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 15th, 16th, 17th, 18th of September 2015 and 13 July 2016, by the Coroner's Court of the said State, constituted of Anthony Ernest Schapel, Deputy State Coroner, into the death of Geoffrey Scott Noakes.

The said Court finds that Geoffrey Scott Noakes aged 43 years, late of 2 Hamra Drive, Smithfield died at Douglas Drive, Munno Para West, South Australia on the 20 February 2013 as a result of acute neck compression due to hanging. The said Court finds that the circumstances of his death were as follows:

1. Introduction and reason for Inquest

1.1. On Wednesday 20 February 2013 Geoffrey Noakes, aged 43 years, was found hanging by his neck from equipment in a playground at Munno Para West. He was located by students from a local college. The time was a few minutes after 3pm. Mr Noakes was deceased. Electrical cord had been used to carry out the hanging.

1.2. Earlier that same afternoon, at about 1.20pm, Mr Noakes had left the Lyell McEwin Hospital at Elizabeth (the LMH) by taxi. He had just been discharged from that hospital. He had been detained at the LMH under the Mental Health Act 2009 since the day before. The detention had been revoked that same afternoon and he had been allowed to leave.

1.3. The evidence conclusively demonstrates, and I so find, that upon leaving the hospital Mr Noakes travelled to the premises occupied by his sister at 2 Hamra Drive, Smithfield. He had been staying there at various times in the recent past. Nobody was home when he arrived. Mr Noakes let himself in. He there wrote a note that foreshadowed his suicide and in which he expressed his love for his partner and daughter. He obtained electrical

cord from the shed and cut it into a length. He then proceeded to the playground at Munno Para West where he used the length of electrical cord to hang himself.

1.4. A post mortem examination revealed that Mr Noakes' cause of death was acute neck compression due to hanging. I find that to have been the cause of Mr Noakes' death.

1.5. Detected in Mr Noakes' blood was the drug Olanzapine which is an anti-anxiety medication. There was also Diazepam which is a sedative, Nordiazepam which is the metabolite of Diazepam, Codeine which is a painkiller and Reboxetine which is an antidepressant. These medications were in non-toxic therapeutic concentrations. They had been prescribed for him. No illicit substances were found in his bloodstream. Alcohol was not detected in the bloodstream.

1.6. There is no evidence that any other person had an involvement in or had witnessed Mr Noakes' act of hanging. It will become obvious to the reader of these findings that Mr Noakes caused his own death and did so with the intention of ending his life. I so find.

1.7. Mr Noakes had a partner by the name of Nicole Wyatt from whom he was essentially estranged. They had a 5 year old daughter who resided with Ms Wyatt in a residence in Renmark. Although estranged, Mr Noakes and Ms Wyatt had recently been cohabiting. That period of cohabitation came to an end on 19 February 2013, the day before Mr Noakes' death.

1.8. Mr Noakes had an extensive history with the South Australia mental health services. At different times he also had a methamphetamine habit. I have already mentioned the fact that shortly before his death Mr Noakes had been discharged from the LMH where he had been a detained patient pursuant to the provisions of the Mental Health Act. The detention had been imposed by Mr Noakes' general practitioner, Dr Ben Baker, who practised principally in Angaston. The reasons underlying Dr Baker's imposition of Mr Noakes' detention will be described in these findings. As a result of that detention, which was imposed at the Angaston Hospital on the evening of 19 February 2013, Mr Noakes was conveyed by ambulance to the LMH where he was admitted. The following day, at about midday, he was examined by a psychiatrist as is required by section 21(5) of the Mental Health Act. The psychiatrist revoked the order for detention and Mr Noakes was allowed to leave the hospital.

1.9. In this Inquest the Court examined the circumstances in which Mr Noakes had been detained pursuant to the provisions of the Mental Health Act, his period of admission within the LMH and the circumstances in which he came to be released from that state of detention. In particular, the Court examined whether Mr Noakes had appropriately been discharged from detention and been allowed to leave the hospital. The Court examined the issue as to whether Mr Noakes' death could have been prevented.

2. Mr Noakes' recent personal circumstances

2.1. According to the statement of Ms Nicole Wyatt[1] she and Mr Noakes had been separated for about two years prior to his death. Notwithstanding their separation Mr Noakes and Ms Wyatt kept in contact with each other. For the five weeks immediately prior to Mr Noakes' death, Mr Noakes had been staying with Ms Wyatt at her premises in Renmark. According to Ms Wyatt's statement this period of resumed cohabitation was designed to enable Mr Noakes to get away from Adelaide in order to avoid amphetamine usage. There was also the fact that his ability to stay with his sister at Smithfield was coming to an end. Mr Noakes was not working during this period.

2.2. Prior to the five week period in which he was staying with Ms Wyatt he had been living with his sister, Ms Linda Kilmartin, at the Smithfield address. Ms Kilmartin's statement[2] explains that Mr Noakes had occasionally been living with her over the past few years. According to Ms Kilmartin the death of their brother in 2002 had caused Geoffrey Noakes to decline emotionally. On a number of occasions in the past he had attempted suicide, including by way of drug overdoses. Most recently Ms Kilmartin had noticed a worrying development in her brother's behaviour. He had withdrawn from the family. She confirmed that Mr Noakes had gone to stay with his ex-partner and his daughter in Renmark. The last time she spoke to her brother prior to his death was by phone on the previous Sunday evening. Mr Noakes had seemed *"okay at the time"*. In this conversation Mr Noakes said that he would be returning to Ms Kilmartin's premises at Smithfield and he wanted to ensure that he could still get in her house. Ms Kilmartin states that at that particular time she was in the process of moving house and as a consequence she told Mr Noakes that he needed to move his things out of her premises. Other evidence suggested that Ms Kilmartin was in the process of resuming a relationship with a former partner and that this was the reason for the imminent change in her

[1] Exhibit C7a
[2] Exhibit C1b

domestic circumstances. All this may have seen Mr Noakes without accommodation once he left Ms Wyatt's premises at Renmark.

