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 10th, 11th, 12th, 15th and 17th days of July 2013 and the 17th day of June 2014, by the Coroner's Court of the said State, constituted of Anthony Ernest Schapel, Deputy State Coroner, into the death of Drew Robin Kolbig.

The said Court finds that Drew Robin Kolbig aged 37 years, late of 9 Eagle Court, Semaphore Park, South Australia died at 1/39 Dudley Street, Semaphore, South Australia on the 21st day of April 2011 as a result of stab wound to the chest. The said Court finds that the circumstances of his death were as follows:

1. Introduction, cause of death and reason for Inquest

1.1. Drew Robin Kolbig was aged 37 years when he died as the result of a self inflicted stab wound to the chest with a knife. He died on 21 April 2011 at the home of his grandmother. Mr Kolbig had a long history of mental illness which was diagnosed as schizophrenia, a debilitating disease of the mind characterised by delusions consisting of, in his case, auditory command hallucinations of multiple voices among other things. It is said that Mr Kolbig's mental illness emerged in his late adolescence.

1.2. At the time of his death Mr Kolbig was living alone at premises situated at Eagle Court, Semaphore Park. On 11 April 2011, ten days prior to his death, Mr Kolbig had been released from the Cramond Clinic, which is the psychiatric unit of the Queen Elizabeth Hospital (the QEH), where since 23 February 2011 he had been subject to an inpatient treatment order pursuant to the Mental Health Act 2009. An inpatient treatment order imposes a mandatory state of detention for the purposes of treatment in respect of a mental illness.

1.3. In the 48 hour period prior to Mr Kolbig's death, Mr Kolbig had exhibited delusional paranoia about people wanting to harm him. On the day before his death he had commented to a mental health worker that the people who wanted to harm him would get him by the end of that day. He could not be comforted by the reality that he was safe and that no one was in fact after him. Mr Kolbig would be dead by the end of the following day. On the day of his death, in an agitated state, Mr Kolbig had stated that he did not want to die. It is not unreasonable to speculate that Mr Kolbig's act of stabbing himself fatally in the chest was the product of delusional thinking that people wanted him to die, he himself acting out and fulfilling that delusion.

1.4. Mr Kolbig stabbed himself in the chest at the home and in the presence of his elderly grandmother, Ms Sherly Kolbig. Ms Kolbig, who was at that time aged in her late 80s, courageously but unsuccessfully attempted physically to stop her grandson from harming himself. Mr Kolbig had taken a kitchen knife from a kitchen drawer at his grandmother's residence. According to the post-mortem report of forensic pathologist, Dr Karen Heath[1], death was due to a stab wound to the left side of the chest which penetrated the heart. There was one single near vertical stab wound. It is clear that this stab wound was no accident. The description of the fatal event as provided by Ms Kolbig leaves no doubt that this was a deliberate act done with the intention of ending his own life and I so find. It is clear that Mr Kolbig's death followed very quickly after the infliction of the stab wound. I find that the cause of Mr Kolbig's death was stab wound to the chest.

1.5. Analysis of a specimen of blood obtained at autopsy showed a greater than therapeutic, but not toxic or lethal, level of quetiapine (otherwise known as Seroquel) and a therapeutic concentration of reboxetine. Seroquel is an antipsychotic drug. Reboxetine is an antidepressant drug. Both of these drugs had been prescribed for Mr Kolbig. Both drugs were taken by way of tablet. As well, the anti-anxiety medication, diazepam (otherwise known as Valium) which is a benzodiazepine, had been prescribed for Mr Kolbig. Valium was also taken by Mr Kolbig by way of tablet. No alcohol, amphetamines, benzodiazepines (including Valium), cannabinoids, morphine, cocaine and other common drugs were detected in the specimen of blood obtained at autopsy. No tablet residue was identified within Mr Kolbig's stomach contents at autopsy.

[1] Exhibit C2a

1.6. In this Inquest the Court examined the issue as to whether Mr Kolbig's death could have been prevented, and in particular whether at the time of his death Mr Kolbig could have been more effectively managed by the State mental health authorities either under a community treatment order or an inpatient treatment order pursuant to the Mental Health Act 2009.

2. Background

2.1. Following Mr Kolbig's diagnosis of schizophrenia at the age of 19, there were periods in which he had managed relatively well and independently in the community. There were nevertheless several admissions to Cramond Clinic in 2006 and 2007. I have already mentioned Mr Kolbig's final admission at the Cramond Clinic for 47 days between February and April of 2011. Mr Kolbig's mental health management within the community was administered for the most part through the Port Adelaide Community Treatment Team, part of the Port Adelaide Mental Health Services which is an arm of the South Australian public mental health services. Mr Kolbig's CBIS electronic casenotes were tendered to the Inquest[2]. The notes cover the period from 2004 to 2011, the year of Mr Kolbig's death. The notes describe psychotic and at times suicidal behaviour. They also illustrate Mr Kolbig's dislike of medications. Mr Kolbig occasionally made it plain to those treating him that he did not like the manner in which medication interfered with his more grandiose delusions. A notation of 21 November 2006[3] relates to a crisis visit by the Port Adelaide Community Treatment Team which described Mr Kolbig's acute presentation as '*psychotic with suicidal ideation, non-compliance with treatments, alcohol consumption and delusional beliefs has special indestructible powers*'. A notation of 23 November 2006 refers to Mr Kolbig's mother's assessment that Mr Kolbig had recently started drinking alcohol again and that his mental state had in part been due to binge drinking with a girlfriend. The same note describes Mr Kolbig's attendance at the Emergency Department of the QEH two days previously, having been suicidal and psychotic, but with no admission. The note indicates that Mr Kolbig was unhappy with his then current medication, namely Consta[4]. Mr Kolbig's opposition to the medication clozapine is also noted.

[2] Exhibit C16a
[3] Exhibit C16a, page 59
[4] That is risperidone Consta

2.2. Mr Kolbig was also seen from time to time by a private general practitioner, Dr Foenander. It is apparent from the large amount of clinical records in relation to Mr Kolbig that over the years there was no shortage of attention to his mental illness either by the State mental health authorities or private practitioners as the case may be. Emeritus Professor Robert Goldney who was tasked by counsel assisting the Coroner to provide an independent expert overview[5] in relation to Mr Kolbig's mental health care observed in his report that on balance Mr Kolbig's condition over a period of time was essentially treatment resistant, as there appears to have only been a few occasions when he was entirely free of symptoms. On the other hand, Professor Goldney observes that there had been extended periods of relative wellbeing, and that although Mr Kolbig insisted that medication had harmed him, it is almost certain that when on relatively high doses of antipsychotic medication, and sometimes when on more than one antipsychotic medication, Mr Kolbig was '*tolerably well*'[6].

2.3. Professor Goldney also notes in his report the various medications that had been tried with respect to Mr Kolbig, including clozapine, olanzapine and risperidone Consta, which is a long acting injectible antipsychotic drug that is administered by way of a periodic depot. More recently, however, Mr Kolbig was managed on the orally taken Seroquel, the medication to which I have already referred. This was taken in varying doses over time. In fact it was this antipsychotic medication that Mr Kolbig was taking at the time of his death. In addition, Mr Kolbig was also on antidepressant and antianxiolytic medications from time to time.

2.4. Between 2007 and 2010 Mr Kolbig was the subject of consecutive community treatment orders that were imposed by the Guardianship Board pursuant to the provisions of the now repealed Mental Health Act 1993. This version of the Mental Health Act was that which immediately preceded the new Mental Health Act 2009 which came into operation on 1 July 2010. Both the repealed and current iterations of the Mental Health Act contain provisions that enable the mandatory imposition of treatment within the community, including the administration of medication without consent, to the mentally ill. A failure to comply with a community treatment order is a relevant consideration in deciding whether an inpatient treatment order should be made in respect of the non-compliant person. As it so happened, the last day of operation of Mr Kolbig's final community treatment order under the Mental Health

[5] Exhibit C18
[6] Exhibit C18, page 10

Act 1993 was 1 July 2010, the date the new Act came into operation. Following that date, no community treatment order was imposed or applied for under the new legislation. As indicated earlier, however, between February and April 2011 Mr Kolbig would be subjected to an inpatient treatment order under the new Mental Health Act 2009 and would be released from that order just prior to his death.

2.5. The community treatment orders imposed upon Mr Kolbig pursuant to the repealed legislation were designed to ensure a level of supervision of Mr Kolbig in the community as well as ensuring compliance with medical treatment including medication. Mr Kolbig appears to have exhibited a grudging acceptance of the medication regime imposed pursuant to the orders; his clinical records reveal that he indicated on a number of occasions that the only reason he was complying with the medication regime was because he was on a community treatment order and that everyone wanted him to keep taking his medication. His customary ambivalence towards medication would be exhibited during his compulsory inpatient treatment admission in Cramond Clinic between February and 11 April 2011. As at the day of his death ten days later, Mr Kolbig was not under any mandatory treatment regime within the community so in that sense his compliance with his medication regime was at his option if not whim. Mr Kolbig's opposition to and dissatisfaction with medication in general and specific medications in particular was very much a recurring theme in his presentation and behaviour, and a predictable theme at that. The period that elapsed between his release from Cramond Clinic and the day of his death would be characterised by inconsistent compliance with medication and psychotic episodes of the kind already described.

2.6. Professor Goldney has observed that whereas during the currency of the community treatment orders that applied in respect of Mr Kolbig between 2007 and 2010 in which period Mr Kolbig experienced a period of relative wellness, he appears to have gone into decline in the period following the lapse of community treatment orders.

2.7. In the latter part of 2010 it is apparent that Mr Kolbig's general decline included a deterioration in his lifestyle, personal habits and behaviour. His environment at home had became squalid. He was reportedly abusing alcohol and at one time was sending abusive text messages to his mother. On 7 January 2011 Mr Kolbig's general practitioner recorded that Mr Kolbig was '*waiting for the next psychosis*', as Mr Kolbig felt better during a psychosis. Professor Goldney is of the view that this is a

particularly interesting observation as sometimes persons with severe psychotic illness, in a paradoxical sense, feel themselves even though they may be extremely unwell. There are other references to Mr Kolbig's preference to be in such a state as distinct from being constantly under the effects of antipsychotic medication. By the end of January 2011 family concern about Mr Kolbig became heightened, exemplified by a communication from Mr Kolbig's mother who reportedly said that if the mental health services contacted Mr Kolbig he would kill '*whoever put him in hospital*'. By February 2011 Mr Kolbig's behaviour had included playing very loud rap music at his home and verbally abusing his neighbour. As well, by this stage there was verbal abuse of members of his family, delusional and grandiose statements, impaired personal hygiene, threats to kill himself, his family or mental health workers if they intervened. Mr Kolbig also entertained a perception that medication murdered his true persona.

2.8. On 22 February 2011 contact was made with Mr Kolbig by mental health workers. It was recorded that he was clearly non-compliant with medications as he was too disorganised to manage them. On the following day Mr Kolbig was taken into care at the QEH pursuant to the Mental Health Act 2009. This followed an incident in which Mr Kolbig had been armed with a knife and had to be restrained by police. When SAPOL, South Australian Ambulance Service and mental health workers attended at his premises that day he was uncooperative, had to be restrained with handcuffs and had to be placed on a barouche secured with a net. He was taken to TQEH where he was admitted to Cramond Clinic.

2.9. The CBIS notation of 23 February 2011 states:

> 'Nevertheless his present circumstances is unlikely to respond to less restrictive interventions (entry by A trotter 22/2/11) and given deteriorating mental state, duration of untreated psychosis, risk to self (suicide, homelessness) and to others (disruptive to neighbours and has threatened to kill family and MHS staff); - there is little option other than to detain him.' [7]

2.10. Another notation made by a mental health worker from the Port Adelaide Community Treatment Team office dated 23 February 2011, following Mr Kolbig's being taken into care, makes a number of pertinent observations. These included that Mr Kolbig previously had intensive supports but that these had been ceased due to him recovering and managing independently, that he had experienced a relapse of his

[7] Exhibit C16a, page 19

psychosis with poor self-care and increasing threats and aggression, that over the last few weeks Mr Kolbig had deteriorated with delusional ideation that included his personal responsibility for all the world's current crises and that Mr Kolbig believed that he was in a *'seventh psychosis'* that must continue such that he would refuse to consider any treatment, hospital or any intervention with a sentiment that he never wanted to see anyone from mental health ever again. It was also noted that a family member had regarded Mr Kolbig's current episode as the worst he has experienced. The notation also made the observation that Mr Kolbig had nil medications for '*some weeks*'.

2.11. An inference is available that while Mr Kolbig had been on a community treatment order he had been generally compliant and, to borrow Professor Goldney's expression, had been '*tolerably well*', but that when the community treatment order was allowed to lapse without renewal, Mr Kolbig deteriorated, and that a consequent lack of compulsion in respect of treatment was a contributing factor to that deterioration. I draw that inference and so find.

2.12. In the next section I will deal with Mr Kolbig's circumstances whilst subject to the inpatient treatment order at the QEH between February and April 2011.

3. Mr Kolbig's inpatient treatment order and discharge

3.1. According to the CBIS consumer summary[8] Dr Andy Geddes, a medical officer of the Port Adelaide Community Treatment Team, assessed Mr Kolbig at 3pm on 23 February 2011 at the QEH. Dr Geddes noted that Mr Kolbig had numerous previous psychotic episodes with similar presentations to his current presentation and that he had been managed on community treatment orders in the past with a good response to treatment, but with frequent non-compliance. The notation also states:

> 'Please use this admission to reapply for a CTO
> Will need a major house clean before discharge
> Consider depot if he remains non-compliant / insightless during the admission'

The point that Dr Geddes was undoubtedly making there was that although previous community treatment orders had been imposed upon Mr Kolbig with good effect, he had a propensity towards non-compliance, with the consequence that a community treatment order should be imposed upon him on his discharge from his current period

[8] Exhibit C9, pages 108-110

of inpatient treatment. All of this was a prescient observation but which would not be fulfilled.

3.2. During his period of inpatient treatment at Cramond Clinic, Mr Kolbig was seen by a psychiatrist, Dr Titus Mohan. Dr Mohan swore an affidavit which was tendered to the Inquest[9]. He also gave oral evidence during the Inquest. Dr Mohan himself saw Mr Kolbig on a weekly basis. As explained in Dr Mohan's affidavit, Mr Kolbig was also reviewed daily by members of the multidisciplinary team. Dr Mohan had daily contact with the psychiatric registrar looking after Mr Kolbig.

3.3. Dr Mohan saw Mr Kolbig for the first time on 25 February 2011. He diagnosed Mr Kolbig with a relapse of schizophrenia which he noted was '*as a result of partial non-compliance with medication*'. Dr Mohan observed that Mr Kolbig was upset about his detention in Cramond Clinic and blamed the mental health services for his problems. Dr Mohan reviewed Mr Kolbig's history.

3.4. As I understood the evidence Dr Mohan had no significant involvement with Mr Kolbig in the past. Rather, Mr Kolbig had been managed for the most part by another psychiatrist, Dr Wilson. Naturally Dr Mohan noticed that Mr Kolbig had been the subject of past community treatment orders. According to Dr Mohan's affidavit, during his initial assessment of Mr Kolbig he thought that a community treatment order should be considered in relation to Mr Kolbig's eventual discharge in light of non-compliance with medication and disengagement with his community team. This was totally consistent with Dr Geddes' assessment. In fact, the actual notation made by Dr Mohan on 25 February 2011 reads simply '*needs CTO*'[10]. The following entry in the note states:

> 'Has been disengaging with least restrictive community management.'

