CORONERS ACT, 2003

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 20th, 21st and 22nd days of August 2012 and the 5th day of September 2012, by the Coroner's Court of the said State, constituted of Mark Frederick Johns, State Coroner, into the death of Damian Kay.

The said Court finds that Damian Kay aged 38 years, late of 9 Potts Crescent, Burton, South Australia died at the Oaks Horizon Hotel, 104 North Terrace, Adelaide, South Australia on the 22nd day of September 2010 as a result of multiple injuries. The said Court finds that the circumstances of his death were as follows:

1. Introduction and cause of death

1.1. Damian Kay was 38 years of age when he died on 22 September 2010. An autopsy was carried out by Dr John Gilbert, forensic pathologist, who produced a report dated 22 February 2011[1]. Dr Gilbert gave the cause of death as multiple injuries and I so find.

1.2. On the night of 21 September 2010 Mr Kay booked a room in the Oaks Horizon Hotel on North Terrace, Adelaide. At approximately 3:05 in the morning of the following day his body was found in a laneway alongside the building. His body was severely injured and it is plain that he jumped from his room on the 16th floor sometime before he was found. An analysis of a specimen of blood obtained at autopsy showed a blood alcohol concentration of 0.71%.

[1] Exhibit C3a

2. Background

2.1. On 11 January 2005 a bushfire was raging on the Lower Eyre Peninsula in the vicinity of Port Lincoln. It became known as the Wangary fire and was the subject of an Inquest conducted by this Court, the finding of which was published on 18 December 2007. The learned Deputy State Coroner investigated the deaths of Jodie Maria Kay, Graham Joseph Russell and Zoe Russell-Kay in the course of that Inquest. Mrs Jodie Kay was the wife of the deceased in the present Inquest, Damian Kay. They lived in Poonindie, a small settlement on the Flinders Highway just north of the Port Lincoln Airport. Mrs Kay had two children. The eldest, Graham Russell, was aged 13 years. The Kay's daughter, Zoe Russell-Kay, was aged 11 years. Damian Kay had been working nightshift at Coles Express and returned home to Poonindie sometime between 6am and 6:30am that morning. However, he had a medical appointment that day at the Queen Elizabeth Hospital in Adelaide and Mrs Kay dropped him at the airport at about 7:40am that morning. He did not return until very late in the afternoon and was absent for the entire day.

2.2. As I have said, the Wangary fire developed into a major bushfire during the course of that day. At sometime after 1:50pm that day Mrs Kay and her children left the family home in their car. The learned Deputy State Coroner found that it was clear that Mrs Kay made that decision 'in the belief that the house and her family were under an extreme and immediate threat from the approaching fire'[2]. The learned Deputy State Coroner found that Mrs Kay encountered conditions on the Lincoln Highway that were extremely difficult. There was almost zero visibility as a result of smoke from the fire. He found that as Mrs Kay was driving north on the bitumen highway, she involuntarily left the road as she was not able to maintain visibility and the vehicle collided with some trees. The impact damage to the vehicle suggested that it was travelling at a considerable speed, possibly in excess of 80 kilometres per hour. It was likely, in the opinion of the learned Deputy State Coroner, that Mrs Kay did not see the trees due to the lack of visibility. Mrs Kay and Graham were killed as a result of injuries sustained in the crash. The cause of death for Zoe was given as undetermined.

2.3. Not surprisingly, Mr Kay was deeply affected by the death of his wife and children. Some 18 months after their death Mr Kay was seen by Dr Natasha Chow, consultant

[2] Inquest 26/2005, Page 283

psychiatrist with the Rural and Remote Mental Health Service. Her report forms part of Exhibit C18. Dr Chow noted that at that time Mr Kay was significantly affected by grief. He had found the previous 18 months very difficult and had increased his consumption of alcohol. He had subsequently lost his job and his friends.

