote audits, whereby the standard of documentation maintained by workers is reviewed by a senior psychiatric registrar, a senior nurse and senior social worker. Mr Calder said that these audits are producing 'positive results' (T83).

5.4. Thirdly, a process called a Death Review Group is convened in the event of the death of a patient. Mr Calder said:

> 'All the people that have had some contact, whether it be by phone, personal contact are included in that review, and we also include our own director of clinical services, the service director, myself and senior discipline people, but we invite an outside consultant psychiatrist, an independent consultant psychiatrist, to be present during those reviews and to give us formal, written comments, recommendations, response for that process.' (T84)

5.5. Fourthly, the UR9.8 form is being reviewed and the form will be changed to deal with ambiguities in the 'tick boxes' method. In particular, the ambiguity about whether, if a box is not ticked, the answer to the question is 'no', or the question is not considered relevant, or the issue was not addressed, will be attended to (T86).

5.6. Mr Calder pointed out that EACIS conduct two clinical meetings a day, at which all cases are reviewed. The Mental Health Unit of the Department of Human Services is currently conducting a review of the ACIS system as a whole, so it would appear that a rigorous process of self-scrutiny is proceeding.

5.7. Professor Goldney acknowledged with approval the changes outlined above (T113).

5.8. I have referred to the issue concerning the presence of the police at Mr Thomson's flat, and whether this interfered with the ability of the EACIS workers to properly assess him. Mr Thomson knew that they were there not only to provide security for the ACIS workers, but also to talk to him about his cannabis plants, which they had

discovered while checking his flat earlier in the day, while he was at the Royal Adelaide Hospital.

5.9. Mr Calder told me that there is no formal written protocol between SAPOL and ACIS to determine how these competing considerations should be addressed, and that it is dealt with on a case-by-case basis. (T87)

5.10. I am aware that a formal protocol was developed between SAPOL and ACIS concerning joint attendance in July 2000. This was discussed during the inquest into the death of Debbie Edgell (Inquest 27/2000).

5.11. I am also aware that SAPOL have entered into an agreement with various agencies dealing with illegal drug abuse, whereby they will not exercise a full law enforcement role when called to an emergency-overdose situation. This was done to avoid the victim's friends being deterred from calling for help in the event of an emergency.

5.12. It seems to me that a similar arrangement would be useful in relation to patients with a psychiatric illness. If it is necessary for SAPOL to attend with ACIS personnel, it would be useful if the patient could be assured that the police are not there to search the premises for drugs, but rather to help ACIS.

5.13. Pursuant to Section 25(2) of the Coroner's Act, 1975, I recommend that:

1. The process of review of ACIS practices and procedures should continue to be supported, not only to improve the performance of ACIS workers, but also to ensure that patients receive access to qualified psychiatric treatment at an early stage;
2. That a protocol be developed, or the existing protocol be modified, to provide guidance to SAPOL and ACIS workers attending at premises, so that psychiatric services can be provided without the prospect of full law-enforcement being carried out as a result of the police presence.

Key Words: *Suicide; Psychiatric/Mental Illness; ACIS Teams; Hospital Treatment; Police Investigation*

In witness whereof the said Coroner has hereunto set and subscribed his hand and

Seal the 3rd day of January, 2002.

……..……
Coroner