3.5. As explained in Dr Mohan's affidavit, Dr Wilson was consulted about Mr Kolbig during the course of this admission. On 1 March 2011 Dr Wilson was contacted and a notation of that date[11] suggests that Mr Kolbig was believed to be fiercely independent and that therefore a community treatment order may be a difficult option to negotiate. Dr Mohan suggests that the concern was that Mr Kolbig might alienate himself from

[9] Exhibit C12
[10] Exhibit C9, page 177
[11] Exhibit C9, page 184

mental health services if he perceived a controlling approach from those services. According to Dr Mohan:

> 'Drew values his autonomy and the emphasis was on building a rapport to get him to engage, rather than assume non-compliance and assert a community treatment order.' [12]

In the event a notation was made that the community treatment order option be deferred until non-compliance was established on follow-up. Dr Mohan's affidavit makes reference to a discharge summary from the year 2006 that referred to the limited benefits of more assertive treatment in the past, resulting in a community treatment order not being pursued at that time. He says:

> 'Thus prior interaction with services shaped the consensus view to defer the CTO option til later.' [13]

3.6. The approach that was adopted at this very early stage of Mr Kolbig's admission is puzzling. The position as it existed in 2006 seems somewhat beside the point when it is observed that Mr Kolbig had been placed upon consecutive community treatment orders since that year and that during the intervening time gap there was a period of relative wellbeing. The attitude adopted on 1 March 2011 is also at odds with the fact that at Mr Kolbig's psychiatric review on that day he is noted as having presented as floridly psychotic and was paranoid about the mental health services and felt persecuted, with outlandish statements to the effect that they were erasing his memory, lying about his medications and that they were killing him. He boasted that he would kill himself before that, which according to Dr Mohan's affidavit would, together with other references to his death, be taken only as a metaphorical, not literal, allusion to death; that is to say a death from not being able to reach the '*seventh level*' of psychosis which Mr Kolbig associated with a heightened awareness and immortality. He demanded cigarettes and alcohol. Mr Kolbig is noted to have only calmed down briefly at the end of the interview when he was informed about the management plan, which as observed did not include the compulsion of a community treatment order.

3.7. During the course of Mr Kolbig's admission he was medicated on Seroquel. There were a number of changes to the daily dosage of this medication. There are several references in the clinical notes to Mr Kolbig's lack of enthusiasm in respect of this

[12] Exhibit C12
[13] Exhibit C12

medication and his unwillingness to engage with staff, if not outright hostility towards them. The objection to medication recorded on 29 March 2011[14] was based upon its interference with his achieving immortality through a seventh psychosis. The same sentiment was expressed on 31 March 2011[15]. As observed by Dr Mohan in his affidavit, Mr Kolbig had shown good clinical response to lower doses of Seroquel during his admissions to hospital in 2006. As well, he was on this medication while in the community and '*it allowed him to function until he began to not comply with the treatment regime*'[16].

3.8. During his admission Mr Kolbig experienced a number of instances of day leave, but I observe that none of these periods of leave involved him taking his antipsychotic medication during leave. He was medicated when back in the clinic.

3.9. On 6 April 2011 Mr Kolbig was seen at Cramond Clinic by members of the Western Mobile Assertive Care (MAC) team with a view to his imminent discharge from hospital and to evaluate his management in the community once discharged. He was seen by two members of the MAC team, neither of whom in the event would see Mr Kolbig once discharged. The meeting took place in the presence of Mr Kolbig's mother. Contained within the CBIS notes is a comprehensive entry relating to the meeting with Mr Kolbig[17]. The salient features of the meeting as recorded in the CBIS notes were that Mr Kolbig was able to ask and answer questions appropriately and appeared interested in his pending discharge and in his reaching future goals. At that time his mental state appeared to be well settled. The issues of alcohol consumption, medication, compliance and re-engagement with mental health and support services were discussed. Mr Kolbig indicated that he wished to consume two to three beers daily when discharged which was a matter of concern due to the fact that his mother had observed that the third beer was one too many and that it made her son aggressive, irresponsible and non-compliant. There is a notation that Mr Kolbig accepted that he needed to be more responsible and would limit his alcohol intake but that continued education would be needed. The question of Mr Kolbig's behaviour in respect of his neighbours, and in particular his propensity to play loud music and be abusive towards them was discussed. During the meeting Mr Kolbig was advised to keep his loud music down to a reasonable level. Mr Kolbig's past history of non-

[14] Exhibit C9, page 229
[15] Exhibit C9, page 232
[16] Exhibit C12, paragraph 17
[17] Exhibit C16a, pages 10-11

compliance with medication, particularly upon discharge from a hospital was noted. During the meeting Mr Kolbig indicated that he felt '*okay about being on this medication*' and was willing to make himself available to staff daily between 4pm and 6pm for medication supervision. It is apparent that during this meeting it was made clear to Mr Kolbig that if he became non-compliant with his treatment a new application for a community treatment order would be submitted to the Guardianship Board. His propensity to withdraw from services and refuse to open his door to staff was also noted. This ultimatum about applying to the Guardianship Board for a community treatment order in the event of non-compliance would become more honoured in its lack of enforcement than in its observance as will be seen. It would be something of a hollow threat.

3.10. Mr Kolbig was discharged from Cramond Clinic on 11 April 2011. He was reviewed that day by Dr Mohan the psychiatrist. Dr Mohan explains in his affidavit that by the end of Mr Kolbig's admission he was accepting of his medication and indicated that he was happy for the MAC team to supervise his medication on daily home visits. In that respect his view was that there was little utility in applying for a community treatment order as the role of the MAC team was serving the same purpose as a community treatment order. Moreover, he said that under the Mental Health Act 2009 a level 1 community treatment order could be instituted by the community team almost instantaneously if compliance to medication was a concern after discharge. This observation is an allusion to the fact that the new legislation enabled the imposition of a community treatment order in the first instance by a member of a community team such as MAC who was either a medical practitioner or authorised health professional, whereas under the previous legislation such an order could only be imposed by the Guardianship Board. Dr Mohan's other observation that the functions and powers of the MAC team were serving the same purpose as a community treatment order can only be sensibly understood if a MAC team was prepared to act swiftly upon non-compliance. In any event, when Dr Mohan reviewed Mr Kolbig he noted in the clinical record in his own handwriting:

> 'If there was a relapse there should be a low threshold for readmission and possibly CTO/clozapine/MAC.' [18]

[18] Exhibit C9, page 243

3.11. Dr Mohan authorised Mr Kolbig's discharge and revoked his detention that day. Dr Mohan also compiled a discharge summary. In that discharge summary Dr Mohan also alludes to the circumstances in which a community treatment order might require further consideration and states:

> 'In addition, a discussion was made with Dr. Wilson to defer a CTO option for this admission until non-compliance is established on follow-up.' [19]

3.12. Also in Dr Mohan's affidavit he asserts that there had been little benefit in community treatment orders in the past and the better approach was to refrain from an application until non-compliance was established. The assertion by Dr Mohan that there had been little benefit to community treatment orders in the past is difficult to understand. And in any event, I do not read the new legislation as requiring a pattern of non-compliance with voluntary treatment to be established before a mandatory CTO can be considered. More of that later.

3.13. In his oral evidence Dr Mohan suggested this:

> 'At this - in Mr Kolbig's case, we did not see a need for a community treatment order because there was already a mechanism by which his medication could - intake could be ensured. The community - the MAC team could go every day and if there was any indication that Mr Kolbig was not engaging with them or if he's distancing himself from treatment, then there could be a community treatment order under the new Mental Health Act which could be invoked in a matter of 24 hours.' [20]

Dr Mohan added the observation that a community treatment order was seen as a punitive or more controlling step at that time and appears to suggest that it would counter any therapeutic relationship or defeat active engagement with the service by placing him under legal orders. That observation is erroneous. There is nothing punitive about a community treatment order and there was in reality nothing that would have augured for a better therapeutic relationship being established on a voluntary basis. As far as the quoted passage is concerned, as will be seen there would be any number of indications between the date of his release from Cramond Clinic and the date of his death that Mr Kolbig was not engaging with the service and was in fact distancing himself from treatment, or at least from treatment either that he did not like or did not consider was providing any benefit. And yet nothing was undertaken in respect of any community treatment order.

[19] Exhibit C9, page 126
[20] Transcript, page 296

3.14. Also in his oral evidence Dr Mohan explained what was a four tiered approach to Mr Kolbig's discharge. This consisted firstly of an assessment that there was no real or current risk of suicide as evidenced by several days of leaves of absence from Cramond Clinic which had been unremarkable. Secondly, he repeated that Mr Kolbig's statements about dying were metaphorical as opposed to literal. Thirdly, Mr Kolbig's mental state had settled down to a reasonable degree and, fourthly, Dr Mohan did not believe that there were any grounds to extend Mr Kolbig's period of mandatory inpatient treatment which in any event was due to expire the following day, namely 12 April 2011[21].

3.15. In cross-examination by Ms Kereru, counsel assisting, Dr Mohan acknowledged that he had originally agreed with Dr Geddes' view about the need for a community treatment order but that his consultation with Dr Wilson had changed his mind[22]. In this context he again referred to the limited benefits of more assertive treatment in the past and the experience form 2006, such that he and Dr Wilson were aware that if anything more assertive or more controlling was put in place for Mr Kolbig, it would be met with more resistance. Again the three year period over which Mr Kolbig was in fact on community treatment orders and living a relatively satisfactory existence does not seem to have been properly evaluated.

3.16. Dr Mohan also agreed with counsel assisting that the approach based on voluntary acceptance of treatment after his discharge from hospital was based on an assumption that those who would attend his home to supervise Mr Kolbig's medication were competent in watching and reporting signs of non-compliance[23]. As to the question of the prospect of Mr Kolbig consuming alcohol and playing loud music whilst under the influence of it, Dr Mohan also appeared to have held an assumption that the professionals who would visit Mr Kolbig on a regular basis were competent in offering counselling in respect of drug and alcohol consumption[24]. He said:

> 'There was an expectation that the team visiting him would have the capacity to address the issue.' [25]

[21] Transcript, pages 301-302
[22] Transcript, page 306
[23] Transcript, page 307
[24] Transcript, page 308
[25] Transcript, page 309

Dr Mohan also reiterated a view about a community treatment orders, he said:

> '… the CTO is also an important measure when somebody is blatantly or overtly disagreeing with treatment or would threaten to run away or would not open their door to treatment.' [26]

This is an observation that would resonate with Mr Kolbig's behaviour over the ten days following his discharge in the sense that it can rightly be said that he did blatantly and overtly disagree with treatment and on one occasion literally would not open his door to treatment.

3.17. Dr Mohan was cross-examined about his final entry in Mr Kolbig's clinical record in which he had suggested that there should be a low threshold for readmission or a community treatment order. Dr Mohan stated that it was implicit that the mental health team visiting Mr Kolbig would have a low threshold for readmitting him, meaning that they would not be required to '*watch and wait*'[27] and that they would always be watchful for any potential worsening in respect of Mr Kolbig. For example, the triggers that might give rise to consideration of readmission would include symptoms of psychosis, auditory hallucinations or more bizarre delusions and open statements about self-harm[28]. Dr Mohan conceded that he did not have any discussion himself with the MAC team about what he meant by a low threshold[29], but pointed out that they had access to the casenotes and would read through them. As well, it was standard practice to bring anybody back to his attention if they had any concerns about a person's mental state[30]. Dr Mohan was tackled about the manner in which he had advocated consideration of a community treatment order as revealed in the hospital discharge summary. It will be remembered that he stated that a community treatment order would not be considered until non-compliance was established on follow-up. He conceded that there was nothing about a low threshold mentioned in the discharge letter. Quite apart from the low threshold being triggered by a worsening of Mr Kolbig's clinical presentation, Dr Mohan acknowledged that one matter that would also need to be taken into consideration was the ensuring of good compliance with medication[31]. He acknowledged that a low threshold would exist for Mr Kolbig because of his history of non-compliance with medication,

[26] Transcript, page 309
[27] Transcript, page 317
[28] Transcript, page 317
[29] Transcript, page 318
[30] Transcript, page 318
[31] Transcript, pages 320-321

although that would not be the only reason for it[32]. He made this acknowledgment on the understanding that when Mr Kolbig was non-compliant with medication, he would relapse into his illness[33]. However, Dr Mohan suggested that for the MAC team to report and readmit on the basis of non-compliance, this would also depend on Mr Kolbig's mental state at the time. This tends to overlook the fact that refusal to take medication in the community in and of itself would inevitably mean that Mr Kolbig would become unwell[34]. Strict compliance with his medication regime was required; intermittent compliance would not be acceptable, the reason being that this would give rise to a very high risk of him becoming unwell again. All of this was acknowledged by Dr Mohan in questioning by me[35]. Dr Mohan also acknowledged that regular consumption of alcohol was a matter that was involved in Mr Kolbig's non-compliance[36]. I asked Dr Mohan whether Mr Kolbig's drinking, his non-compliance and the tendency to relapse when non-compliant would have triggered the low threshold for re-admission. He said:

> 'That would be grounds for - that would be a low threshold for re-admission.' [37]

Dr Mohan stated that if Mr Kolbig was not opening the door to the MAC team, he would expect that the MAC team would readmit him. Dr Mohan was asked this:

> 'Q. When you mentioned the words 'low threshold', I'd suggest that what you had in mind was that there would need to be - the MAC team would need to be satisfied of strict compliance with medication.
>
> A. That is correct and that is why he's been referred to the MAC team in the first place.
>
> Q. Yes. And careful observation of Mr Kolbig's drinking patterns.
>
> A. Yes, if they would interfere with his medication intake.
>
> Q. And careful monitoring of his frame of mind.
>
> A. That's correct. Mental state examination.
>
> Q. And if there were any concerns about any of those matters, that would trigger the low threshold, wouldn't it, that you had in mind.
>
> A. Yes.' [38]

[32] Transcript, page 323
[33] Transcript, page 323
[34] Transcript, page 323
[35] Transcript, page 323
[36] Transcript, page 324
[37] Transcript, page 325
[38] Transcript, page 326

4. Mr Kolbig is discharged from Cramond Clinic

4.1. Mr Kolbig was discharged from Cramond Clinic on 11 April 2011. The arrangement was that he would be visited by a member of the Western MAC team on a daily basis such that his taking of his daily Seroquel dose of 1000mg could be supervised. Mr Kolbig's daily dose would be administered and taken at the time of the visit at around 5pm. The reboxetine prescription was to be taken in the morning at his own initiative. No community treatment order was put in place. These arrangements depended upon the continuing cooperation of Mr Kolbig.

4.2. The MAC workers who would visit Mr Kolbig until and including the day of his death included registered mental health nurses or an occupational therapist as the case may be. He was also seen by Dr Parthasarthy, a psychiatrist, on 12 April 2011 at the Port Adelaide facility and again on 20 April 2011 at the facility in an unscheduled appointment. This occurred when Mr Kolbig presented in an obviously distressed, anxious and delusionally paranoid state. I will come to that event in due course.

4.3. Mr Kolbig lived alone at his premises. The first few days of Mr Kolbig's release into the community occurred at a time when his parents were overseas. His elderly grandmother, Ms Sherly Kolbig lived at Semaphore. When Ms Elizabeth McHugh, an occupational therapist with MAC, visited Mr Kolbig on the late afternoon of 15 April 2011 to administer and supervise his Seroquel medication, she found him at home playing loud music that could be heard from the car park. Mr Kolbig was sitting on a couch drinking VB beer and was noticeably intoxicated. There were eight empty cans on a coffee table in addition to the can that he was consuming, and there was one can left in the fridge. Mr Kolbig appeared not to recognise Ms McHugh, notwithstanding that she had visited him on the day of his release. Whereas on the day of his release four days earlier she had noted that he had been bright and reactive, had initiated conversation with good content and body language with good eye contact and had taken his medications as directed, he was noted to be passive aggressive and intoxicated. Mr Kolbig boasted to Ms McHugh that he consumed two to three cartons of beer per week and planned to purchase another carton the following day. Ms McHugh advised him of the dangers of mixing alcohol with medication and of the negative impact this behaviour had on his mental state. This was all met with a flippant response on the part of Mr Kolbig that was accompanied by remarks that he had 'heard it all before'. He insisted that he intended to maintain

this lifestyle. He repeatedly attempted to terminate the home visit. On this occasion Mr Kolbig did take his evening antipsychotic medication, that is the Seroquel, but Ms McHugh made the following note:

> '? complaince (sic) with mane meds if low and depressive mood continues.'

This was intended to record a concern on Ms McHugh's part that Mr Kolbig's compliance with his morning medication would be questionable. He was left with his morning medications.

