

SOUTH



AUSTRALIA

FINDING OF INQUEST

An Inquest taken on behalf of our Sovereign Lady the Queen at Port Lincoln in the State of South Australia, on the 18th day of March and the 11th day of April 2003, before Wayne Cromwell Chivell, a Coroner for the said State, concerning the death of Dimitrios Yialas.

I, the said Coroner, find that, Dimitrios Yialas aged 23 years, late of 181 New West Road, Port Lincoln, South Australia died at Port Lincoln, South Australia on the 2 May 2001 as a result of neck compression due to hanging.

1. Introduction

- 1.1. At about 6:50am on Wednesday 2 May 2001, Dimitrios Yialas was found by a passer-by, hanging by a rope around his neck attached to a steel pole, at the back of his parents' property in Port Lincoln.
- 1.2. The police were called, but there was no medical intervention because it was obvious that Mr Yialas was dead.

2. Cause of death

- 2.1. A post mortem examination of the body of the deceased was performed by Dr J D Gilbert, Forensic Pathologist, on 4 May 2001 at the Forensic Science Centre in Adelaide. Dr Gilbert's diagnosis was that the cause of death was neck compression due to hanging.
- 2.2. Dr Gilbert commented:
 - '1. Death was due to neck compression due to hanging.
 2. Analysis of a specimen of blood obtained at autopsy reportedly showed a blood alcohol concentration of nil and no common drugs were identified.

3. There were no injuries or other markings on the body to indicate the involvement of another person in the death.
4. No natural disease that could have caused or contributed to the death was identified at autopsy.'

(Exhibit C3a)

I accept Dr Gilbert's conclusions about these matters.

3. Background

- 3.1. Dimitrios Yialas was born on 3 January 1978. He has a twin brother and younger sister.
- 3.2. It would seem that the boys were behaviourally disordered from a very early stage in their development. The case notes from the Investigator Clinic (Exhibit C15) record that a paediatrician, Dr G J Smith, was consulted in 1981 for an assessment of their behaviour. Dr Smith did not diagnose any particular medical disorder, but gave suggestions as to how their behavioural disorders could be addressed.
- 3.3. The evidence of Mr Anthony Shillabeer, the Community Corrections Officer at Port Lincoln, establishes that Dimitrios Yialas had a considerable number of dealings with the police. He appeared in the Port Lincoln Magistrates Court on 22 August 2000 and was dealt with for a large variety of offences going back as far as 1996. Those offences included larceny, arson, drug offences, driving offences including driving under the influence of liquor, and disorderly behaviour.
- 3.4. The first record of Mr Yialas displaying psychiatric symptoms was in December 1998 when he saw a doctor at the Investigator Clinic for sleeplessness and apparent anxiety as a result of the death by suicide of three friends. At that time the doctor noted that he was not suicidal. There were a number of similar attendances at the Clinic arising from various events, including forthcoming appearances in Court and overindulgence in alcohol and drugs.

4. Contacts with the health system

- 4.1. On 21 October 1999, Mr Yialas presented to the Eyre Peninsula Regional Mental Health Unit where he was seen by Mr A Sommerville, a Community Health Nurse. He complained of hearing 'voices' and Mr Sommerville noted at the time that he had suffered from depression for approximately twelve months and was being medicated

with 'Endep'. On 29 October 1999, it was noted that Mr Yialas had failed to attend any follow-up appointments with Mr Sommerville.

- 4.2. On 20 October 2000, Mr Yialas presented to the Port Lincoln Hospital with a deep wound to the right arm as a result of putting it through a glass window. He was seen by Dr Richard Watts, who noted that he was intoxicated with either alcohol or other drugs. Dr Watts sutured the wound and Mr Yialas discharged himself from the hospital soon afterwards. He represented on 23 October 2000 with an infection, and was admitted to hospital and given intravenous antibiotics, after which the condition slowly improved. Dr Watts noted at the time:

'He has also been offered counselling for his substance abuse which I understand includes intravenous drugs.'

(Exhibit C13)

- 4.3. On 7 March 2001, Mr Yialas attended Port Lincoln Hospital again. Mr Sommerville noted in the case notes:

'Admission of a 23 year old male who has a long history of drug abuse. Has admitted IV use. Has a history of violent behaviour with previous admissions for self injury. He has recently been exhibiting bizarre behaviour talking to himself and threatening to his mother for no apparent reason.'