2.4. In February of that year the Inquest to which I have referred was underway in Port Lincoln. Mr Kay was detained at that time as a result of threats of harm that he had made towards Country Fire Service officers whom he felt were responsible for his family's death. In the 4 months following that detention Mr Kay had been depressed and withdrawn and was spending his days inside with the blinds drawn. He had experienced poor concentration, poor energy and poor sleep with frequent nightmares. He was consuming up to 12 stubbies of beer per day in addition to spirits. He was going on benders lasting several days at a time. He had decided that he would move to Adelaide as he felt that he was unable to function in Port Lincoln.

2.5. Mr Kay's early life was also described by Dr Chow. She said that he had been married for 14 years to Mrs Kay who was his most significant partner. As I have already said, they had two children. Mr and Mrs Kay worked together managing a local hotel and a limousine business. Mr Kay had also worked as a security guard. They had lived in Port Lincoln for 14 years. Mr Kay's childhood had been very difficult with multiple moves due to his family managing hotels in local regions. He had attended multiple schools and had had difficulty sustaining friendships due to this.

2.6. At the time of Dr Chow's consultation, Mr Kay was being treated with the antidepressant Venlafaxine. Dr Chow assessed him as presenting with a major depressive episode in the context of unresolved grief over the loss of his family and longstanding alcohol dependence. She noted that there was a lack of social support and because of the difficulties he had experienced as a child and adolescent in sustaining relationships because of his frequent moves due to his father's employment, Dr Chow considered that the loss of Mr Kay's own family would have been particularly difficult for him.

2.7. After Mr Kay came to Adelaide he started seeing psychiatrist Professor Galletly. He also formed a relationship with Shannon Carr, starting in approximately July 2006. Their relationship progressed to the point at which they described themselves as

fiancées. Ms Carr described their period living together between March 2008 and September 2010. She described how Mr Kay would resort to alcohol and would become particularly affected around anniversaries relating to his family. She said that from October 2009 their relationship began to deteriorate. In June 2010 Ms Carr's sister moved in with Mr Kay and Ms Carr. This caused further tensions in the relationship. Events culminated on the evening of Sunday 19 September 2010. Ms Carr and Mr Kay had decided that their problems arose out of the fact that they were working together at a chauffeur company. It was decided that things would be better if she were to get a new job. Mr Kay offered to help her write her resume and began using her laptop computer. As he was doing this he found evidence of her communication with another male person who used to work at the chauffeur company. This resulted in Ms Carr admitting to him that she had been unfaithful to him and wanted to end the relationship. Shortly after this Mr Kay started writing out a list of how they would split up their assets. Mr Kay then left the house saying that he needed to clear his head. Shortly after this Ms Carr entered the bedroom and saw a note that had been written by Mr Kay which was on her bed. She read it and quickly realised that it was a suicide note. Shortly after this she rang triple 0 and reported the matter to police.

3. Mr Kay is detained by police officers

3.1. As a result of Ms Carr's notification to police, SAPOL instigated efforts to locate Mr Kay. It is not necessary for me to describe in detail how this unfolded. It is sufficient to note that at around 11:50pm on 19 September 2010 Constable Durant and Constable Davies located Mr Kay. Constable Durant had a short conversation with Mr Kay and observed that he was agitated. Constable Durant decided to detain Mr Kay under section 57 of the Mental Health Act 2009 because of his behaviour and the fact that he had left a suicide note. After initial reluctance, Mr Kay agreed to accompany the police to hospital. Constables Durant and Davies then drove Mr Kay to the Lyell McEwin Hospital in a police vehicle arriving at approximately midnight.

3.2. Constable Durant gave evidence that on the drive to the Lyell McEwin Hospital Mr Kay told the police about his wife and children and how they had died in the Port

Lincoln fires[3]. Constable Durant was also aware of the fact that Mr Kay had broken up with his fiancée.