4.4. On 16 April 2011 Mr Kolbig was visited by Mr David Bambrick who was a mental health nurse. On this occasion Mr Kolbig was noted to be guarded as he did not invite staff in as usual. I am not certain whether the evidence established whether Mr Kolbig did take his medication on that occasion.

4.5. On 17 April 2011 Mr Bambrick received a phone call from a worker from another community organisation. The worker had visited Mr Kolbig at about midday that day. The worker had expressed concern that in spite of the fact that Mr Kolbig and the worker had known each other for a long period of time, there had been no recognition of her by Mr Kolbig. Mr Bambrick visited Mr Kolbig later that afternoon. Although loud music was playing, Mr Kolbig did not respond to continuous door knocking. On this occasion there was non-compliance with medication.

4.6. On 18 April 2011 Mr Bambrick again attended and on this occasion Mr Kolbig accepted his medication. Mr Bambrick assessed Mr Kolbig in the light of the worker's concerns from the day before. Mr Bambrick noted that on this occasion Mr Kolbig was bright and reactive, pleasant and cooperative. Mr Kolbig did not invite Mr Bambrick in but made good eye contact. Mr Kolbig stated that he had been at home the previous evening but must have been asleep. He said, however, that he was still drinking and that he was as good as can be expected.

4.7. Ms McHugh visited Mr Kolbig on 19 April 2011 for the purpose of administering his medication. Two attempts were required before Mr Kolbig would answer the door. He was loud and confronting in approach and he asked her whether she had brought any '*useful drugs*'. She asked him what he defined as useful and informed him that she had his usual prescription medication. Mr Kolbig said that the medication did not work and that the MAC team knew this so queried why they bothered giving it to him.

Ms McHugh replied by saying to Mr Kolbig that the medication was effective and she attempted to dispense it to Mr Kolbig. He refused stating that he would not take the medication anyway and slammed the door. She noted that she should make an outpatient appointment for Mr Kolbig at the Port Adelaide facility.

4.8. In fact Mr Kolbig came into the clinic unannounced on the following day, 20 April 2011. Prior to that attendance Mr Kolbig had attended at the Emergency Department of the QEH and then at the surgery of his private general practitioner Dr Foenander in Commercial Road, Port Adelaide.

4.9. The QEH Emergency Department triage note relating to Mr Kolbig's presentation[39] records that Mr Kolbig presented shortly before 6:30 on the morning of 20 April 2011. The triage assessment was 3. It is recorded as follows:

> 'HX OF SCHIZOPHRENIA, STATES IS HAVING A RELAPSE, HAS BEEN TAKING HIS MEDS. HEARING VOICES, HAVING PANIC ATTACKS, C/O[40] SUICIDAL IDEATIONS.' [41]

There is a further notation timed at 10:20am that Mr Kolbig had left the Emergency Department without being seen. It records that Mr Kolbig had not been seen in the Emergency Department since 8am.

4.10. Shortly before 9:30am Mr Kolbig attended at Dr Foenander's rooms in Port Adelaide. Dr Foenander recorded that Mr Kolbig came in requesting intramuscular risperdal and Valium. He was very stressed. He admitted to making mistakes and did not want to repeat them. He said that he wants '*risperidone Consta now*'. He was observed to have pressured speech, ruffled hair and was obviously upset. Mr Kolbig was prescribed with Valium by Dr Foenander.

4.11. Later that day Mr Kolbig presented in the waiting room of the Port Adelaide Community Treatment Team and said that he wanted to see a MAC worker. He was also requesting medication. Ms McHugh, the occupational therapist, was on the premises at this time. After speaking to Dr Parthasarthy she attended to Mr Kolbig. She observed him to be obviously distressed and anxious. He was clammy and shaking and was exhibiting pressure of speech in that he was speaking quite quickly. Mr Kolbig's T-shirt was on backwards and inside out. He was voicing delusional

[39] Exhibit C9, pages 5-6
[40] C/O = Complains of
[41] Exhibit C9, page 5

paranoid themes about people being after him and wanting to harm him and he commented that they would get him by the end of the day. He was distracted by what she recorded as '*racing thoughts*'[42]. Mr Kolbig could not be reassured, convinced or comforted by the reality that he was safe and that no one was after him. Mr Kolbig referred to Ms McHugh's attendance at his home the day before where he had slammed the door. He apologised for that. He also said that he had not taken his medication the previous night, nor this morning because in his words '*it's not working, I want a depot*'. Mr Kolbig's reference to a depot is a reference to periodic intramuscular antipsychotic medication such as risperidone Consta. Despite Ms McHugh's explanation about how his current medication, Seroquel, was meant to work if taken as prescribed, Mr Kolbig was insistent that he be provided with new medication then and there. She explained to him that she was not able to provide this and that he would have to see a doctor but that the doctor may not be available for some days. Although he was calmed somewhat, he was still insistent that he required other medication.

4.12. Ms McHugh then spoke to Dr Parthasarthy and in the event an appointment was made for Mr Kolbig to see Dr Parthasarthy at 2pm. Ms McHugh remained with Mr Kolbig for some time.

4.13. Ms McHugh gave oral evidence in the Inquest. She was questioned about the conversation that she conducted with Dr Parthasarthy after she had seen Mr Kolbig. She was asked specifically whether she had told Dr Parthasarthy that Mr Kolbig was expressing delusional paranoia. Ms McHugh gave slightly confusing evidence about this. She said that she could not recall the specific content of what she had said to Dr Parthasarthy that day, but said that it was likely that she did say that he was expressing delusional paranoia[43]. When specifically asked whether Mr Kolbig's statements that people were wanting to harm him and that they would get him by the end of the day were imparted to Dr Parthasarthy, Ms McHugh said that she could not specifically recall saying those words to Dr Parthasarthy, but that it was likely that she would have conveyed to him in some manner that Mr Kolbig was scared and was having thoughts that people were after him and that it was likely that it was a delusional belief system at work rather than a reality based event. She did say that in

[42] Exhibit C16a, page 8
[43] Transcript, page 541

2011 she would not have interpreted Mr Kolbig's delusional beliefs as evincing suicidal ideation[44].

4.14. Dr Parthasarthy also gave oral evidence at the Inquest. He had provided a witness statement dated 1 March 2012[45]. In his witness statement Dr Parthasarthy describes his first appointment with Mr Kolbig. This took place at the Port Adelaide Community Treatment Team office on 12 April 2011 which was the day after his discharge from Cramond Clinic. Mr Kolbig reported feeling better over the previous two weeks and said he had been taking his medications. Mr Kolbig appeared to be optimistic. Dr Parthasarthy agreed to see Mr Kolbig again in two months. In the meantime he would be managed by the MAC team.

4.15. On 19 April 2011 during a clinical review meeting with the MAC team Dr Parthasarthy was informed that Mr Kolbig had started drinking again. Dr Parthasarthy's statement suggests that because intake of alcohol had been commenced soon after discharge, he was concerned about Mr Kolbig becoming non-compliant with medication. He said:

> 'However I was satisfied that he was being monitored daily and that his medications were being supervised by MAC staff every day.'

Dr Parthasarthy's witness statement is silent as to whether at this meeting or at any other time he was told by any of the MAC workers that non-compliance with his antipsychotic medication had already occurred to that point. As seen, Mr Kolbig had not answered the door on 17 April 2011. As well, Mr Kolbig would not comply with his antipsychotic medication that evening.

4.16. Dr Parthasarthy's statement then goes on to assert that on the following day, 20 April 2011, he received a phone call from Mr Kolbig's general practitioner who, as indicated earlier, had been visited by Mr Kolbig that morning. Dr Parthasarthy then asserts that he spoke with a MAC team case manager who confirmed to him that Mr Kolbig's medications were being supervised daily and that MAC staff had his medications for supervision later that day. Again, there is no suggestion here that Dr Parthasarthy was informed of the two instances of non-compliance including from the previous evening.

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[44] Transcript, page 545
[45] Exhibit C17

4.17. Dr Parthasarthy later that day saw Ms McHugh who informed him that Mr Kolbig had presented at the Port Adelaide Community Treatment Team office. He agreed to see Mr Kolbig later that day and indeed did see him together with a registered nurse, Mr Dermot McNeil, at about 1:45pm for about 30 to 40 minutes. Dr Parthasarthy's statement and oral evidence deal with this consultation[46].

4.18. Dr Parthasarthy gave oral evidence at length. Dr Parthasarthy told the Court that Ms McHugh had told him that Mr Kolbig was seeking risperidone Consta and that he was obviously distressed and anxious. However, he said that she did not tell him that Mr Kolbig was suffering from delusional paranoia and that he believed that people were wanting to harm him. He also said that she did not tell him that he had not taken his medications the previous night or that morning.

4.19. Dr Parthasarthy also suggested that the information that Ms McHugh had about Mr Kolbig's delusion that people wanted to harm him was not information that he would have necessarily needed to know because Dr Parthasarthy was going to speak to Mr Kolbig himself. This would probably be an understandable attitude provided Dr Parthasarthy could elicit the same information himself. However, there is no suggestion that in the consultation between Dr Parthasarthy and Mr Kolbig that Mr Kolbig expressed any delusional ideation and in particular that people were wanting to harm him and that they would get him by the end of the day[47]. Thus it was that the psychiatrist, Dr Parthasarthy, who was in essence now Mr Kolbig's principal therapist, did not know of Mr Kolbig's paranoid ideation that day. It seems trite to suggest that Ms McHugh and Dr Parthasarthy should at least have conferred about that.

4.20. Dr Parthasarthy told the Court that in his consultation with Mr Kolbig on the afternoon of 20 April 2011, Mr Kolbig indicated that he had not been sleeping properly for the last few days and that his extended release preparation of Seroquel was not working for him. Dr Parthasarthy agreed to switch from an extended release preparation to the plain preparation because the latter had a much more potent sedative effect due to its more rapid onset. Dr Parthasarthy told the Court that when he changed to the plain preparation Mr Kolbig was placed onto a prescription of 1200mg per day which represented an increase of 200mg per day. Dr Parthasarthy

[46] Exhibit C8, page 111
[47] Transcript, page 269

also added diazepam (Valium) at 10mg twice per day to allay any anxiety or alcohol withdrawal. Mr Kolbig seemed to be happy at the change in medication and in particular in respect of the Valium prescription and said that he had derived some benefit from the Valium that had been administered to him by Dr Foenander that morning. The prescription of Valium for alcohol withdrawal seems to have been based on a somewhat naïve assumption that Mr Kolbig would refrain from, or limit, his alcohol consumption. It will be remembered that in spite of assurances that Mr Kolbig would limit his alcohol intake, he had boasted in the week since his release from Cramond Clinic that he would drink two or three cartons of beer per week, that he had planned to purchase more beer and that this was no empty boast having regard to his noticeable intoxication when visited by Ms McHugh on the afternoon of 15 April 2011 and the empty cans in his premises.

4.21. Dr Parthasarthy said that he did not feel the need to ask Mr Kolbig about suicidal ideation due to the fact that during the consultation he received a telephone call from a team leader at a non-Government organisation with which Mr Kolbig was engaged and Mr Kolbig appeared to entertain plans that included activities at the Easter break and for the following week. He also indicated his contentment with the change of medication. In response to questions from me Dr Parthasarthy did acknowledge the possibility that in an acute event, suicidal ideation might be triggered by a psychosis that included voice commands to kill himself[48]. He agreed that this was something that might not be predictable. Dr Parthasarthy said that during the consultation he did make attempts to clarify Mr Kolbig's psychotic symptoms and that all Mr Kolbig had said was that he felt that people became aware of his thoughts. He said that there was no evidence that he was hearing voices during the consultation[49].

4.22. Dr Parthasarthy said that Mr Kolbig seemed calmer and happier at the end of the consultation.

4.23. Dr Parthasarthy told the Court that he had been aware that Mr Kolbig had presented at the QEH Emergency Department earlier that day. Dr Parthasarthy did not attempt to access the triage information from the QEH, saying that his goal had been to ensure that Mr Kolbig's needs were addressed immediately rather than having to chase information from three or four different places. It will be remembered that the QEH

[48] Transcript, page 213
[49] Transcript, page 214

triage assessment included reference to the fact that Mr Kolbig was having a relapse of schizophrenia despite his medication, was hearing voices, having panic attacks and was complaining of suicidal ideation. Dr Parthasarthy said that this information would not have made any difference to his management, to the point of asserting in his evidence that he would not even have asked Mr Kolbig about suicidal ideation as part of his own consultation with him. In saying this, Dr Parthasarthy said that he would point out that Mr Kolbig had complained of suicidal ideation in the past but that it was important to assess in terms of risk whether anything was imminent. He repeated that Mr Kolbig appeared to be optimistic about the future when speaking to the non-Government organisation worker on the telephone in his presence. Counsel assisting, Ms Kereru, pressed Dr Parthasarthy about his failure to elicit other evidence of delusional or paranoid thinking on the part of Mr Kolbig other than a belief that people were gaining access to his thoughts. In the end Dr Parthasarthy did assert that he did specifically ask whether Mr Kolbig was hearing voices and Mr Kolbig said '*no, I believe people come to know about my thoughts*'[50]. I was not convinced that Dr Parthasarthy did ask Mr Kolbig whether the latter was hearing voices. I also regarded Dr Parthasarthy's assertions that information about Mr Kolbig's complaints of suicidal ideation at the QEH would not have made any difference to his management of Mr Kolbig as intrinsically unconvincing.

4.24. When Mr McNeil gave oral evidence he said that he was present during the consultation. Mr Kolbig said he wanted to change the medication because the medication he was on was not working for him. He said that he was concerned that people were hearing his thoughts and he felt very uncomfortable about that situation. He was anxious and quite distressed. Mr McNeil corroborated Dr Parthasarthy as to the complaint about not sleeping. Mr McNeil said that he did not know anything about Mr Kolbig's belief that people were wanting to harm him[51]. He did not recall Mr Kolbig saying anything to Dr Parthasarthy about people wanting to harm him or that they would get him by the end of the day. Mr McNeil did say that he would have been concerned about the fact that Mr Kolbig had been experiencing delusional paranoia earlier in the day. However, he emphasised that he believed that Ms McHugh would have conversed with Dr Parthasarthy prior to Dr Parthasarthy's appointment.

[50] Transcript, page 264
[51] Transcript, page 380

4.25. Mr Kolbig's daily MAC team visit later that day was conducted by Ms McHugh. He told her that he felt less stressed and anxious since he had seen Dr Parthasarthy and indicated that he was happy that his medication had been changed to plain Seroquel with the addition of Valium. He was observed to be less pressured in speech and no concerns were voiced about people trying to harm him. There was no indication of alcohol use at the time of that home visit. He took two Seroquel tablets in the presence of Ms McHugh and said that he would take the other two tablets before he went to bed. He also took his Valium. His morning medication was left with him.