(Exhibit C13)

- 4.4. Mr Yialas was seen by Dr Watts who diagnosed an acute psychosis. Dr Watts told me that in his opinion the psychosis was drug-induced. Mr Yialas was admitted to hospital and remained there overnight where he slept as a result of the medication.

- 4.5. On 8 March 2001 Mr Yialas discharged himself against medical advice at around 4:30pm. After announcing his intention to leave, the nursing staff called Mr Michael Wallis, who is the Coordinator of the Eyre Peninsula Regional Mental Health Unit. Mr Wallis is a social worker, and not a psychiatric nurse. He said that Mr Yialas was uncommunicative and uncooperative with him. He checked the case notes to ascertain Mr Yialas' condition and telephoned the Rural and Remote Health Service to check whether the medication he had been taking could have an adverse reaction on him if he left the hospital. He was told that that could be the case, and that it would be preferable if Mr Yialas remained in hospital, but after having been counselled about that, Mr Yialas insisted on leaving. Mr Wallis also telephoned Dr Watts and told Dr Watts that in his opinion, Mr Yialas was not detainable under the Mental

Health Act. Dr Watts also advised that Mr Yialas should remain in hospital, but agreed that nothing could be done to prevent him from discharging himself.

- 4.6. In an attempt to secure some follow-up for Mr Yialas, Mr Wallis arranged for a 'telemedicine' interview with a psychiatrist in Adelaide for the following day. An appointment was made for him at 3:00pm on Friday 9 March 2001, but despite a telephone reminder, Mr Yialas did not attend. His sister telephoned at 5:45pm advising that Jim could not keep the appointment.
- 4.7. On Monday 12 March 2001 Mr Simon Boyce telephoned Mr Yialas at 9:30am and asked why he failed to attend, and Mr Yialas expressed surprise that he had an appointment. Mr Boyce noted that his speech was clear and that he indicated that he would attend a further appointment at 11:30am that day, and a 'telemedicine' conference with an Adelaide psychiatrist at 2:00pm that day. Mr Yialas did not keep either appointment.
- 4.8. No further contact was had with Mr Yialas after 12 March 2001. Mr Wallis said that Mr Yialas' case would have been discussed at a weekly 'clinical meeting', but since Mr Yialas was in the care of his family it was decided that no further interventions would be useful.
- 4.9. Mr Wallis told me that since Mr Yialas' death, the practice had changed in that where a patient fails to attend follow-up appointments, a letter is sent. An example is Exhibit C13c. The letter strongly advises the patient to contact the Unit, or his or her general practitioner as soon as possible.

5. Events of 1-2 May 2001

- 5.1. On 1 May 2001, Mrs Yialas had a long discussion with Dr Hayden Baillie, another medical practitioner at the Investigator Clinic. Dr Baillie's note of that conversation is as follows:

'Long discussion with mother re her son.

Drug induced psychosis.

? schizo

Advised her should call police if he gets violent, until then we can't help'

(Exhibit C15)

- 5.2. At about 10:50am that day, Mrs Yialas attended at the Port Lincoln Police Station and spoke to Mr Gilbert Green, the Senior Community Constable. Mr Green's statement records as follows:

'Mrs Yialas told me that she was concerned for her son Jimmy. She told me that she believed that Jimmy was taking drugs and whenever he got his pay he would go out and obtain drugs. I asked if Jimmy used a needle to administer the drugs and she said that she was not sure but 'thinks he may do that'. Mrs Yialas said that she was concerned for her son because of his behaviour when he takes drugs. She said that 'Jimmy talks about hearing voices and gets very angry and he locks himself in his room only to come out for food and to go to the toilet'.

I asked Mrs Yialas if her son had been seeing a doctor and she told me that he had been seeing Dr Watts and Dr Bailey. I asked her what have the doctors been doing for her son, and she said that the doctor told her that 'Jimmy can only be helped if he was to admit to himself that he had a problem. And for her to come to the Police'. She stated that Jimmy had been attending the doctors since December 2000 or January 2001. I asked if Jimmy had made any threats of hurting himself or anyone else, and she said he sometimes talks a little silly but not about hurting himself. I asked if he every hurt anyone at home she said that he has attacked her in the past when he is taking drugs.