3.3. Constable Durant said that on arrival at the hospital Mr Kay was seen by the triage nurse. Constable Durant could not recall at the time of giving evidence whether he had the suicide note that Mr Kay had written and which had been found by Ms Carson the previous evening. However, he would certainly have had access to it. His statement[4] said that he had been provided with the note before he left the Salisbury police station to search for Mr Kay. In all likelihood it was still in the police vehicle when Constables Durant and Davies were in the Emergency Department with Mr Kay. In any event, Constable Durant did not bring the note into the Emergency Department with him[5]. Constable Durant did inform the triage nurse about the existence of the suicide note and this is reflected in the content of the triage form contained in the notes[6]. Constable Durant said that he informed the triage nurse of the fact that the suicide note had left directions as to the way in which Mr Kay's property should be divided after his death[7].

3.4. Constable Durant also completed a proforma document entitled 'mental health assistance form'[8]. That document has been brought into existence as a result of a memorandum of understanding between SAPOL and SA Health[9]. The form contains provision for the police officer detaining a person under section 57 of the Mental Health Act 2009 to insert a description of the circumstances in which the person was detained. Constable Durant entered the following:

> 'Broke up with fiancée on the night and left a 3 page suicide note stating he was going to end his life. Broke down his possessions in the note stating who got what. Believed he was going to end his life however no plan of action has been stated.'

3.5. Mr Kay was kept in the Emergency Department from the time of arrival shortly after midnight until he was discharged at 2:50am according to a note in the Lyell McEwin Hospital medical record[10]. It may have been that he was discharged a little later than this, however the police officers were clearly back at the Salisbury police station at

[3] Transcript, page 22
[4] Exhibit C24
[5] It might be suggested that Constable Durant should have brought the note in. For reasons he explained in his evidence, he chose not to. For the reasons that follow, I have found that it was incumbent on Dr Nguyen to seek the note out as soon as he became aware of its existence.
[6] Exhibit C18
[7] Transcript, page 26
[8] Exhibit 16o
[9] Exhibit C30b
[10] Exhibit C18

3:20am when material was added to the computer investigation diary by an entry made at that time[11]. Disturbingly, that entry stated that Mr Kay:

> '… was eventually signed off at 2:40am by a doctor who had not even spoken with the mp (missing person) at that point.'

4. The exchange between the police officers and Dr Nguyen

4.1. At this point it is convenient to deal with what, in the end, I was satisfied was a misunderstanding between Constable Durant and Dr Nguyen. It arose out of the mental assistance form to which I have already made reference. That form contains a section for the medical practitioner to whom the police delivers a person detained under section 57 to complete. Dr Nguyen's evidence was that he understood the form to be an acknowledgement of transfer of custody of a person, and nothing more. In any event, Dr Nguyen signed the form before he examined Mr Kay. In the process of signing the form he completed that part of it which required him to state whether the patient was detained or not detained. He circled the option 'not detained'.

4.2. For his part, Constable Durant understandably received the impression that Dr Nguyen had thereby indicated a decision that Mr Kay would not be detained under the Mental Health Act 2009 for treatment at the Lyell McEwin Hospital, even though at that point Dr Nguyen had not examined Mr Kay. Understandably, Constable Durant was extremely concerned at such a state of affairs. It was this which led to the note in the investigation diary which I have quoted above.

4.3. Dr Nguyen gave evidence that he did indeed circle the 'not detained' option before seeing Mr Kay. His explanation was that he did not regard that form as indicating his final position on that matter. He certainly did not intend, by circling that option, to convey to anyone that he had at the time of circling the option, formally decided not to detain Mr Kay. He made it quite plain in his evidence that he would never make any decision about the care of a patient without having first examined the patient. I accept his explanation and his evidence on that point.

4.4. In what followed it is plain to me that Constable Durant held significant concerns for Mr Kay's welfare. In fact, in his statement[12] which was prepared a mere 48 hours after these events, he said that when he and Constable Davies were driving Mr Kay

[11] Exhibit C16c
[12] Exhibit C24

away from the Lyell McEwin Hospital after his discharge, Constable Durant had the feeling that Mr Kay was likely to 'follow through and end his life in one way or another in the future' and that he had 'a personal feeling that he would harm himself or commit suicide in the future'[13]. This assessment was starkly different from that which was ultimately arrived at by Dr Nguyen and which will be described below.