4.26. In his oral evidence Dr Parthasarthy was questioned about Mr Kolbig's management since his release from Cramond Clinic. In answering many of those questions Dr Parthasarthy would point out that Mr Kolbig had a history of threatening to kill himself if he was taken to hospital or if mental health services were contacted about him. He had also refused intervention because he was enjoying his psychosis. He felt that on every occasion that his psychosis was treated, the doctors were killing who he was. Dr Parthasarthy agreed that it would be important to recognise the early warning signs in Mr Kolbig and to deal with them appropriately. By warning signs he meant a cessation of taking his medication, lack of insight and disengagement from his family. Dr Parthasarthy indicated that if Mr Kolbig had been refusing medication he would need to be taken to an appropriate approved treatment centre for treatment. Dr Parthasarthy indicated that he did not believe that any of these signs were being observed by the staff who had seen him[52]. In addition, Dr Parthasarthy suggested that it was important to have regard to the fact that in considering the appropriateness or effectiveness of a community treatment order, the Mental Health Act encouraged the use of the least restrictive alternatives to be explored prior to the use of such an order[53]. He believed that as long as Mr Kolbig was accepting of his medication there was no requirement for a community treatment order until non adherence was established[54]. Dr Parthasarthy told the Court that no person had contacted him about applying or not applying for a community treatment order, but that he had observed from the Cramond Clinic discharge summary that the treating team had considered that question and had decided not to apply for such an order. However, he said that he believed that a community treatment order would not have made any difference to Mr Kolbig's treatment because it was decided that Seroquel was the most effective

[52] Transcript, page 218
[53] Transcript, page 225
[54] Transcript, page 219

medication in Mr Kolbig's case and that he had indicated to the treating doctor on the ward that he was happy with that medication and was willing to take it so that there was therefore no means of enforcing a community treatment order. He also said that even with a CTO in place, MAC staff would still have acted no differently in that they would have gone to Mr Kolbig's doorstep, held out the medications to him and have asked him to take it. This tends to overlook the fact, of course, that Mr Kolbig's consistent acceptance of medication would be a matter that would be out of character for him and in any event be proved to be an illusory concept in this particular instance. In addition, with no CTO in place Mr Kolbig could refuse medication without any compunction, and having regard to his well known self-confessed tendency to accept medication only because of the existence of a CTO, refusal was a matter that could reasonably be foreseen to become more likely than less likely. With a CTO in place, treatment can be given despite absence of consent. Dr Parthasarthy told the Court that he was unaware of Dr Mohan's instructions concerning the necessity of a community treatment order in the event of non-compliance with medication in the community or, to use Dr Mohan's precise instruction, that there should be a low threshold for the imposition of the same. He was aware, however, that in discussion with Dr Wilson a community treatment order option was to be deferred until non-compliance had been established. I asked Dr Parthasarthy specifically how many non-compliances with medication it would take to trigger a community treatment order[55]. Dr Parthasarthy said that he was unable to provide a number but suggested that a period of non-compliance had to be established and that the patient had to be disengaging and '*absolutely refusing medications for least restrictive options to changeover to more coercive methods*'. He also went on to say:

> 'So, the Act specifies that all these restrictive methods should be employed and there should be least restrictive alternative available to the treating clinician before a CTO or community treatment order is applied for.' [56]

As will be seen below, the Mental Health Act 2009 does not state that all least restrictive methods have to be employed before a community treatment order can be imposed. What the Act does require is that less restrictive methods be considered before a community treatment order is imposed. Dr Parthasarthy did agree that in considering whether or not to impose a community treatment order one would have to

[55] Transcript, page 251
[56] Transcript, page 251

be satisfied that a patient was complying with medication[57]. Dr Parthasarthy acknowledged that Mr Kolbig had been drinking and that on at least one occasion he had refused to take his medication. He also acknowledged that he knew nothing of the details of Mr Kolbig's presentation at the QEH Emergency Department on the morning of 20 April 2011 and knew nothing of what Mr Kolbig had said to Ms McHugh in terms of delusional and paranoid thinking. He did say that he would have wanted to know that the following day Mr Kolbig in the presence of MAC team members had said that he did not want to die and agreed that one interpretation of such a statement was that he was experiencing an overwhelming desire to end his own life[58].

4.27. Dr Parthasarthy at no point during his evidence suggested that the successive community treatment orders imposed pursuant to the repealed legislation between the years 2007 and 2010 had been superfluous, ineffective or counterproductive and acknowledged that Mr Kolbig had not had an episode of self-harm or attempted self-harm since an impulsive overdose on medication in 2006.

5. <u>The events of 21 April 2011 – the day of Mr Kolbig's death</u>

5.1. I have already referred to Ms McHugh's attendance upon Mr Kolbig's premises on the afternoon of 20 April 2011 following his consultation with Dr Parthasarthy. That night Mr Kolbig went to the home of his grandmother Ms Sherly Kolbig, arriving sometime in the early hours of the morning of 21 April 2011. Ms Kolbig lived at premises at Semaphore. Ms Kolbig gave oral evidence at the Inquest. Ms Kolbig lived alone. She described her grandson upon his arrival as '*restless, sad and not talkative*'[59]. She said that Mr Kolbig was walking around and twisting his hands. He appeared to be '*electric*'[60]. Mr Kolbig did not say much and declined food. He went almost immediately to bed. Mr Kolbig had driven his car to her premises.

5.2. The next morning Ms Kolbig had breakfast with Mr Kolbig. She asked him about his morning tablets. He indicated that they were at his own premises. A plan was made for him to go there and obtain them. During the course of that morning Ms Kolbig and her grandson went to the premises of one of Ms Kolbig's daughters, Ms Deborah Fraser, who lived at West Lakes. Both Ms Fraser and her husband, Mr Simon Fraser,

[57] Transcript, page 252
[58] Transcript, page 288
[59] Transcript, page 89
[60] Transcript, page 90

observed Mr Kolbig that morning. Mr Fraser would also see Mr Kolbig again later that same day when Mr Kolbig returned to that premises and asked Mr Fraser if he had any guns.

5.3. Ms Fraser gave oral evidence at the Inquest. Ms Fraser told the Court that her mother and Mr Kolbig arrived at her house at about 9:30am. She described Mr Kolbig as very agitated with leg shaking, hand wringing and an inability to stay in the one place for any length of time. In his statement[61] Mr Fraser does not describe anything out of the ordinary about Mr Kolbig's demeanour at that stage. Mr Fraser said that for the most part he was in and around the house minding his own business. When Ms Fraser sat down with Mr Kolbig and her mother, Mr Kolbig told her that he was hearing voices and that he had been to see his doctor who would not give him any more medication. He said he had also been to the emergency department of the hospital, had sat there for hours and nobody had spoken to him. Mr Kolbig asked Ms Fraser if she had any medication. She did not have any medication. He said that he was still hearing voices. He said that the voices were telling him to hurt himself but that he did not want to; he saw himself as a '*benevolent God*' and that he had never hurt anyone, the inference being that he did not deserve to be hurt. Ms Fraser told the Court that Mr Kolbig said that the voices were telling him to kill himself, specifically that he should die, and this prompted Mr Kolbig to say to her '*I don't want to die*'[62]. Ms Fraser's impression of Mr Kolbig was that he was totally psychotic.

5.4. Ms Fraser gleaned that Mr Kolbig had not taken his morning medication. She also advised him to go to his home and take his medication. Ms Fraser deduced that this was her mother's and Mr Kolbig's plan.

5.5. Following this visit Ms Kolbig and Mr Kolbig returned to her premises where Mr Kolbig collected his car. The arrangement was that he would go to his own premises, obtain his medication and return with it to Mr Kolbig's premises. In the event he did not return to her premises.

5.6. Mr Kolbig returned to the home of his aunt, Ms Fraser. At that time Mr Fraser was at home alone. Mr Kolbig arrived in his car. He was very agitated and was carrying a full unopened carton of VB cans. Mr Kolbig did not seem intoxicated when he arrived. Mr Fraser and Mr Kolbig sat together at the rear of the premises where they

[61] Exhibit C7a
[62] Transcript, page 137

both drank two beers. Mr Kolbig said, among other things, that he had voices in his head and that it was not worth living. He spoke very negatively about life. He asked Mr Fraser if Mr Fraser had any guns on the property. Mr Fraser formed the opinion that Mr Kolbig was suicidal. Mr Fraser advised Mr Kolbig to see his doctor, Dr Foenander, and Mr Kolbig promised that he would do that. By the end of their conversation Mr Kolbig had calmed somewhat and was in a better frame of mind. Mr Fraser walked Mr Kolbig out to his car and Mr Kolbig indicated that he was going straight to see his doctor.

5.7. There is no evidence that Mr Kolbig went to see Dr Foenander. In fact it is apparent that Mr Kolbig returned to his own premises.

5.8. Ms Sandra Paues was a neighbour of Mr Kolbig. She had been his next door neighbour for approximately ten years. She knew that Mr Kolbig had a mental illness. On 21 April 2011 Ms Paues was in the car park at her premises when Mr Kolbig came over to her, held onto her arm and said '*don't leave me, I am stressed, I want somebody to help me*'. Mr Kolbig added that nobody would help him. Ms Paues offered to ring ACIS[63] and returned to her own premises for that purpose. At about the same time a friend of Mr Kolbig, Mr Greg Anderson, arrived. Ms Paues describes Mr Kolbig as very agitated, fidgeting and sweating a lot. Ms Paues told the Court in her oral evidence that she had never seen Mr Kolbig like that before. Ms Paues' call to ACIS was recorded. It is apparent that Ms Paues telephoned ACIS at 1:36pm and spoke to the ACIS operator, Ms Looyestyn[64]. A transcript of the telephone conversation was tendered to the Inquest[65]. The transcript reveals that Ms Paues told Ms Looyestyn that Mr Kolbig had been waking up at 5:30am very restless, that he could not sleep, that he was very shaky and felt like everybody hated him, that the whole world was against him and that people wanted to kill him. I infer that Mr Kolbig had said all of that to Ms Paues just prior to her making the phone call. The operator suggested that Ms Paues allow Mr Kolbig to speak to her. Ms Paues then went to Mr Kolbig's premises and handed him the phone. The remainder of the transcript is of Mr Kolbig's verbal exchange with Ms Looyestyn, the operator. The salient features of what Mr Kolbig said to the operator was that he needed medication, that his key worker was due at 5pm that afternoon and that he was not getting enough

[63] Assessment and Crisis Intervention Service
[64] Exhibit C11, paragraph 8
[65] Exhibit C11, BL-1

medication to help himself. Ms Looyestyn suggested that the MAC workers provided an intensive mental health service to which Mr Kolbig replied that he knew that, but that they were not doing anything for him. He said '*no, they are only bringing minimal medication for me at 5 o'clock and that*'. Mr Kolbig indicated that he needed medication to calm his nerves and needed a benzodiazepine or '*any medication that will do the trick please*'. He said that because the MAC team was not arriving until 5pm he needed to receive some medication now to keep his mind at ease. At the end of their conversation Ms Looyestyn telephoned Mr David Bambrick at Western MAC. The connection appears to have taken place at 1:42pm. Ms Looyestyn told Mr Bambrick that a neighbour of Mr Kolbig's had telephoned saying that someone needed to see him urgently, that Mr Kolbig could not wait until 5pm for his medication and that he was wanting someone to come out to his premises immediately to give him something. Mr Kolbig was then put through to Mr Bambrick. Unfortunately there is no transcript or other record of that conversation. Ms Paues was asked in evidence as to whether in Mr Kolbig's conversation with the person to whom he spoke, whom we know to be Mr Bambrick, he had described death or dying. Ms Paues answered negatively, but said that Mr Kolbig would hang onto his head indicating that he had '*bad thoughts*'

5.9. Ms Paues waited at Mr Kolbig's premises until his grandmother, Ms Sherly Kolbig, arrived. She was present in the front yard when the MAC team arrived. Ms Paues did not remain during the subsequent interaction between members of the MAC team and Mr Kolbig. It appears that Ms Paues may have been in Mr Kolbig's presence for as long as approximately 90 minutes. Counsel assisting asked Ms Paues to sum up Mr Kolbig's demeanour while in her presence that afternoon. She said that he was sweating a lot, getting up, sitting down and moving around. He would say '*I want pills, I want pills*'[66]. She said that although he did not say what his bad thoughts were, he did say '*I don't want to die*'[67]. Ms Paues said that he said that in conjunction with his statements that he had bad thoughts. Ms Paues attempted to reassure him that he would not die while she and others were with him.

5.10. I accepted Ms Paues' evidence. I found her to be an impressive witness who had held a genuine concern for Mr Kolbig that afternoon. In my view her evidence establishes

[66] Transcript, page 44
[67] Transcript, page 44

conclusively that Mr Kolbig was experiencing a delusion that people wanted to kill him and that he did not want to die.

5.11. I have already referred to the arrival of a male friend of Mr Kolbig. That person was Mr Greg Anderson who had been a friend of Mr Kolbig's for approximately 18 years. He had met Mr Kolbig through a mental health facility operated by the Adelaide Clinic. Mr Anderson lived at Grange. He gave evidence at the Inquest. Mr Anderson remained for a little time at Mr Kolbig's premises. He left and later returned with his mother who was a retired registered nurse.

5.12. Mr Anderson indicates that when he arrived at Mr Kolbig's premises on the first occasion, Mr Kolbig was '*very uptight*'[68]. Mr Kolbig repeatedly said that he needed medication to calm his racing thoughts. His statement suggests that when he later returned with his mother, the mental health workers had already arrived, as had Mr Kolbig's grandmother. In his evidence, however, he said that he thought that the team arrived after his arrival. I do not believe anything turns on that discrepancy. Mr Anderson told the Court that when the mental health team was present inside of Mr Kolbig's premises, Mr Kolbig had told them that he needed medication, that he was very stressed out and that he needed to go back to hospital[69]. He was saying things like the paedophiles were after him but that he was not a paedophile. He said that Mr Kolbig begged for medication[70]. As to the response of the mental health team, he said that they thought that Mr Kolbig did not need hospitalisation, whereas he, Mr Kolbig's grandmother and Mr Anderson's mother were telling the team that he did need to go back to hospital and that he could harm himself. Mr Anderson was not certain whether he himself had said that. Mr Anderson said that Mr Kolbig was very upset and stressed out and did not seem to calm down after the mental health team had arrived[71]. Mr Anderson asserted that on more than three occasions Ms Kolbig had asked the team to take her grandson to hospital[72]. Their response had consisted of them saying that Mr Kolbig did not need to be in hospital. Mr Anderson was asked in cross-examination by counsel, Ms Wells, on behalf of Central Adelaide Local Area

[68] Exhibit C13, page 2
[69] Transcript, page 24
[70] Transcript, page 25
[71] Transcript, page 27
[72] Transcript, page 28

Health Network Incorporated, Dr Parthasarthy, Dr Mohan, Ms Looyestyn, Mr Bambrick and Mr McNeil:

> 'Q. You would agree, wouldn't you, that he was responding to the questions of the ACIS nurses.
>
> A. He didn't agree with it; he wanted to be medicated and then hopefully go back into hospital and they said 'No'.' [73]

5.13. Mr Anderson told the Court that on about two or three occasions Mr Kolbig said that he did not want to die. He said that Mr Kolbig had said that in the presence of the mental health team workers.

5.14. Mr Anderson agreed that there had been discussion concerning Ms Kolbig staying with his grandmother, and also in respect of some activities that she and Mr Kolbig might engage in later, such as watching a DVD and playing scrabble. Mr Anderson agreed that this discussion occurred in an attempt to calm Mr Kolbig down and to reassure him, but that in his view his friend Mr Kolbig needed to be medicated. He did concede that Mr Kolbig appeared comfortable with the plan that he remain with his grandmother because he loved his grandmother a lot. He could not say, though, whether his grandmother was comfortable with it herself. Ms Kolbig herself would give evidence about that aspect of the matter.

5.15. Mr Anderson's mother, Ms Rosemary Anderson, gave evidence at the Inquest. She also provided a statement to police dated 13 August 2011[74]. Ms Anderson is a retired registered nurse having been Director of Nursing at the Philip Kennedy Centre. Ms Anderson knew Mr Kolbig as a friend of her son, Greg. She knew that Mr Kolbig suffered from schizophrenia.

5.16. Ms Anderson stated that she attended with her son at Mr Kolbig's premises at approximately 3pm. She remembered this time because her son had collected her from the West Lakes Shopping Centre at approximately 2:50pm, the time being established by a watch that audibly announced the time. Her son told her that Mr Kolbig was not well and asked whether in her capacity as a nurse she could arrange for his hospitalisation. She and her son drove to Mr Kolbig's premises where they found Mr Kolbig sitting on the lounge next to his grandmother. Two men from the mental health team were also present at that stage. Mr Kolbig was extremely agitated

[73] Transcript, page 32
[74] Exhibit C15

and mentioned a belief on his part that there were paedophiles outside. Mr Kolbig then started pleading with or begging the mental health workers for help and for them to give him a tablet to stop his head from racing. One of the gentlemen responded by saying that Mr Kolbig was doing well. Mr Kolbig said in their presence that he wanted medication and specifically '*I don't want to die*'[75]. Ms Anderson made this assertion both in her original statement to police given in 2011 and in her oral evidence. Ms Anderson told the Court that Mr Kolbig was all of the time pleading for something because his head was racing. At different times Ms Anderson, her son and Ms Kolbig said '*like a lot of parrots*'[76] that Mr Kolbig needed to be in hospital to which the invariable response was that Mr Kolbig was fine and doing well. The mental health workers urged Mr Kolbig to take his medication at the usual time of 5pm and said that they would see him tomorrow morning[77]. It occurred to Ms Anderson that the reluctance on the part of the mental health workers to consider hospitalisation for Mr Kolbig owed itself to the fact that it was about 4pm on the Thursday before the Easter public holiday weekend[78].