I told Mrs Yialas that the Police could only become involved if an offence had been committed. I told her that I could phone the hospital to see if the Drug and Alcohol councillor was able to come to her home and talk to Jimmy. I phoned the hospital and was put through to the Community Health section. I was unable to speak to the councillor and explained the situation to the person I was speaking to. I was advised that the councillor would phone me back later in the day to organise a time to see Jimmy.

I did not receive a phone call nor did anyone get in contact with me in any way.'

(Exhibit C11, p1-2)

- 5.3. Ms Jennifer Barker is a Community Health Nurse employed by the Drug and Alcohol Services Council (DASC) in Port Lincoln. At the time of Mr Yialas' death, she was employed for twenty hours per week, and she told me that she spent half of her time counselling, and the other half doing community development work.
- 5.4. Ms Barker confirmed that on 1 May 2001 she was absent from work on sick leave. She said that she returned to work on or about 3 May 2001, and found a note left for her by the receptionist. The receptionist was not employed by DASC, but rather was part of the Community Health Service which was then a separate organisation in a separate building on the Port Lincoln Hospital campus.

5.5. The message is not marked 'urgent' and reads:

'A lady concerned for her 23 year old son, a IV drug user and concerned his behaviour may affect others. Doesn't know if he'll be inagreeance (sic) with any sort of counselling.'

(Exhibit C12a)

5.6. Ms Barker said that she tried to contact Mr Green on a couple of occasions, but was unable to do so.

5.7. Ms Barker pointed out that DASC did not operate a crisis intervention service, and she would not have been able to attend at the Yialas family house to speak to Dimitrios, even if she had been at work that day. She said that she only dealt with voluntary clients, and anybody exhibiting signs of mental illness would probably have been referred to the Mental Health Service. Ms Barker indicated that she may have been able to assist Mrs Yialas if Dimitrios had declined to undergo counselling with her (T25).

6. Intervention resources available in Port Lincoln

6.1. Eyre Peninsula Regional Mental Health Unit

I heard evidence from Mr Michael Wallis, the Coordinator of the Unit, who told me that his organisation also did not provide a crisis intervention service of the type which is available in the metropolitan area. He told me that if Mr Green had telephoned his organisation on 1 May 2001, his staff would have suggested that the police should use their powers under Section 23 of the Mental Health Act to detain Mr Yialas, if they considered that he was a danger to himself or others, and convey him to the Port Lincoln Hospital where he could be assessed by a doctor. He said that usually in that situation, the doctor would call in a Community Health Nurse to assist in this process.

6.2. Mr Wallis told me that the situation had improved somewhat since Mr Yialas' death in that a number of these agencies have now been co-located as part of the Community Health Centre, and in particular DASC and the Mental Health Service operate in closer proximity and are able to cooperate more freely with each other than was the case in May 2001.

- 6.3. Mr Wallis also told me that they were developing a new intake system which would be operated by a more highly skilled worker than an ASO1 clerical officer, as was the case in May 2001. He said that such workers would receive training in a number of disciplines, including drug and alcohol and mental health issues. I infer that had such a person received Mr Green's call on 1 May 2001, he or she may have been able to redirect his enquiry to a more appropriate organisation, which could have provided the intervention that I previously discussed. I agree with Mr Wallis that this is a positive step and I encourage the development of this new system as soon as possible.
- 6.4. General Practitioners
I heard evidence from Dr Richard Watts, the General Practitioner who had the most to do with Mr Yialas before his death. In particular, Dr Watts treated Mr Yialas during the incident in March 2001.
- 6.5. Dr Watts told me that the Mental Health Service was well regarded by General Practitioners in Port Lincoln, and that he had great confidence in their competence and reliability.
- 6.6. Dr Watts said that Mr Yialas was a person with whom it was very difficult to establish any kind of rapport or engagement. He said that he attempted to do so on a number of occasions in order to provide counselling for him, but these attempts were always unsuccessful.
- 6.7. Dr Watts told me that he had great sympathy for Mr Yialas' parents, and Mrs Yialas in particular, as Dimitrios was a very frightening person when he was in an aggressive frame of mind. Dr Watts said that he was very apprehensive for his own safety when dealing with Mr Yialas.
- 6.8. Notwithstanding these apprehensions, Dr Watts did not consider that Mr Yialas was detainable under the Mental Health Act on any of the occasions that he dealt with him. He told me that detention was still a drastic step to take in Port Lincoln in that it was a very expensive process, it involved a risky trip with an agitated patient to Adelaide on an aeroplane, and that GP's were under constant pressure from health administrators to exercise their powers of detention with circumspection (T94-95).
- 6.9. Dr Watts pointed out that the Port Lincoln Hospital was not an 'approved treatment centre' for the purposes of the Mental Health Act, and that it could not be used to