5. Cathryn Lambert - mental health nurse

5.1. Ms Lambert gave evidence at the Inquest. She was a mental health nurse on duty in the Emergency Department that night. On becoming aware that Mr Kay had presented she made a computer search in a database called CBIS[14]. However she was unable to obtain data from CBIS because Mr Kay's history was in a different database, namely the Rural and Remote Health Service database. She contacted the relevant person at Glenside Hospital and they indicated that they had some material which they would fax to her. In the result the fax machine at Lyell McEwin Hospital was broken and Ms Lambert had to arrange for it to be sent to a different fax number. By the time it was received Mr Kay had left.

5.2. Ms Lambert said that her recollection was that she and Dr Nguyen arrived at approximately the same time at Mr Kay's cubicle in the Emergency Department. She offered to join Dr Nguyen during his examination of Mr Kay, however Dr Nguyen declined that offer. Ms Lambert was never aware of the existence of a suicide note. Ms Lambert was only aware of information she had been given by another member of the nursing staff and this was that Mr Kay had been drinking and was suicidal over his breakup with his girlfriend. She was also made aware of the background involving the death of his wife and children but not that there was a suicide note.

5.3. Ms Lambert had offered to Dr Nguyen that she was prepared to see Mr Kay after Dr Nguyen had seen him. She had also offered to arrange for Northern ACIS to do a follow-up but Dr Nguyen declined those offers.

5.4. Ms Lambert said that Mr Kay appeared to be in a hurry and appeared to want to go home.

[13] Exhibit C24
[14] Community Based Information System

6. Arrangements for Mr Kay's transport from the Emergency Department

6.1. During the exchange between Constable Durant and Dr Nguyen it was Constable Durant's recollection that Mr Kay was quite agitated on hearing Dr Nguyen say that the police could go. Mr Kay was wanting to have the police assist him in transporting him from the Lyell McEwin Hospital. An exchange occurred in which the Constables agreed to remain for what they understood would be a relatively short period so that they could drive Mr Kay from the hospital to his destination.

7. Dr Nguyen

7.1. Dr Nguyen was in his first year as an RMO[15] at the Lyell McEwin Hospital after completing his intern year in 2009. He had been working in the Emergency Department for 1 to 2 months as at 19 September 2010. He was under the supervision of consultants and registrars and he said that there were always senior registrars available for him to consult with about any issues that he had with a patient. He said that he would have seen some 20 to 30 patients presenting with self-harm issues before the night in question. He said that he had in fact detained some, including some brought in by police but that he would consult with senior staff before making a decision to detain.

7.2. Dr Nguyen remembered seeing Mr Kay. He said that it was a busy night. Dr Nguyen looked at the triage notes which, it will be recalled, made reference to a suicide note. Furthermore, he would have had access in the notes as at that time to an entry made by a member of the nursing staff which stated:

> 'Fiancée broke up with him tonight. Wrote a 3 page note of self-harm. Recently gone off antidepressants.'

At the time Dr Nguyen saw Mr Kay the facsimile material sought by Ms Lambert had not arrived. Furthermore, Dr Nguyen was not aware that it was expected. This is an indication of the brevity of the exchange between Dr Nguyen and Ms Lambert.

7.3. I have already dealt with Dr Nguyen's understanding of the form provided to him by Constable Durant and it need not be further explored. Dr Nguyen thought that he would have spent some 10 to 15 minutes talking to Mr Kay[16]. He later conceded that it may have been as little as 10 minutes[17]. Dr Nguyen said that he got the impression

[15] Resident Medical Officer
[16] Transcript, page 146
[17] Transcript, page 164

that Mr Kay was remorseful and was almost laughing the issue off. Dr Nguyen gave evidence that he was 100% convinced in what Mr Kay told him[18]. Dr Nguyen did not speak to a senior colleague as he believed everything that Mr Kay told him. Dr Nguyen said that he was aware of the existence of a suicide note and that he did not ask the police about it. He said that this was an oversight which he now acknowledged. Dr Nguyen said that he completely believed what Mr Kay told him and that he 'wasn't as perhaps as systematic as I should have been because of that'[19]. He said that he should have read the suicide note and that he placed a lot of weight on what Mr Kay said. He said he should have used what he described as 'the collateral history'[20]. He said that if he were in the same situation now he would be more systematic. He said that the questions that he failed to ask that night might have changed his assessment. He acknowledged that he did not offer any follow-up management[21] to Mr Kay.