5.17. Ms Anderson told the Court that Mr Kolbig himself said that he wanted to be hospitalised[79].

5.18. Ms Anderson said that there was some discussion concerning Mr Kolbig's grandmother giving him his antipsychotic tablets at 5pm. The tablets were provided to Ms Kolbig with that in mind. This was Mr Kolbig's usual antipsychotic medication that in the normal course of events would be delivered at around 5pm and consumed at that time. By this stage it was about 4pm. Ms Anderson had the impression that there was an element of insistence of the part of the mental health workers that Mr Kolbig not take his medication until the usual time of around 5pm and she was somewhat frustrated by the fact that, as far as she was concerned, there appeared to be no reason why he could not take his medication then and there. She said that the medication was given to Ms Kolbig for her to oversee its administration.

5.19. Ms Anderson did not hear any enquiry made by mental health workers of Mr Kolbig as to whether he had plans to harm himself or whether he was hearing voices[80]. Ms Anderson also did not recall whether there had been any discussion about the

[75] Transcript, page 62
[76] Transcript, page 66
[77] Transcript, page 66
[78] Transcript, page 66
[79] Transcript, page 79
[80] Transcript, page 65

activities that Mr Kolbig might be able to engage in that afternoon, such as watching a movie or playing scrabble, but told the Court that she did not think that Mr Kolbig was in any condition to have managed any such activity whether it was sitting down watching a DVD or playing scrabble. She did not think that his mind would have allowed for the necessary concentration.

5.20. Ms Anderson told the Court that the matter was left on the basis that Mr Kolbig would be administered his medication at 5pm and that his grandmother would take possession of the medication for that purpose. Ms Anderson regarded Mr Kolbig as being in an absolute crisis[81] and that the mental health workers had not done anything to calm him down. Mr Kolbig was begging to the last minute for something to stop his racing head. She had never seen Mr Kolbig in that state before[82]. The team left at about 4pm and at the door Ms Anderson told the workers that they all felt that Mr Kolbig should be in hospital, particularly given that Mr Kolbig's parents were away and that his grandmother was elderly. One thing that Ms Anderson did recall about this conversation was that when they were leaving the workers asked her whether Mr Kolbig had been drinking to which she responded that she was not aware.

5.21. Ms Anderson told the Court that when Mr Kolbig had said that he did not want to die, nothing had been said on the topic of suicidal ideation[83]. She said '*he just kept saying "I don't want to die. Could you please give me some medication, give me something."*'[84].

5.22. Ms Anderson did not believe that she had indicated to the mental health workers that she herself was a nurse. She told the Court that her desire during this incident was that she would have liked to have seen Mr Kolbig hospitalised, or at least that a medical practitioner could be asked to authorise the immediate provision of his medication[85]. She told the Court that it did not occur to her that she and her son might herself take Mr Kolbig to hospital. She said this:

> 'After we suggested it and it was pushed aside by the experts then we felt too the safest place was granny's.' [86]

[81] Transcript, page 64
[82] Transcript, page 68
[83] Transcript, page 70
[84] Transcript, page 70
[85] Transcript, page 73
[86] Transcript, page 80

She agreed with counsel, Ms Wells, that Mr Kolbig and his grandmother were comfortable with the plan to return to her premises once the MAC team left, but said this was a last resort seeing as he could not be left at his own premises by himself. In addition, Mr Kolbig felt safe with his grandmother[87].

5.23. As indicated earlier Ms Sherly Kolbig gave oral evidence that included an account of the visit by the MAC team. Ms Kolbig told the Court that '*to the most careless observer*'[88] her grandson needed to be returned to hospital. She said that Mr Kolbig's tension was the most obvious feature of his presentation, that he was tight and pacing around and constantly picking things up and putting them down.

5.24. Ms Kolbig could not recall conversation about her grandson wanting to be taken to hospital. She said that she could not exactly remember saying to the mental health workers that her grandson should be going to hospital, but she said '*I certainly thought it*'[89]. The impression I had from Ms Kolbig was that she did not have a perfect recollection of what had taken place in this incident and that the precise detail of the event did not remain in her memory. Her lack of memory of detail is unsurprising given her participation in the traumatic events later that afternoon. Ms Kolbig did leave an impression with the Court that while the mental health workers were present Mr Kolbig was still in the restless demeanour that he had been in all morning[90]. What Ms Kolbig did tell the Court about this incident was that when she indicated to the mental health workers that Mr Kolbig had slept at her premises the previous evening, this was met with an enquiry as to whether or not she would accommodate him and manage his tablets. She said that one of the men offered her the box of medication and had said '*well that's great, you can have his tablets and, you know, give them to him on the right times*'[91]. Ms Kolbig told the Court that her grandson had wanted his medication when the mental health workers were present. She said that he asked several times for his medication and when it was realised who she was and that she would agree to have Mr Kolbig stay with her, it was at that stage suggested by one of the men that she could therefore administer the medication herself.

[87] Transcript, page 80
[88] Transcript, page 93
[89] Transcript, page 105
[90] Transcript, page 109
[91] Transcript, page 93

5.25. Ms Kolbig gave evidence that there had been discussion about Mr Kolbig and herself playing games at her premises, but she told the Court that the discussion was only a suggestion in an attempt to calm Mr Kolbig down.

5.26. In the event Ms Kolbig took Mr Kolbig back to her premises. She took with her the medication that the mental health workers gave her. When they arrived at her premises Mr Kolbig started agitating for his medication. In the event she gave it to him earlier than directed because she could see how stressed he was. In her statement she describes the incident in which Mr Kolbig took his own life. Mr Kolbig went into the kitchen where he opened a drawer and pulled out a knife. He walked into the courtyard where he pressed the knife to his chest with both hands. Ms Kolbig tried to pull his hands off the knife but he was too strong for her. Ultimately the knife penetrated Mr Kolbig's chest. In her evidence Ms Kolbig told the Court that while he was pressing the knife into his body Mr Kolbig said '*it's time*'[92].

5.27. Police located at the premises of Ms Sherly Kolbig four Seroquel tablets of 300mg[93].

5.28. The MAC team members who attended on the afternoon of 22 April 2011 at Mr Kolbig's premises were Mr McNeil and Mr Bambrick, to both of whom I have already referred.

5.29. Both Mr Bambrick and Mr McNeil would make notes of their attendance on the CBIS record. They say that the notes were made at a time before they knew of Mr Kolbig's death. There is no evidence to the contrary. Certainly there is no reference to Mr Kolbig's death in either note, nor in any note within the CBIS record that preceded either of Mr Bambrick's or Mr McNeil's note. Both Mr Bambrick and Mr McNeil gave oral evidence at the Inquest.

5.30. Mr Bambrick's note, which is the shorter of the two sets of notes, describes Mr Kolbig's presentation that afternoon as being anxious but reactive. He was fixated on medication and continued to ask if he could have an injection or his regular dose and he repeated this many times during the meeting. There was only one mention by Mr Kolbig about voices. Mr Kolbig said that he would like them stopped. Mr Bambrick recorded that Mr Kolbig did not want people thinking he was crazy and that he wanted others to like him. Mr Kolbig had said that he was a nice guy and that he did

[92] Transcript, pages 102-105
[93] Statement of Acting Sergeant Benjamin Partington, Exhibit C6a, page 5

not understand why others did not like him. Mr Bambrick noted that Mr Kolbig should focus on other things to which Ms Kolbig had offered to take Mr Kolbig back to her home and watch television or play cards in order to occupy his mind until it was time for his medication. To this Mr Kolbig had indicated that it was a good idea and he would like that. There was discussion with Ms Kolbig about the fact that Mr Kolbig would stay with her until the return of his parents from overseas. Mr Bambrick recorded that he and Mr McNeil agreed to allow Ms Kolbig to administer Mr Kolbig's medication later that evening and in the following morning so that Mr Kolbig could consume it in a timely manner. The night and morning medications were then provided to her. There is a notation that there would be a visit the following day.

5.31. Mr McNeil's note records that Mr Kolbig was fearful of being seen as a bad person whereas he was not like that. He said he requested an injection. There was discussion recorded in Mr McNeil's notes about the consultation with Dr Parthasarthy the day before, and in respect of other possible further medication options if Mr Kolbig remained unhappy with his current medication. Mr McNeil noted that Ms Kolbig seemed pleased with this information and that Mr Kolbig himself indicated assent by nodding his head but that he asked for an injection. Some discussion of an unspecified nature is noted concerning Mr Kolbig's grandmother's knowledge of when Mr Kolbig needed to take his medication. Also noted is a discussion about the fact that Mr Kolbig would be staying with his grandmother while his parents were overseas. There was recorded discussion as to how alcohol would lessen the effects of his medication to which Ms Kolbig said she understood this and to which Mr Kolbig indicated that he would not be drinking. The notes suggest that Mr Kolbig was reassured with these plans and was happy to stay with his grandmother. Some '*coping strategies*' were discussed along the lines that Mr Kolbig and his grandmother would play scrabble together and possibly see the movie 'Australia' and about Mr Kolbig taking his dog for a walk. Mr McNeil recorded '*no indication of any suicidal ideation*'. Mr McNeil also recorded that Mr Kolbig was anxious but did not appear distracted and that his behaviour was appropriate to the situation. Mr McNeil's note does not say anything about Mr Kolbig hearing voices and wanting them stopped, a notation that appeared in Mr Bambrick's note.

5.32. Neither Mr Bambrick nor Mr McNeil's make any reference to the following matters:

- Request for hospitalisation;
- Any perception on Mr Kolbig's part that there were paedophiles in the vicinity;
- Any anxiety about, or statements to the effect, that Mr Kolbig did not want to die;
- Any behaviour on the part of Mr Kolbig that could be characterised as begging for medication;
- A presentation of extreme agitation on the part of Mr Kolbig;
- Any specific enquiry as to whether Mr Kolbig was experiencing suicidal ideation or of any response, other than the bare note in Mr McNeil's record that there was no indication of any suicidal ideation;
- Any enquiry on the part of either member about the nature of the voices which, as noted by Mr Bambrick, Mr Kolbig would like stopped.

5.33. In his oral evidence Mr Bambrick told the Court that Mr Kolbig looked anxious and that he was fidgety with rapid speech. He believed that Mr Kolbig's presentation on that day was roughly the same as it had been on other visits. There was nothing about him that generated concern[94]. He could not remember whether anyone present had said that he should be hospitalised. He said that he would have considered this had it been requested, but he said he did not think it necessary in any event.

5.34. Mr Bambrick said that Mr Kolbig spoke in a reasonable tone. Although he was at first hesitant about Mr Kolbig going home with his grandmother, after discussion with Ms Kolbig about his medication and about her ability to keep him occupied with games and other activity, he felt comfortable. He believed that Ms Kolbig thought it was a good idea that Mr Kolbig go back to her place and to undertake such activities. Ms Kolbig gave an undertaking to provide Mr Kolbig with his medication at 5pm.

5.35. At first, Mr Bambrick said that he could not recall any enquiry made either by himself or by Mr McNeil as to whether Mr Kolbig was experiencing any suicidal thoughts[95], but later in his evidence said that in order for Mr McNeil to have made a note that there had been no indication of suicidal ideation, Mr McNeil must have made that

[94] Transcript, page 149
[95] Transcript, page 151

enquiry[96]. He said that Mr Kolbig was definitely not experiencing psychosis[97] which in the view of the Court seems at odds with his hearing voices and wanting them stopped. Mr Bambrick acknowledged that he did not ask Mr Kolbig what the voices were saying, the reason for this being that Mr Kolbig for the most part was directing his conversation towards Mr McNeil[98] whereas he did say that he was '*pretty sure*' that Mr McNeil had asked him about that[99]. Mr Bambrick could not tell the Court what Mr Kolbig's response had been to Mr McNeil's question about voices. In any event Mr Kolbig appeared comforted or reassured by what Mr McNeil said to him. Mr Bambrick did agree that it would be standard practice to question a person who claimed to be hearing voices, and particularly commanding voices, as to whether the voices were telling the person to kill him or herself. Mr Bambrick said that he had no realisation that a feature of Mr Kolbig's illness was that he experienced command auditory hallucinations[100]. Mr Bambrick said that he did not believe that he had any obligation to explore the question of voices with Mr Kolbig as he was confident that Mr McNeil had done so[101]. When asked by counsel assisting if he had asked Mr Kolbig whether he would act upon the voices he was hearing he said '*Not by me, no*'[102]. It will be observed that Mr McNeil did not make any notation of Mr Kolbig hearing voices, let alone make a note of any enquiry that had been made about what the voices were saying or of Mr Kolbig's response if any.

5.36. Mr Bambrick said that he did not ask Mr Kolbig whether he was thinking of harming himself and did not recall whether Mr McNeil had asked him that question. He acknowledged that it was a fundamental question that needed to be asked of a schizophrenic person and agreed that it should have been asked.

5.37. As far as Mr Kolbig's medication is concerned, when they left at about 3:30pm or 4pm Mr Kolbig had not taken his medication by that stage. He agreed that in normal circumstances this would have taken place in his presence[103] in accordance with Mr Kolbig's plan. He agreed that Mr Kolbig had wanted to take his medication early and assumed that Mr McNeil for some good reason had not wanted him to take it at that

[96] Transcript, page 191
[97] Transcript, page 151
[98] Transcript, pages 166-167
[99] Transcript, page 167
[100] Transcript, page 168
[101] Transcript, page 169
[102] Transcript, page 170
[103] Transcript, page 174

particular time. He agreed that there was no guarantee that Mr Kolbig would take his medication at a time after they left[104].

5.38. When Mr Bambrick left Mr Kolbig's premises he did not think that Mr Kolbig was at any current risk of suicide[105].

5.39. In cross-examination by Ms Kereru, counsel assisting, Mr Bambrick stated that he was not aware that Mr Kolbig had been on a community treatment order in the past. He said he did not recall having read the discharge summary from Cramond Clinic[106]. Mr Bambrick also said that he had not been aware that upon Mr Kolbig's discharge from Cramond Clinic his treating psychiatrist had said that if there was a relapse, there was to be a low threshold for re-hospitalisation[107]. He agreed with counsel assisting that there were a number of occasions during the week leading up to Mr Kolbig's death in which the MAC team could not be sure that Mr Kolbig had taken his medication[108]. He did not know that on 20 April 2011 Mr Kolbig had attended the QEH Emergency Department because the latter had been hearing voices. Nor did he know that he had attended at his local general practitioner on the same day asking for medication. He agreed that all of that information would have been useful to him on the occasion of his attendance on 21 April 2011[109].

5.40. Counsel assisting put to Mr Bambrick that those present at the house with Mr Kolbig on 21 April 2011 expressed a view that Mr Kolbig should be hospitalised, to which Mr Bambrick said '*no, don't remember*'[110]. He did agree that Mr Kolbig, from what he could remember, had begged them to give him something to calm down his racing thoughts[111].

5.41. Mr Bambrick was asked whether Mr Kolbig had said in his presence '*I don't want to die*'. Mr Bambrick's response was '*I can't remember those specific words*'[112]. At no stage during his cross-examination on that subject did he deny that Mr Kolbig had said '*I don't want to die*'. Mr Bambrick was asked about the possible significance of a statement such as that. Mr Bambrick did say that he would have had to ask Mr

[104] Transcript, page 174
[105] Transcript, page 152
[106] Transcript, page 156
[107] Transcript, page 179
[108] Transcript, page 162
[109] Transcript, page 163
[110] Transcript, page 165
[111] Transcript, page 166
[112] Transcript, page 194

Kolbig what he meant by that. When asked whether such a statement might be an indication of suicidal ideation, Mr Bambrick said '*possibly*'[113].

5.42. Mr Bambrick denied that there had been any anxiety on his part or on the part of Mr McNeil about the inconvenience that might be caused if Mr Kolbig had to be detained under the Mental Health Act that afternoon. He said that it would not have worried either of them[114].