detain patients even if the patient was not a security risk. (I was informed by Mr Wallis that there are plans to change this situation, in that Port Lincoln and a number of other regional health centres will soon be declared approved treatment centres, but only for dealing with 'non-combative' patients.)

6.10. Dr Watts told me that there was a severe drug problem in Port Lincoln, pointing out that the needle exchange program issues an average of 2,000 syringes a month, and on one month issued 5,000 syringes. He said the resources of DASC in Port Lincoln were inadequate, and that to be an effective service, these resources needed to be increased (I note that Ms Barker's hours have increased to some extent, but she is still part-time and Dr Watts gave the clear impression that a far greater increase in resources is called for).

6.11. Police

Dr Watt's told me that, in his experience, the police in Port Lincoln were always cooperative if they were requested to take action by one of the local general practitioners pursuant to Section 23 of the Mental Health Act. He described the relationship between the local medical practitioners and the police as 'very positive' (T100).

6.12. Mr Green said that when Mrs Yialas came to see him, he did not consider detention under Section 23 of the Mental Health Act:

'Because we only had three people on, it would have tied two people up at the hospital and just one person left to look after the rest of the town' (T17)

I infer that his attitude may well have been different had Dr Baillie contacted the police rather than Mrs Yialas.

6.13. Mr Green was a Community Constable and not a sworn police officer, so it is understandable that he was not as familiar with the relevant legislation as more senior police officers might have been. He told me that he had had more training since that time which has made him more aware of the issues involved (T16).

6.14. In all the circumstances, and having regard to Dr Watts' comments in particular, I do not consider that any further action by SAPOL to improve procedures in relation to persons suffering from mental illness is required.

7. Conclusions

- 7.1. It is clear that Mrs Yialas did everything she could to obtain assistance for her son in the day or so before his death. This was the latest in a long list of incidents which must have been frustrating and frightening for her and her family. She consulted Dr Baillie, and followed his advice by contacting the police. If appropriate mechanisms had been in place, this should have resulted in an appropriate intervention to help her son who had become psychotic by then.
- 7.2. Unfortunately nobody intervened to assess Dimitrios Yialas' mental state. It should not be assumed that even if someone had done so, they would necessarily have been able to predict his suicide, as suicidality is a notoriously difficult thing to predict. I have heard evidence from experts in this field on a number of occasions which makes this point.
- 7.3. However, the Mental Health Service exists in order to provide an intervention where possible, and if they had been contacted as a result of Mrs Yialas' concerns for her son, it is possible that some intervention could have taken place which may have changed the tragic outcome. As I have said, however, this is not certain.
- 7.4. I do not attribute responsibility for the failure to help Mr Yialas on 1 May 2001 to any particular person or organisation. It seems to me that the root cause of the absence of intervention to help him and his family can be traced to the telephone call Mr Green made to DASC on 1 May 2001, which was not answered (through no fault of Ms Barker) until after Mr Yialas had died. If Mr Green had been redirected to the Eyre Peninsula Regional Mental Health Unit, they may have been able to provide an appropriate intervention.

8. Recommendations

- 8.1. I am empowered by Section 25(2) of the Coroners Act to make recommendations if I am of the opinion that to do so may prevent a recurrence of an event similar to Mr Yialas' death.
- 8.2. I have already mentioned the proposal to develop a new intake system at the Community Health Centre. This will hopefully provide better assistance to people telephoning them who, like Mr Green, do not have a clear idea of the particular

service required. I would encourage the development of this system as a matter of urgency, as the fragmentation of services for people with multiple diagnoses is a very undesirable situation, and is unnecessary in a regional community.

- 8.3. I therefore recommend that the Department of Human Services proceed with all haste with the development of the new intake system as described by Mr Wallis before me.

Key Words: Mental Illness; Regional Mental Health Services

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

Seal the 11th day of April, 2003.

Coroner