7.4. Dr Nguyen said that the only elaboration that he obtained from Mr Kay as to the content of the suicide note was Mr Kay's description to him that he had said he would 'top himself off' in the note[22]. Dr Nguyen got nothing else from Mr Kay about its contents.

7.5. Dr Nguyen did not recall Ms Lambert offering to attend Mr Kay with him, nor did he recall her offer to see Mr Kay afterwards. Furthermore he did not recall that she had offered for Northern ACIS follow-up[23]. Dr Nguyen acknowledged that he did not think of encouraging or persuading Mr Kay to remain, notwithstanding his view that he was not detainable. He said he should have been more thorough and spent more time with Mr Kay. Dr Nguyen acknowledged that the note that had been written by Mr Kay was at odds with the version of events that Mr Kay provided him during the examination. He acknowledged that if he had read it, it would have heightened his suspicions and that he would have spoken to someone senior[24].

7.6. After Mr Kay had left Ms Lambert, having received the faxed material provided by Glenside Hospital, showed Dr Nguyen that facsimile. It is contained within the Lyell McEwin Hospital notes[25] and consists of the report of Dr Natasha Chow dated 27 July

[18] Transcript, page 147
[19] Transcript, page 150
[20] Transcript, page 150
[21] Transcript, page 151
[22] Transcript, page 157
[23] Transcript, page 160
[24] Transcript, page 172
[25] Exhibit C18

2006 which I have referred to above. Dr Nguyen admitted that he read the letter and recalled that Ms Lambert had asked him if they should consider calling Mr Kay back because Dr Chow's letter made reference to the fact that Mr Kay had made a suicide attempt via overdose some 8 months before she had seen him, and this was a significant feature of which they had not been aware when they saw Mr Kay. Dr Nguyen said that it was not necessary to recall Mr Kay, because there were no features in his presentation that required it be done[26]. He acknowledged in his evidence that that was a time when he could have sought senior assistance.

7.7. Dr Nguyen acknowledged that he did not elicit from Mr Kay any details about the circumstances in which Mr Kay had ceased his antidepressants. Dr Nguyen acknowledged that he should have given more weight to that issue because of the possible adverse effects that a sudden cessation of antidepressants can sometimes produce[27].

7.8. In summary, Dr Nguyen made the following omissions:

1) He failed to request that he be provided with, and then to read, the suicide note that had been written by Mr Kay;
2) He failed to attribute any significance to the fact that, according to the notes which he had available to him that night, Mr Kay had 'recently' ceased antidepressants;
3) He failed to take advantage of the offer of Ms Lambert to accompany him when seeing Mr Kay;
4) He failed to take advantage of the offer of Ms Lambert to see Mr Kay after Dr Nguyen had seen him;
5) He failed to take advantage of the offer of Ms Lambert to arrange follow-up with Northern ACIS for Mr Kay and gave no thought to that matter himself;
6) He failed to appreciate the significance of the reference to a previous suicide attempt in the material that became available afterwards through Dr Chow's report received through facsimile transmission;
7) He failed to take the opportunity suggested by Ms Lambert that Mr Kay be recalled in consequence of the new information that there had been a previous suicide attempt;

[26] Transcript, page 149
[27] Transcript, page 156

8) He failed to attempt to persuade or encourage Mr Kay to remain on a voluntary basis[28];

9) He failed to seek advice from a more senior staff doctor, despite his acknowledgement that these resources were readily available to him on the night.

8. Dr Andrew Champion

8.1. Counsel assisting obtained an expert overview in this matter from Dr Andrew Champion who is the Clinical Director of Mental Health Services at Noarlunga Hospital. He produced a report in which he considered the material relating to Mr Kay's treatment. The report was admitted[29].