5.43. Mr McNeil also gave oral evidence. Mr McNeil has been a registered mental health nurse since 1991. He has been nursing since approximately 1979. Mr McNeil gave some general evidence as to the appropriateness of a community treatment order or enforced hospitalisation. Mr McNeil suggested that one would need to look at the history of the client to that point in time, including their history of non-compliance, but that one would clearly need to demonstrate that the person has been non-compliant when applying for a community treatment order[115]. Mr McNeil stated that if a client categorically said that they would not take medication unless an order was in place, this would usually be sufficient for the Guardianship Board to make a determination that a community treatment order would be appropriate. Of course, this attitude on the part of a client was the very attitude that Mr Kolbig had displayed and expressed during the currency of community treatment orders in the past. Mr McNeil told the Court that for the purposes of the new Mental Health Act he was an authorised health professional and that he was authorised to impose a community treatment order[116]. When assessing as to whether it was appropriate to consider a community treatment order, Mr McNeil cited such matters as sudden disengagement from a service, not being at home on given days and so on[117]. He said that his service liked to support independent living on the part of the recovering patient and that there needs to be a sense of self responsibility in terms of their treatment[118].

5.44. Mr McNeil told the Court that he had been aware of the circumstances in which Mr Kolbig was detained in February 2011 and believed that the rest of the MAC team would also have been aware of his symptoms and features of risk[119]. As seen, Mr

[113] Transcript, page 193
[114] Transcript, page 195
[115] Transcript, page 340
[116] Transcript, page 342
[117] Transcript, page 341
[118] Transcript, page 342
[119] Transcript, page 349

McNeil had been present at the unscheduled consultation that Mr Kolbig had with Dr Parthasarthy on 20 April 2011.

5.45. On 21 April 2011 Mr McNeil became aware that Mr Bambrick had taken a phone call about Mr Kolbig and, due to the fact that he was free that afternoon, said that he would go with Mr Bambrick saying to him '*yeah, I'll come out with you if you wish*'[120].

5.46. In his evidence in chief Mr McNeil gave evidence that was consistent with his note of the attendance. He did not recall that any view had been expressed by any person that Mr Kolbig should be hospitalised[121]. He did not believe that Mr Kolbig's presentation had been any different to what it had been the day before, except in relation to the nature of his concerns about people hearing his thoughts from the day before on the one hand and not being seen as a good person this day on the other.

5.47. As to Mr Kolbig's medication, when asked as to why he was not given his Seroquel while the MAC workers were there, he referred to the lateness of Mr Kolbig having taken his morning medication that day and said he had been slightly concerned about giving a second dose so soon after the first. Of course this reasoning could not have applied to the Seroquel administration because he had not taken any that morning. Mr Kolbig was scheduled to take that at around 5pm of an evening.

5.48. Mr McNeil said he did not have any concerns about leaving Mr Kolbig in the care of his elderly grandmother as he did not have any sense that Mr Kolbig was an intimidating person, and he referred to the fact that Mr Kolbig had stayed the previous night with Ms Kolbig. He said that Mr Bambrick did not express any concerns either[122]. Ms Kolbig had volunteered to take the evening medication and hold it for Mr Kolbig. There was some discussion about the two of them playing scrabble and walking the dog. He said that '*Drew at every point and every suggestion, Drew was very happy and very willing to – had agreed to that plan*'[123]. He said that Mr Kolbig's grandmother seemed prepared as well.

[120] Transcript, page 358
[121] Transcript, page 360
[122] Transcript, pages 362-363
[123] Transcript, page 364

5.49. Mr McNeil said that in the 30 to 45 minute period during which they were present at Mr Kolbig's premises he had calmed down[124]. He said that if either Mr Kolbig or his grandmother had not been comfortable with the plan, they would have returned and visited Mr Kolbig at 5pm, which I took to be a reference to them returning to provide him with his antipsychotic Seroquel medication at the usual time of 5pm. As will be seen, in fact there was no clinical or pharmacological reason why the antipsychotic medication could not have been given then and there.

5.50. As to suicidal ideation, Mr McNeil said that it was not expressed[125]. He said that neither Mr Kolbig's neighbour, Mr Kolbig himself, nor his grandmother had expressed any fear that Mr Kolbig was suicidal. He said that Mr Kolbig was quite happy for the MAC team to come around, that he was engaging with the MAC team and was willing to take his medications. None of those indicators for Mr McNeil rang any '*alarm bells*'[126] in terms of suicidality. He said that Mr Kolbig had many protective factors around him including his family and the MAC team and his neighbours. This of course begged the question as to whether or not Mr McNeil had asked Mr Kolbig specifically whether Mr Kolbig had been, or was at the time, experiencing suicidal ideation, a matter I will come to in a moment.

5.51. Mr McNeil said that he had been unaware of the fact that on the previous day Mr Kolbig had told Ms McHugh, the occupational therapist in the MAC team, that Mr Kolbig had said to her that people were wanting to harm him and was not able to be convinced that he was safe[127]. He said that Mr Kolbig himself had not said this during the consultation with Dr Parthasarthy. He said:

> 'I don't recall him saying that, no.' [128]

5.52. Mr McNeil eschewed the suggestion that had been made by Mr Bambrick in effect that he, Mr McNeil, had assumed the lead role at the home visit of 21 April 2011. In this regard he pointed out that Mr Bambrick had seen Mr Kolbig on a number of occasions during the course of that week.

5.53. Mr Kolbig, according to Mr McNeil, did not beg for medication and would not have considered that he was agitated. There was no getting up and down – to Mr McNeil

[124] Transcript, page 365
[125] Transcript, page 366
[126] Transcript, page 366
[127] Transcript, page 380
[128] Transcript, page 384

he was sitting down, he was calm. His memory was quite the opposite to the picture of significant agitation described by those people who knew him[129].

5.54. In cross-examination Mr McNeil said that Mr Kolbig had claimed that he could hear voices and wanted them stopped, which was the manner in which Mr Bambrick had noted Mr Kolbig's presentation. When asked whether he had asked Mr Kolbig what the voices had been saying, he responded negatively and said that he wanted to be liked. He felt that people did not like him and he wanted that to be stopped[130]. When again asked whether he asked Mr Kolbig what the voices were saying, he said he had assumed that the voices had been saying something derogatory about him, but that he had not actually ventilated the issue any further. He would not agree with the possibility that the voices could have been telling Mr Kolbig to kill himself[131]. He was aware that Mr Kolbig's illness had involved command auditory hallucinations but that this had been part of his presentation in 2006. When Mr McNeil was asked whether the delusion from the day before that people were wanting to harm Mr Kolbig and that they would get him by the end of the day, gave rise to a concern that any harm that was to befall Mr Kolbig might be self-inflicted, he said '*I was unaware of that*', meaning that he had been unaware of the expressed delusion of the day before. But he did agree that one might act out such a delusion by harming themselves. He said:

> 'Yes, it's possible. It's possible that they won't harm themselves either.' [132]

When asked as to whether Mr Kolbig had said at the premises '*I don't want to die*', he said:

> 'I don't recall him saying that, no. That would have raised alarm bells for me. That would have been a very different situation.' [133]

The specific concern that such a statement would have engendered, said Mr McNeil, was that it meant that Mr Kolbig's delusions were more pronounced than they had been the previous day. Mr McNeil was closely questioned about the significance of a statement in terms of '*I don't want to die*' and said that it would mean that he had been more unwell than they had anticipated. He agreed that it was possible that the statement reflected a delusional belief on Mr Kolbig's part that someone was going to

[129] Transcript, page 392
[130] Transcript, page 393
[131] Transcript, page 394
[132] Transcript, pages 395
[133] Transcript, page 395

kill him and he acknowledged the possibility that it was reflective of Mr Kolbig's difficulty in controlling his own actions. He agreed that all this would raise a high level of concern in the mind of any person who heard it[134]. Mr McNeil agreed that he did not ask Mr Kolbig whether or not he was experiencing any suicidal thoughts[135]. He was asked this question and gave this answer:

> 'Q. If you had seen the entry of Ms McHugh's from the day before about someone wanting to harm him or Ms McHugh had told you that, would you have been concerned enough on the following day to ask Mr Kolbig whether he had suicidal thoughts.
>
> A. If Ms McHugh had told me on that day I would have asked her why she wasn't doing anything about it on that day, not leaving it to the following day or the day after.' [136]

I regarded that answer as evasive in terms of the question, those terms being concerned with how Mr McNeil would have acted in respect of Mr Kolbig on 21 April 2011 as distinct from what he would have done in respect of Ms McHugh's statements on 20 April 2011.

5.55. Mr McNeil was cross-examined about the fact that they did not administer Mr Kolbig's Seroquel that afternoon but instead placed it in the possession of his grandmother for her to administer later. He indicated to counsel assisting that in fact they could have administered the Seroquel then and there. The concern earlier that he had expressed about administering medication so soon after Mr Kolbig had taken his morning medication was related more to the diazepam. When asked why then did he not provide the antipsychotic medication when they were there and had the opportunity to do so, he said '*I hadn't considered it*'[137]. He agreed that there did not need to be a time gap in relation to the Seroquel[138]. Mr McNeil was forced to agree that an important part of Mr Kolbig's supervision by the MAC team, namely supervision of the taking of medication, did not occur as it should have in accordance with Mr Kolbig's management plan. In essence, Mr Kolbig's grandmother was delegated with the responsibility of overseeing the taking of his antipsychotic medication, a responsibility that belonged to the MAC team. Mr McNeil, however,

[134] Transcript, page 396
[135] Transcript, page 396
[136] Transcript, page 396
[137] Transcript, page 402
[138] Transcript, page 402

would not agree that this amounted to a contravention of the usual and expected practice[139].

5.56. Counsel assisting took Mr McNeil through the events of the previous week. He agreed that Mr Kolbig had been non-compliant with his medication on a number of occasions[140]. He was asked whether in the light of that he could be sure that Mr Kolbig would take the medication that had been given to his grandmother, to which he said:

> 'There had also been periods where he had been compliant during that week.' [141]

Mr McNeil agreed that over a short period of time an irregular and inconsistent pattern of compliance with medication had been established[142]. Underlying that pattern of irregular compliance was continued consumption of alcohol. He had not been aware of the fact that on one occasion during the week Mr Kolbig had been noticeably intoxicated with several empty beer cans in evidence at his premises. He said that '*ordinarily*' he would agree that as team leader he should have been made aware of all of those developments[143]. However, he said he could not agree with the proposition that little confidence could be placed in Mr Kolbig's compliance as of 20 and 21 April 2011[144]. He did not consider whether or not non-compliance had been established in that week[145]. Mr McNeil then endeavoured to explain his position by saying that a community treatment order is a process that takes a period of time and which did not happen overnight unless an urgent request was made to the Guardianship Board. He said that none of the triggering requirements such as non-compliance or future non-compliance with medication was established within the ten days that Mr Kolbig was working with the MAC team. He said that he would have imagined that by the end of the week or the end of the second week had his alcohol consumption continued and non-compliance with medication continued, then in those circumstances they would have had evidence to go to the Guardianship Board for a community treatment order to be put in place[146]. All of this of course overlooks the fact that although the Guardianship Board would be required in the course of a 28 day community treatment order to review the order, a community treatment order in the

[139] Transcript, page 405
[140] Transcript, page 410
[141] Transcript, page 411
[142] Transcript, page 413
[143] Transcript, page 414
[144] Transcript, page 414
[145] Transcript, page 414
[146] Transcript, page 415

first instance could have been imposed either by Mr McNeil himself or by a medical practitioner who had been made aware of the relevant facts.

5.57. I have carefully considered the evidence given by the persons who were present at Mr Kolbig's premises on the afternoon of 21 April 2011. In my view the evidence is convincing that in the presence of the two MAC team workers that afternoon Mr Kolbig displayed a significant level of agitation that was evidenced by unsettled physical activity and features of distress. I have found that there were a number of requests made of the team to consider hospitalising Mr Kolbig that afternoon. I have further found that Mr Kolbig in the presence of the MAC team workers did say on a number of occasions '*I don't want to die*'. Both Mr Anderson and his mother told the Court that Mr Kolbig had said this in the presence of the MAC team workers. I have accepted their evidence in that regard. That Mr Kolbig was concerned that afternoon that he was going to die and that he did not want that to happen is corroborated by the fact that he said the same thing to Ms Paues at a time before the MAC team arrived. I am mindful of the fact that Ms Sherly Kolbig did not give any evidence about that statement having been made, but in my view this does not detract from a finding that Mr Kolbig said '*I don't want to* die' in the presence of the MAC team workers. In many ways it would have been surprising if Mr Kolbig had not said that, particularly having regard to the fact that he had said it on a number of occasions previously that day. I have found that there was no exploration of Mr Kolbig's concerning comment by the MAC team workers. Nor was there any specific enquiry made by either worker about the nature of any voices that Mr Kolbig believed he was hearing. Nor was there any enquiry made as to whether or not Mr Kolbig was experiencing any suicidal ideation when the fact that he was hearing voices and had said that he did not want to die should naturally if not inevitably have prompted such an enquiry. The fact that he did not express any suicidal ideation was neither here nor there when his statements that he did not want to die placed the possibility of suicidal ideation very much on the table. This is all the more so when one considers that the day before he was recorded as having said that people were wanting to harm him and that they would get him by the end of the day, a matter unfortunately not known by Mr McNeil when he visited on 21 April 2011. All this needed to be considered, particularly having regard to the fact that the new type of Seroquel medication prescribed from the

day before was, in Mr Kolbig's mind at least, simply not working, regardless of whether or not it was going to be administered at 4pm or at 5pm that day. I find that there was no reason in any event why his Seroquel medication could not have been given at 4pm as opposed to 5pm.

6. The evidence of Professor Robert Goldney

6.1. I have already referred to some of the opinions of Professor Goldney. Professor Goldney is a consultant psychiatrist who was asked to provide an overview of Mr Kolbig's management. Professor Goldney is an experienced consultant psychiatrist who has maintained a particular interest in and involvement with suicide prevention. His Doctorate concerned suicidal behaviour. His ongoing interest commenced in approximately 1974. He has participated in research projects concerning suicidal prevention. He has been President of the International Association of Suicide Prevention and also President of the International Academy for Suicide Research. In 2013 Professor Goldney was awarded an AO for his contribution to research, particularly in the field of suicidal behaviour.

6.2. I add here that I also regarded Dr Mohan and Dr Parthasarthy as experts in the field of psychiatry. I have given consideration to their expert opinions as I have to those of Professor Goldney.

6.3. I have already referred to Professor Goldney's assessment of Mr Kolbig's responses to treatment while under a community treatment order for some years prior to mid 2010 and to his decline since that time while not under an order. I indicate that I have accepted Professor Goldney's analysis of the situation.

6.4. Professor Goldney prepared a report in respect of his opinions[147] and also gave oral evidence at the Inquest.

6.5. In his report and in his evidence Professor Goldney proffered a number of opinions concerning Mr Kolbig's management. One topic related to the question of Mr Kolbig's medication and the adjustments made to it, particularly while in Cramond Clinic between February and April 2011. I have found it unnecessary to make any finding or comment on this issue. Dr Mohan was closely questioned about the reasons for Mr Kolbig's Seroquel prescription being adjusted from time to time.

[147] Exhibit C18

Professor Goldney had a certain view about that which I think can be summarised by saying that he did not believe that Mr Kolbig's prescription was of a high enough magnitude. I have found that in all of the circumstances there really is no criticism to be directed at any person in relation to this issue. The issue involved clinical decisions made in good faith and which were based upon the clinical circumstances concerning Mr Kolbig as they existed at any point in time. I was more interested in Professor Goldney's opinions about Mr Kolbig's management generally, and in particular his management following discharge from Cramond Clinic on 11 April 2011. I add here that for reasons similar to those that I have just expressed in relation to the issue about Mr Kolbig's medication, I have not found it necessary to express any view about the appropriateness of Mr Kolbig's discharge from Cramond Clinic and whether it was appropriate at that particular point in time.

6.6. Professor Goldney expressed a number of opinions in general about community treatment orders. He regarded the prevention of suicide as not being the primary relevant consideration, although it is one relevant consideration. The underlying purpose of an order in his view is the treatment of the underlying psychiatric illness. Professor Goldney expressed the view that an experienced psychiatrist should not be swayed by the patient's desire not to be the subject of an order because the patient's reasons for not wanting it can commonly be part of the patient's delusional system. He cited as an example Mr Kolbig's belief that any clinicians who would endeavour to impose mandatory treatment upon him were trying to kill him. He said that to countenance such a consideration would, in sense, be to condone or collude with the patient. Similarly, considerations such as Mr Kolbig's supposed fierce independence was also a matter of limited relevance[148]. As to alternative regimes to ensure compliance, Professor Goldney was of the view that one was entitled to take into account whether the patient would be compliant within the community, such that if a person was compliant in hospital then it would be reasonable to offer voluntary treatment in the community whereby parameters were set and, if breached, a community treatment order would be imposed. Professor Goldney also expressed the view that if one adopted the least restrictive approach to treatment and did so without having a good knowledge of the patient, one was not providing the patient with the benefit of a professional opinion. He made the point that a detention or a community treatment order is not a punishment but a part of good medical practice. While

[148] Transcript, page 431

Professor Goldney was prepared to agree that the MAC team's regime for Mr Kolbig constituted an approach to treatment that could be characterised as the least restrictive means of administering treatment of his illness, he pointed out that because of his history longitudinal history of non-compliance and of non-compliance in the days following his release from Cramond Clinic, it was a regime that was not likely to result in the treatment being implemented. He said that the difficulty with the least restrictive means being adopted in Mr Kolbig's case was that it was not working.

6.7. As far as Mr Kolbig's situation was concerned Professor Goldney noted that a low threshold for the imposition of a regime of mandatory treatment had been contemplated for Mr Kolbig upon his release. He interpreted this as meaning that one would take into account concerns about the continuing progress of the patient involving such matters as non-compliance with treatment, worsening of symptoms and the behavioural manifestations of his symptoms worsening. In terms of Mr Kolbig's behaviour, what Professor Goldney suggested the MAC team needed to watch for and have regard to were several matters including poor self-care, risk of self-harm, alcohol abuse, deliberate self-harm, non-compliance, whether Mr Kolbig was engaging with visiting staff and how Mr Kolbig was getting on with his neighbours. As to the suggestion that fluctuations in Mr Kolbig's mood and behaviour were to have been expected, Professor Goldney responded by pointing out that his behaviour was inappropriate, and not consistent with him being compliant with the treatment regime that had been implemented. Professor Goldney believed that by 19 April 2011 Mr Kolbig had reached the threshold that Dr Mohan had referred to in the Cramond Clinic notes[149]. Professor Goldney believed that there should have been strict adherence to the ultimatum that had been given to Mr Kolbig to the effect that if he was non-compliant an application for a community treatment order would be made to the Guardianship Board. He said it was an imperative. For there to have been non-compliance within such a short time of discharge was not a good omen, the 'warning bells' should have gone off and steps should have been taken to introduce a community treatment order at that stage. He pointed out that if people get away with things, they will get away with more and they will push the limits more. In fact Professor Goldney suggested that a community treatment order should have been ordered when there were early signs of non-compliance[150].

[149] Transcript, pages 441-442
[150] Transcript, page 508

6.8. Finally on the subject of a mandatory regime of treatment for Mr Kolbig, Professor Goldney commented upon Dr Parthasarthy's regime of instituting the least restrictive means of ensuring treatment, and whether Dr Parthasarthy was working within the guidelines of the Mental Health Act. While agreeing that Dr Parthasarthy's views were reasonable in respect of his professional judgment, Professor Goldney opined that his professional judgement had not been correct[151].

6.9. Professor Goldney was asked whether, having regard to Mr Kolbig's attitude to and history of community treatment orders and his express agreement to work with the MAC team when they visited him on 6 April 2011, it was reasonable that a community treatment order should be deferred until non-compliance was established. He conceded that if one were to simply '*pick out the bits that you have picked out*'[152] then he would agree, but one had to look at all of the other matters within Mr Kolbig's history. If one did that one would see that his potential for compliance was very questionable, particularly in relation to medication. If medication had been problematic in hospital, then Professor Goldney was of the view that this would not engender much hope for compliance within the community. Professor Goldney was of the view that if one were to look at Mr Kolbig's picture overall:

> 'I think there is enough questionable behaviour there to make it most unlikely that he's going to be compliant on discharge.' [153]

6.10. As to the events of 20 April 2011, which was the day before Mr Kolbig took his life, Professor Goldney expressed the view that a full assessment of Mr Kolbig had been required[154]. Professor Goldney expressed the view that there did not appear to be an adequate assessment performed by Dr Parthasarthy. Professor Goldney suggested that Dr Parthasarthy should have elicited from Mr Kolbig the psychotic thinking that he had displayed to Ms McHugh earlier that afternoon. He stated that the information was relevant and that Dr Parthasarthy should have obtained that information himself. Professor Goldney said:

> 'It should be very clear to an experienced psychiatrist that something pretty serious is wrong.' [155]

[151] Transcript, page 500
[152] Transcript, page 488
[153] Transcript, page 488
[154] Transcript, page 447
[155] Transcript, pages 449-450

Professor Goldney said he was not unduly critical about the fact that Ms McHugh may not have told Dr Parthasarthy about Mr Kolbig's concerns about people getting him by the end of the day because it was the kind of information that Dr Parthasarthy should have elicited himself[156]. Professor Goldney regarded the delusions as significant because if a person believes that other people are going to kill them and they are experiencing feelings of guilt, the ultimate way of punishment is to kill one's self[157]. There had also been the expression of suicidal ideation at the Emergency Department of the QEH earlier that day. Professor Goldney believed that on that day there were grounds to detain Mr Kolbig under the Mental Health Act[158]. In cross-examination Professor Goldney was asked whether the psychotic symptoms that were displayed by Mr Kolbig on this day simply reflected his usual level of psychosis. Professor Goldney agreed that it may have, except that on this occasion he had been distressed and agitated and that things were going wrong. He was actively seeking help. The other matter of course that needs to be considered here is that on the occasion of 20 April 2011 not only was Mr Kolbig expressing delusional thought, but he was expressing delusional thought that may have involved suicidal ideation and concepts of death.

6.11. As to the change of the type of medication and Mr Kolbig having expressed difficulties about sleeping, Professor Goldney suggested that his difficulty sleeping was not the underlying problem. The underlying problem was that Mr Kolbig was psychotic and was experiencing hallucinations that people were going to get him. In those circumstances it was not unexpected that he would have a sleep disturbance. Accordingly, Professor Goldney viewed Dr Parthasarthy's alteration of the type of medication as '*fiddling at the edges*'[159]. Similarly, the introduction of diazepam was not something that was going to treat the underlying psychotic illness, but would simply make Mr Kolbig feel more comfortable. In his opinion the response of merely adjusting Mr Kolbig's medication was not an adequate response. Professor Goldney suggested that he would have considered admission to hospital, a change of antipsychotic medication and a community treatment order[160]. As to the significance if any of the fact that Mr Kolbig appeared much calmer to the MAC team later that

[156] Transcript, page 450
[157] Transcript, page 450
[158] Transcript, page 452
[159] Transcript, page 494
[160] Transcript, page 457

day when they visited him at his home, this in Professor Goldney's view was simply consistent with the effect of the Valium that he had taken earlier[161].

6.12. As to the events of 21 April 2011, the day of Mr Kolbig's death, Professor Goldney said that although the MAC team workers were not bound to act upon any expressed desires that Mr Kolbig be placed in hospital, they should nevertheless give them consideration. The fact that Mr Kolbig had said that he was hearing voices should have prompted an enquiry as to what those voices were saying to him, and in particular whether they were telling him to do anything, specifically to kill himself[162]. The statement by Mr Kolbig that he did not want to die, which I find to have been made in the presence of the MAC workers, should in Professor Goldney's opinion have elicited an enquiry on their part as to the reason he was saying this, and specifically whether he believed that someone was going to kill him, or indeed if he was going to kill himself. In addition, the events of the previous day also needed to be taken into consideration. He suggested that as a professional person one needed to balance what was taking place in front of them on 21 April 2011 with the events of the day before including what had taken place at the QEH Emergency Department, what had occurred with his general practitioner and what had transpired when he was seen by Dr Parthasarthy. A conclusion could have been reached that because of the concerns expressed by both Mr Kolbig's neighbour and his grandmother, the changes implemented by Dr Parthasarthy had not resulted in Mr Kolbig becoming settled. After all, as Professor Goldney pointed out, the two mental health nurses attended at the premises as a matter of urgency and in response to the neighbour's ACIS call that day.

6.13. Professor Goldney could see no reason why Mr Kolbig's antipsychotic medication, as well as his diazepam, could not have been given to Mr Kolbig during the MAC team visit that afternoon.

6.14. Professor Goldney believed that it was unreasonable to have expected somebody of Ms Kolbig's age to have been given responsibility for Mr Kolbig's welfare, a responsibility that other people did not want to seem to accept[163].

[161] Transcript, page 458
[162] Transcript, page 461
[163] Transcript, page 467

6.15. Finally, Professor Goldney expressed certain reservations about the capacity of persons entrusted with domiciliary visits to persons with psychotic illnesses to assess the nature and clinical significance of severe psychotic symptoms. He suggested that while in Mr Kolbig's case there had been documentation raised concerning psychosocial issues, such as the strategies that were thought to be of assistance to Mr Kolbig by way of playing games with his grandmother, there was no documentation of a good assessment of Mr Kolbig's illness. He suggested that the MAC team members had been in an invidious situation and that they had probably been let down by a lack of control exerted by psychiatric personnel prior to Mr Kolbig being in the community and remaining in the community[164]. He suggested that the MAC team members may not have had adequate training to equip them to ask the relevant questions, for example about Mr Kolbig's voices and his not wanting to die. He referred to the pointlessness of Mr Kolbig being '*jollied along*'[165] by the prospect of playing scrabble or watching a movie which activity had simply been beyond Mr Kolbig, a man with a severe psychotic illness. The real task had been to ensure that Mr Kolbig's illness was treated adequately[166].

7. The Mental Health Act 2009

7.1. On 1 July 2009 the Guardianship Board pursuant to section 20 of the repealed Mental Health Act 1993 imposed upon Mr Kolbig what would be his final community treatment order (CTO) for the maximum period of 12 months. This order was stated to expire on 1 July 2010. The new Mental Health Act 2009 came into effect on that same day. Under the repealed legislation the sole entity which could impose a CTO was the Guardianship Board. As seen Mr Kolbig was the subject of an inpatient treatment order imposed in February 2011 by the virtue of the new legislation. Mr Kolbig was released from that inpatient treatment order on 11 April 2011 which was ten days prior to his death. There was no community treatment order imposed under the new legislation upon his release and so no such order was in place at the time of his death. The new legislation contains provision for the imposition of level 1 and level 2 community treatment orders. The imposition of a CTO under the new Mental Health Act 2009 is governed by sections 10 and 16 respectively of that Act[167].

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[164] Transcript, page 465
[165] Transcript, page 466
[166] Transcript, page 466
[167] Level 1 community treatment orders are governed by section 10 of the Act. Level 2 community treatment orders are governed by section 16 of the Act

7.2. Under the new Act a level 1 community treatment order can be imposed by a medical practitioner or authorised health professional. A level 1 community treatment order, if subsequently confirmed by the Guardianship Board, expires on a day not later than 28 days after the day on which it was made. In Mr Kolbig's case a medical practitioner or authorised health professional could have imposed a level 1 community treatment order on his discharge from the inpatient treatment order on 11 April 2011 or at any time subsequently provided the necessary criteria were met. The Guardianship Board would have been required to review that order and either have revoked it or confirmed it[168].

7.3. A comparison of the criteria for the imposition of community treatment order under both the repealed Act and the new Act is worthwhile. I here set out section 20 of the repealed Mental Health Act 1993:

> '20—Treatment orders for persons who refuse or fail to undergo treatment
>
> (1) If the Board is satisfied, on an application under this section—
>
> (a) that a person has a mental illness that is amenable to treatment; and
>
> (b) that a medical practitioner has authorised treatment for the illness (not being prescribed psychiatric treatment) for the person but the person has refused or failed, or is likely to refuse or fail, to undergo the treatment; and
>
> (c) that the person should be given treatment for the illness in the interests of his or her own health and safety or for the protection of other persons; and
>
> (d) that an order under this section should, in all the circumstances, be made,
>
> the Board may, by order, authorise the giving of treatment to the person for his or her mental illness for a period, not exceeding 12 months, specified in the order.
>
> (2) An application under subsection (1) may be made by the Public Advocate, a medical practitioner or a guardian, relative or medical agent of the person the subject of the application.
>
> (3) Treatment may be given pursuant to an order under this section notwithstanding the absence or refusal of consent to the treatment.
>
> (4) The Registrar must, not less than two months before the expiry of an order under this section that endures for a period of six months or more, send a notice to the person who made the application for the order and to each other person empowered to make such an application, reminding him or her of the date on which the order will expire.'

[168] Section 15 of the Mental Health Act 2009

The above provision had to be examined against the stated objectives of the 1993 Act which provided that a person or body in performing functions under the Act must seek '*to minimise restrictions upon the liberty of patients and interference with their rights, dignity and self respect, so far as is consistent with the proper protection and care of the patients themselves and with the protection of the public*'[169].

7.4. I set out section 10 of the new Mental Health Act 2009:

'**10—Level 1 community treatment orders**

(1) A medical practitioner or authorised health professional may make an order for the treatment of a person (a ***level 1 community treatment order***) if it appears to the medical practitioner or authorised health professional, after examining the person, that—

(a) the person has a mental illness; and

(b) because of the mental illness, the person requires treatment for the person's own protection from harm (including harm involved in the continuation or deterioration of the person's condition) or for the protection of others from harm; and

(c) there are facilities and services available for appropriate treatment of the illness; and

(d) there is no less restrictive means than a community treatment order of ensuring appropriate treatment of the person's illness.

(2) In considering whether there is no less restrictive means than a community treatment order of ensuring appropriate treatment of the person's illness, consideration must be given, amongst other things, to the prospects of the person receiving all treatment of the illness necessary for the protection of the person and others on a voluntary basis.

(3) A level 1 community treatment order must be made in writing in the form approved by the Minister.

(4) A level 1 community treatment order, unless earlier revoked, expires at a time fixed in the order which must be 2 pm on a business day not later than 28 days after the day on which it is made.

(5) If a level 1 community treatment order has been made by a person other than a psychiatrist or authorised medical practitioner, the following provisions apply:

(a) a psychiatrist or authorised medical practitioner must examine the patient within 24 hours of the making of the order;

(b) if it is not practicable to examine the patient within that period, a psychiatrist or authorised medical practitioner must examine the patient as soon as practicable thereafter;

[169] Section 5(1)(b) of the Mental Health Act 1993

(c) after completing the examination, the psychiatrist or authorised medical practitioner may confirm the level 1 community treatment order if satisfied that the grounds referred to in subsection (1) exist for the making of a level 1 community treatment order, but otherwise must revoke the order.

(6) A medical practitioner or authorised health professional may form an opinion about a person under subsection (1) or (5) based on his or her own observations and any other available evidence that he or she considers reliable and relevant (which may include evidence about matters occurring outside the State).

(7) A psychiatrist or authorised medical practitioner who has examined a patient to whom a level 1 community treatment order applies may vary or revoke the order at any time.

Note—

A psychiatrist or authorised medical practitioner who revokes a level 1 community treatment order may, in substitution, make a level 1 inpatient treatment order under Part 5 Division 2.

(8) Confirmation, variation or revocation of a level 1 community treatment order must be effected by written notice in the form approved by the Minister.'

The objects of this new legislation include to ensure that persons with serious mental illness '*retain their freedom, rights, dignity and self-respect as far as is consistent with their protection, the protection of the public and the proper delivery of the services;*'[170]. The new legislation also imposes an obligation upon persons administering the legislation to be guided in the performance of their functions by principles including that '*the services should be provided on a voluntary basis as far as possible, and otherwise in the least restrictive way and in the least restrictive environment that is consistent with their efficacy and public safety, and at places as near as practicable to where the patients, or their families or other carer or supporters, reside;*'[171].