8.2. Dr Champion noted that Dr Nguyen's history omitted several areas directly relevant to the assessment of suicide risk including past suicide attempts, history of alcohol use, past behaviour which might have indicated a proneness to impulsivity and past contact with mental health services. Dr Champion said that knowledge of Mr Kay's previous suicide attempt was critical information as it is well-established that individuals with a history of any suicide attempt have a greater lifetime risk of dying by suicide than individuals who have never attempted suicide.

8.3. It was Dr Champion's opinion that the suicide note, in giving instructions for the disposal of his assets, demonstrated a high level of implicit intent regardless of Mr Kay's subsequent statements. That much should have been obvious to Dr Nguyen even from the limited information that was available to him about the suicide note in the absence of him having called for it.

8.4. It was Dr Champion's view that in Mr Kay's case there was evidence of significant suicidal risk and that Dr Champion considered that there were grounds to make a detention and treatment order. Dr Nguyen conceded this in his evidence[30]. Dr Champion also made some very useful suggestions for systemic improvements which I will return to later in this finding.

8.5. I was particularly struck by a comment made by Dr Champion early in his evidence that people presenting with suicidal ideation are, and always have been, part of the core business of Emergency Departments and doctors practising in Emergency

[28] This could have been facilitated by the offer of a taxi voucher home and by the suggestion that a sick leave certificate could easily be provided for work for the following day
[29] Exhibit C30
[30] Transcript, page 187

Departments. I asked Dr Champion whether he believed that that view was shared by all people who practice in Emergency Departments and he acknowledged that, sadly, he did not believe it was as widely accepted as it should be.

8.6. Dr Champion said that the 3 page suicide note, in setting out the disposition of assets upon death, was indicative of a plan and was thus more significant than a note which expressed feelings and emotion. He said that he would have spoken to the police and asked if they had read the note and asked them where it was. He said that he would have certainly read the note and discussed it with Mr Kay. It was Dr Champion's opinion that the note showed no evidence of ambivalence. He said that Mr Kay's statements at interview with Dr Nguyen were very much at odds with the content of the note which showed clear thinking and a clear plan. It was Dr Champion's view that the fact that Mr Kay had not actually attempted to carry out an act of suicide between writing the note and being found by the police did not diminish his risk.

8.7. It was Dr Champion's view that it would be usual, although not invariable, for a mental health nurse to interview a patient alongside a junior doctor rather than duplicate that process. It will be recalled that Dr Nguyen specifically declined that opportunity. Dr Champion was of the view that there were systematic blind spots in understanding suicidal risk on the part of Dr Nguyen. He thought that Dr Nguyen took a very narrow view of the options that were open to him and did not ask for historical information to balance what the patient was telling him.

8.8. Dr Champion said that it would have been possible for Dr Nguyen to have accessed a computer system called the OASIS system on the night. I note that had he done so, he would have been able to obtain access to a document contained on the Rural and Remote Mental Health Service notes[31] being a final separation summary dated 11 February 2006. That summary would have alerted Dr Nguyen to at least some history including Mr Kay's detention in February 2006, his threats against the lives of certain members of the Country Fire Service, his alcohol dependence and the fact that he was taking the oral antidepressant, Venlafaxine, and that he had been doing so over the long-term. He would have also noted that Mr Kay left the ward against medical advice.

8.9. Dr Champion tended to think that that separation summary may have given some false comfort to Dr Nguyen had he made the necessary search and seen it on the night.

[31] Exhibit C21

I accept that what Dr Champion says may be correct, however, the note would certainly have opened up other lines of inquiry and would have revealed the existence of a mental health history which in itself would have called for further investigations. This was another opportunity that was not taken and it is disappointing that a young medical practitioner would not avail himself of electronic methods of information retrieval that would assist him in obtaining collateral history for a mental health patient.