7.5. Upon comparing the two provisions it will be noted that the new legislation, in respect of the imposition of a level 1 community treatment order, contains a requirement that there is no less restrictive means than a community treatment order of ensuring appropriate treatment of the person's illness. Section 10(2) imposes a further requirement that in considering whether a less restrictive means of ensuring appropriate treatment is available, consideration must be given to the prospects of the person receiving all treatment of the illness necessary for the protection of the person and others on a voluntary basis. It seems to the Court that the prospects of the person

[170] Section 6(a)(ii) of the Mental Health Act 2009
[171] Section 7(1)(b) of the Mental Health Act 2009

receiving the appropriate treatment on a voluntary as opposed to a mandatory basis would have to be considered favourable before it could be said that there are less restrictive means available than a community treatment order of ensuring appropriate treatment. Put in another way, if the prospects of the person receiving the appropriate treatment on a voluntary basis were poor, the discretion for the imposition of a community treatment order would be enlivened because in those circumstances it could readily be concluded that there are no less restrictive means than a community treatment order of ensuring appropriate treatment.

7.6. If it was thought that the requirements of the new legislation were more stringent than the requirements under the old legislation, and that there would be insurmountable difficulty in fulfilling those new requirements, such a belief in my view would be wholly misplaced. A less restrictive means than a community treatment order of ensuring appropriate treatment of Mr Kolbig's illness could only have been constituted by his receiving treatment on a voluntary basis. The less restrictive means contemplated by the new provision still had to have as its focus the *'ensuring'* of appropriate treatment. It is difficult to see how in Mr Kolbig's case his receiving appropriate treatment for his illness could have been ensured by him acting voluntarily. To my mind the expression '*ensuring*' contemplates a high degree of likelihood that the subject individual will undergo appropriate treatment voluntarily. As well, if the prospects of the person receiving on a voluntary basis all treatment of the illness necessary for the protection of the person and others are poor, it could not be said that a less restrictive means than a community treatment order would ensure appropriate treatment of the person's illness.

7.7. I observe in this regard that a mental health care plan dated 7 September 2009, which was devised during the currency of the final community treatment order under the old legislation, stated that a community treatment order for Mr Kolbig was '*essential*'[172]. The plan went on to state that with a community treatment order in place Mr Kolbig accepted the legal requirements and would comply. As well, the note suggested that full compliance and non abuse of alcohol would cease in the absence of a CTO insofar as Mr Kolbig' attitude was that with no legal order in place there was no need for him to take his medications. And as seen earlier, elsewhere in Mr Kolbig's clinical record it is revealed that the perceived reason why Mr Kolbig would continue

[172] Exhibit C8, page 47

taking his medication was '*because I am on a CTO and everyone wants me to keep taking it*'[173]. This appears to reflect a statement actually made by Mr Kolbig to his clinicians and reflects a state of mind whereby his compliance could only be ensured, particularly in relation to the taking of medication, because he was under legal compulsion to comply. It seems to this Court that not only was the existing community treatment order under the old legislation appropriate having regard to that state of mind, it would go a long way to satisfy the requirement under the new legislation that there was no less restrictive means than a community treatment order of ensuring appropriate treatment of Mr Kolbig's illness and that the prospects of him receiving treatment on a voluntary basis were at best questionable, and at worst extremely bleak.

7.8. Mr Kolbig had been under a community treatment order under the old legislation since mid 2007. The community treatment order was renewed annually until the final community treatment order lapsed on 1 July 2010, which as seen was the first day of operation of the new legislation. Dr Parthasarthy referred to this change of legislation in his oral evidence before the Court. Although Dr Parthasarthy, correctly in the opinion of the Court, did not hold the view that the new legislation imposed a more restrictive regime as far as the placement of people on a community treatment order was concerned[174], his view was that the new Mental Health Act provided guidelines that encouraged the use of less restrictive alternatives to be explored prior to the imposition of a community treatment order. It was Dr Parthasarthy's understanding that Dr Wilson had decided to allow the community treatment order to lapse without renewal in July 2010 on an apparent acceptance by Mr Kolbig that he would take his medication. I am not certain whether this was the actual reason or was one reason out of a number of reasons for the non-renewal of a community treatment order under the new legislation in July 2010. However, if that decision had been based on an impression that the new legislation in some way mandated a treating psychiatric team to actually implement all less restrictive alternatives before a community treatment order could be applied for, this was an erroneous interpretation in my view. While the new legislation mandated consideration as to whether there was no less restrictive means than a community treatment order of ensuring appropriate treatment of the person's illness, nowhere is it said that all less restrictive means had to be actually attempted before a community treatment order could be imposed. The legislation

[173] Exhibit C8 - Mental Health Care Plan of 13 July 2009 (page 247) & Mental Health Care Plan of 13 October 2009 (page 25)
[174] Transcript, page 225

does not mandate nor encourage the engagement of futile experiments in respect of the treatment of mental illness, or worse, require patients to be set up for probable failure. For example, a decision to defer the imposition of a community treatment order until non-compliance with treatment, such as non-compliance with medication, is established would be misconceived if all other criteria for the imposition of a community treatment order were satisfied. For instance, if non-compliance with medication was to be regarded as likely, or put in another way that the prospects of the person complying voluntarily with medication were poor, then it would be ill advised to defer the imposition of a community treatment order until non-compliance occurred because it is conceivable that one instance of non-compliance could give rise to a situation of danger for the patient or be otherwise counterproductive to treatment. That would be even more so if one were to defer consideration of a community treatment order until an established pattern of non-compliance with medication existed. Although the guiding principles in the Act mandate that the services provided should be provided on a voluntary basis as far as possible, I do not read this requirement as mandating voluntary provision of services in the face of evidence indicating that voluntary provision would be an unrealistic proposition.

7.9. Insofar as it was thought that unquestioning reliance had to be placed on Mr Kolbig's outward acceptance of a voluntary regime of treatment at the hands of the MAC team, such reliance was misplaced. There was no obligation on anyone to accept Mr Kolbig's assurances of compliance when the weight of the evidence pointing to non-compliance became practically overwhelming.

8. Conclusions

8.1. The Court reached the following conclusions. On 21 April 2011 Mr Kolbig took his own life by inflicting a stab wound to the chest. I find that he did so with the intention of ending his own life.

8.2. Mr Kolbig suffered from schizophrenia. One of the characteristics of his illness was that he experienced command auditory hallucinations. Mr Kolbig had been treated for many years for this illness with differing types of antipsychotic medication and with various results.

8.3. Mr Kolbig had been the subject of community treatment orders under the Mental Health Act 1993 between 2007 and 1 July 2010. In that period he had experienced a

time of relative stability and wellness. However, he indicated that he was only compliant with the medication regime imposed by virtue of those orders because of the existence of those orders. Mr Kolbig from time to time expressed a preference for remaining in a state of psychosis and evinced a belief that antipsychotic medication was interfering with the enjoyment of his psychoses. Mr Kolbig also had a propensity to consume alcohol in a quantity that was neither conducive to a stable psychiatric condition nor to compliance with medication.

8.4. On 1 July 2010 when Mr Kolbig's final community treatment order lapsed a further community treatment order under the new Mental Health Act 2009 was not imposed. Mr Kolbig's mental state of wellbeing thereafter deteriorated to the point where, in February 2011, he was subjected to an inpatient treatment order under the Mental Health Act 2009. During the currency of this order Mr Kolbig was detained in Cramond Clinic which is the mental health facility of the QEH. When Mr Kolbig was first admitted to Cramond Clinic it was envisaged by a medical practitioner, Dr Geddes, that Mr Kolbig would be placed on a community treatment order upon his release.

8.5. Mr Kolbig was discharged from the inpatient treatment order at Cramond Clinic on 11 April 2011. On that day a notation was made in the clinical record by Dr Mohan that if there was a relapse in Mr Kolbig there should be a low threshold for readmission and possibly a community treatment order. However, the QEH discharge summary also compiled by Dr Mohan suggested that a discussion with Dr Wilson, who previously had been involved in Mr Kolbig's management, had resulted in a decision being made to defer a community treatment order option until non-compliance was established on follow-up. In the event no community treatment order was put in place upon Mr Kolbig's discharge from Cramond Clinic.

8.6. If a decision to defer the imposition of a community treatment order was made because it was thought that less restrictive means than a community treatment order of ensuring appropriate treatment of Mr Kolbig's illness needed to be actually attempted prior to any community treatment order being considered, then in my view this would have been an erroneous approach.

8.7. In the event I find that following Mr Kolbig's discharge from Cramond Clinic his behaviour and compliance with treatment quickly became erratic and unpredictable. To the knowledge of members of the MAC team which was responsible for Mr

Kolbig's management in the community, Mr Kolbig commenced exhibiting behaviour for which he was previously well known including excessive consumption of alcohol, playing loud music to the annoyance of his neighbours and inconsistent acceptance if not outright refusal of antipsychotic medication.

8.8. Whether or not Mr Kolbig's non-compliance could be said to have been 'established', I find that Mr Kolbig's behaviour between 11 April 2011 and 20 April 2011 did require careful consideration being given to the imposition of a community treatment order in order to secure compliance with antipsychotic medication that had been prescribed for him. By 20 April he had experienced the very relapse that Dr Mohan had originally contemplated and which in his view would trigger consideration being given to readmission or the imposition of a community treatment order.

8.9. On 20 April 2011 Mr Kolbig presented at the QEH Emergency Department where he indicated that he was hearing voices and complained of suicidal ideation. He apparently left before he was seen by a doctor. He also visited his general practitioner. On the same day Mr Kolbig attended at the Port Adelaide Community Treatment Team's office and there was seen firstly by an occupational therapist and then by the psychiatrist, Dr Parthasarthy. Among other things Mr Kolbig was distressed and anxious and expressed delusional paranoia about people wanting to harm him and suggested that they would get him by the end of the day. Mr Kolbig could not be convinced as to reality. I find that the information about Mr Kolbig's paranoid thinking concerning people wanting to harm him was not imparted to Dr Parthasarthy, nor was it elicited from Mr Kolbig by that psychiatrist. This information should have been made available to Dr Parthasarthy. I find that this represented a missed opportunity for Mr Kolbig to be completely reassessed. The focus of Dr Parthasarthy's consultation was an intimation from Mr Kolbig that he was having difficulty sleeping. Dr Parthasarthy adjusted Mr Kolbig's medication to facilitate better sleep. He also prescribed diazepam to counter alcohol withdrawal. Mr Kolbig's underlying difficulty on that occasion was not so much the difficulty that he had in sleeping, which was a difficulty to be acknowledged in itself, but was his underlying emerging paranoid psychosis. This was not dealt with at all. It is clear, and I find, that at times during 20 April 2011 Mr Kolbig was experiencing delusional paranoia about people wanting to harm him and had a strong conviction that the people who wanted to harm him would do so by the end of that day. All this together

with Mr Kolbig's unease about the quality of his medication and his inconsistent acceptance of it dictated intervention on the part of his carers.

8.10. I find that on 21 April 2011 Mr Kolbig was again experiencing delusional paranoia. I find that he mentioned to a number of people who saw him that day that he did not want to die. In addition, I find that at times during that day, if not for most of the time, Mr Kolbig was hearing voices. The clearest indication of Mr Kolbig's state of mind is reflected in what his neighbour Ms Paues told the ACIS operator that included a reiteration of an assertion made to Ms Paues by Mr Kolbig himself that people wanted to kill him. He had told his aunt Ms Fraser that the voices were telling him to hurt himself but that he did not want to do this. He told his aunt that he did not want to die. He told his aunt's husband, Mr Fraser, that he was hearing voices in his head and he made negative comments about his own continued existence to the point of asking Mr Fraser whether he had any guns in his possession. I find that Mr Kolbig did say in the presence of the two MAC team members who visited Mr Kolbig that afternoon '*I don't want to die*'. I find that neither Mr Bambrick nor Mr McNeil asked Mr Kolbig anything about the nature of voices that he was hearing and wanted stopped. I think it is highly likely that if Mr Kolbig had been asked about the voices, he would have said that the voices were either telling him to kill himself or that he should die by one means or another. I find that it was essential for this topic to have been explored by Messrs Bambrick and McNeil.

8.11. I also find that at the home visit of the afternoon of 21 April 2011 made by the MAC team members Messrs Bambrick and McNeil that Mr Kolbig was significantly agitated and wanted medication, either requesting his regular dose of antipsychotic medication that was due that afternoon, or the administration of a depot injection. I also find that persons present at this incident expressed a view to the MAC team members that Mr Kolbig required hospitalisation.

8.12. I further find that on this occasion no proper enquiry was made of Mr Kolbig by the MAC team members as to Mr Kolbig's suicidal ideation. Such an enquiry should have been made in terms. It was not an adequate strategy to have placed reliance on the absence of any expression of suicidal ideation by Mr Kolbig himself. In any event his statement that he did not want to die should in itself have been sufficient to prompt an enquiry as to whether Mr Kolbig was experiencing suicidal ideation.

8.13. I find that there was no sensible reason why Mr Kolbig could not have been provided with his antipsychotic medication, Seroquel, when the MAC team members were present at his residence on the afternoon of 21 April 2011. The management plan devised for Mr Kolbig involved the MAC team members delivering his antipsychotic medication to Mr Kolbig at his premises in the late afternoon and that he should be seen to take it in their presence. This did not occur on this occasion. It should have occurred on this occasion. Instead, the administration of Mr Kolbig's antipsychotic medication was left to his elderly grandmother. I find that this was inappropriate.

8.14. The events of 21 April 2011 represent another missed opportunity for Mr Kolbig to have received proper and adequate mental health care. The imposition of an inpatient treatment order under the Mental Health Act should have been considered for him that day. Certainly he should have been asked whether he was prepared to be hospitalised voluntarily. To my mind it is likely that Mr Kolbig would have agreed. In any event, his condition and his statements that afternoon should have been related to Mr Kolbig's psychiatrist. If it had been established through proper enquiry of Mr Kolbig that he was experiencing strong suicidal ideation on 21 April 2011, which I find was the case, it is virtually inevitable that some action would have been taken by those responsible for his mental health care to ensure his safety. This should have occurred.

8.15. I find that if intervention had occurred on either 20 or 21 April 2011 Mr Kolbig's death may have been prevented in the short term. It is not possible to say whether it would have been prevented in the long term.

9. Recommendations

9.1. 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.

9.2. I have had regard to the affidavit of Ms Karla Bergquist who is the Executive Director for SA Health's Mental Health Directorate for the Central Adelaide Local Health Network. Much of her affidavit is not especially germane to the issues in this Inquest, the principal issue being the ability of therapists to ask the right questions of acutely mentally ill patients and eliciting responses from which an informed assessment of their risk can be made.

9.3. The Court makes the following recommendations directed to the Minister for Mental Health and Substance Abuse:

1) That South Australian Mental Health Services therapists, including but not limited to mental health nurses, occupational therapists and social workers, receive up to date training in relation to the identification of suicidal ideation and the conduct of mental state examinations;

2) That within the South Australian Mental Health Services it be rendered mandatory for Mobile Assertive Care team members to immediately report to a psychiatrist actual or suspected suicidal ideation identified in a patient;

3) That psychiatrists, medical practitioners and authorised health professionals be properly advised as to the legislative requirements concerning the imposition of Level 1 and Level 2 community treatment orders under the Mental Health Act 2009 and, in particular, be advised that there is no legal requirement that less restrictive means than a community treatment order or inpatient treatment order of ensuring appropriate treatment of a person's mental illness need actually be implemented before a community treatment order or inpatient treatment order can be considered. In this regard psychiatrists, medical practitioners and authorised health professionals should be discouraged from embarking upon pointless experimentation in respect of a patient's care when it is clear that in all of the circumstances a community treatment order or inpatient treatment order is appropriate;

4) That within the South Australian Mental Health Services the continuity of care in respect of the identity of a treating psychiatrist should be encouraged, if not considered essential, in the treatment of a patient with mental illness.

Key Words: Suicide; Psychiatric/Mental Illness

In witness whereof the said Coroner has hereunto set and subscribed his hand and Seal the 17th day of June, 2014.

Deputy State Coroner