9. Summary

9.1. In summary, Dr Nguyen made the following omissions:

1) He failed to request that he be provided with, and then to read, the suicide note that had been written by Mr Kay;
2) He failed to attribute any significance to the fact that, according to the notes which he had available to him that night, Mr Kay had 'recently' ceased antidepressants;
3) He failed to take advantage of the offer of Ms Lambert to accompany him when seeing Mr Kay;
4) He failed to take advantage of the offer of Ms Lambert to see Mr Kay after Dr Nguyen had seen him;
5) He failed to take advantage of the offer of Ms Lambert to arrange follow-up with Northern ACIS for Mr Kay and gave no thought to that matter himself;
6) He failed to appreciate the significance of the reference to a previous suicide attempt in the material that became available afterwards through Dr Chow's report received through facsimile transmission;
7) He failed to take the opportunity suggested by Ms Lambert that Mr Kay be recalled in consequence of the new information that there had been a previous suicide attempt;
8) He failed to attempt to persuade or encourage Mr Kay to remain on a voluntary basis[32];
9) He failed to seek advice from a more senior staff doctor, despite his acknowledgement that these resources were readily available to him on the night.

[32] This could have been facilitated by the offer of a taxi voucher home and by the suggestion that a sick leave certificate could easily be provided for work for the following day

10. SAPOL response

10.1. I have already commented that Constable Durant, having advised of the existence of the suicide note and summarised its contents, did not actually produce it. In my view he was entitled to assume that it would be requested by Dr Nguyen if the latter needed it. However, in the course of closing addresses I asked Mr Bailes, counsel for Constable Durant, to raise the matter with the Police Association of South Australia to see if there might be an appropriate way to assist police in dealing with such situations. I pointed out that Constable Durant had – quite properly – regarded the suicide note as property seized by police, and that may have accounted for his reluctance to offer it to junior nursing staff. I was reluctant to suggest an amendment to the General Orders, which are complex enough as it is.

10.2. I have subsequently received a letter from the Commissioner of Police, Mr Burns. The relevant section of this letter states as follows:

> 'I advise that I have met with PASA and intimated I will be instructing the Operational Safety Portfolio to include in next year's Incident Management and Operational Safety Training (IMOST), as a 'Topical Issue' the need to volunteer the best form of information available (such as a suicide note) to medical authorities making Mental Health Detention assessments.
>
> As you will be aware all 'operational members' of SAPol, up to and including the rank of superintendent must undergo annual IMOST qualification. I agree with your apparent comment on the volume of General Orders and consider training better reinforces the relevant point.'

10.3. In my opinion, that is a very sensible way of dealing with the issue. I commend Commissioner Burns and the Police Association of South Australia for their very constructive and speedy response. I thank Mr Bailes for drawing the matter to their attention. In view of this helpful collaboration, there is no need for me to offer any recommendation on this aspect of the case.

11. Recommendations

11.1. Pursuant to Section 25(2) of the Coroners Act 2003 I am empowered to make recommendations that in the opinion of the Court might prevent, or reduce the likelihood of, a recurrence of an event similar to the event that was the subject of the Inquest.

11.2. Dr Champion suggested that the following improvements could be made. I formally recommend to the Minister for Mental Health and Substance Abuse as follows:

1) That the Department of Health should ensure that training in the assessment of suicidal risk should be provided both to medical undergraduates and also to doctors working in Emergency Departments'

2) That a junior doctor or a mental health nurse should not discharge a suicidal patient, particularly one brought in by police under section 57(1)(c) of the Mental Health Act 2009, from an Emergency Department without having sought advice from a senior medical colleague - either an Emergency Department senior registrar or consultant, or else a psychiatric registrar or consultant on-call;

3) That a minimum set of information should be obtained before discharging a suicidal patient from the Emergency Department. It would also be appropriate wherever possible to obtain information both from family members and from current treatment doctors or other therapists. This sometimes might not be possible until the next day when an individual presents to the Emergency Department overnight;

4) There should be assertive follow-up of suicidal patients. They should be offered by community mental health services, with expectations about timely face to face follow-up. Follow-up should be routinely offered to such patients and community mental health teams should be assertive and persistent in their attempts to see them face to face.

Key Words: Psychiatric/Mental Illness; Suicide

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

Seal the 5th day of September, 2012.

State Coroner