2.3. According to Ms Wyatt, in the week prior to Mr Noakes' death he had been talking about suicide.

2.4. On 19 February an incident occurred at the Renmark premises which precipitated Mr Noakes being taken to the Angaston Hospital where he was detained under the Mental Health Act. The same evening he was transferred to the LMH, still under detention. The following day he was released from the LMH and he died that same day. I return to discuss all of those events in more detail below.

3. Mr Noakes' mental health history

3.1. During his life Mr Noakes had formed two significant relationships. He had twin boys from the first relationship and a daughter from the second, which relationship was with Ms Wyatt. I have already referred to the fact that the daughter was 5 years of age at the time of his death. Mr Noakes had three brothers all of whom had pre-deceased him. He had a sister, Ms Kilmartin.

3.2. Mr Noakes first commenced taking antidepressant medication after the death of one of his brothers in 2002. There is no evidence of further recurrence of depression until around the time that he commenced Interferon treatment for hepatitis C. Interferon is a medication that has a known association with depression.

3.3. Mr Noakes also experienced other medical conditions including a ligament tear in his knee that required a knee reconstruction. This injury had an adverse effect on Mr Noakes' ability to perform his work as a truck driver.

3.4. The first formal involvement with the mental health system occurred in June 2008 when Mr Noakes was admitted to the Angaston Hospital. From this point forward there was much to suggest that Mr Noakes suffered from a depressive illness although, as will be seen, this diagnosis would ultimately be doubted by the psychiatrist who examined him on the day of his death.

3.5. Mr Noakes' general practitioner was Dr Benjamin Baker who practised principally from Angaston. Dr Baker provided a statement[3] to the Inquest and gave oral evidence. I was impressed by Dr Baker. His evidence made a lot of sense. He had obviously harboured a genuine concern for Mr Noakes throughout the period in which the latter was his patient. In his oral evidence Dr Baker outlined Mr Noakes' medical history from 2007 when he first started seeing him. Dr Baker told the Court about Mr Noakes' diagnosis with hepatitis C and his placement on Interferon. In January 2008 Dr Baker identified the emergence of symptoms suggestive of depression in Mr Noakes. As a result Mr Noakes was prescribed with Zoloft which is an SSRI antidepressant. After approximately one month the medication was changed to Effexor.

3.6. At one point Mr Noakes received injuries in a quad bike accident that necessitated the knee reconstruction.

3.7. In separate consultations with Dr Baker in May 2008 Mr Noakes reported feeling depressed and teary and said that he did not want to go out or see anybody. Although not overtly suicidal, Mr Noakes indicated that on occasions he felt that he could not go on. At the second consultation he said that his medication had made no difference to his depressive symptoms, adding that he had no energy and was not interested in doing anything. To exemplify this he cited not being interested in participating in the wedding of a friend of 25 years standing, a loss of interest in fishing, being irritable with his children, having no self-esteem and losing weight.

3.8. On 5 June 2008 Mr Noakes was admitted to the Angaston Hospital. For the previous six months he had experienced periods of anxiety and depression as well as suicidal ideation. His antidepressant medication had elicited an unfavourable response. At that point he was assessed as having no obvious current suicidal ideation, but he was nevertheless admitted to the Angaston Hospital with a plan that he should have an appointment with Northern ACIS, an entity in the government mental health services. On this occasion Mr Noakes remained as a voluntary patient in the Angaston Hospital until his discharge on 8 June 2008.

3.9. On 11 June 2008 as planned, Mr Noakes saw Dr Lauren Taylor, a psychiatric resident medical officer employed at Northern ACIS. Dr Taylor formed the opinion that Mr Noakes satisfied the criteria for a diagnosis of Major Depressive Disorder. She recorded

[3] Exhibit C19a

this opinion in a comprehensive written report[4] that would be included within Mr Noakes CBIS computerised mental health services clinical records. In support of this diagnosis Dr Taylor described prominent features of depressed mood, lack of motivation and irritability. The report refers to an "*impulsive attempt*" to cut his neck with a knife in the previous week. The attempt had failed because of the bluntness of the knife. The report also refers to intermittent depressive symptoms over the past few years but a more chronic depressed mood having existed over the previous nine months. Reference is also made to Mr Noakes' own description of himself as being "*an emotional wreck*" with a lack of interest in activities and with frequent tearful episodes of the order of twenty times per day. There is reduced appetite noted, as well as feelings of guilt. It was recorded that Mr Noakes said that he regularly experienced suicidal ideation but reported that he was able to effectively distract himself from those thoughts. Mr Noakes was prescribed Reboxetine and a continuation of Olanzapine. He was referred to the Rural and Remote/Riverland Mental Health Team for ongoing monitoring of his mental state.

3.10. It was Dr Taylor's diagnosis that would ultimately be brought into question in the 24 hour period prior to Mr Noakes' death. However, I observe that in the comprehensive note of Dr Taylor she has recorded that she discussed Mr Noakes' case with a psychiatrist Dr Toh who agreed with the trial of Reboxetine. In a letter to Dr Baker, Dr Taylor had also emphasised that the case had been extensively discussed with the Northern ACIS consultant psychiatrist. The diagnosis of Major Depressive Disorder, having regard to the supporting evidence that is meticulously recorded in Dr Taylor's notes, is one that would have been difficult to resist.

3.11. The episode of June 2008 and the consequent diagnosis of Major Depressive Disorder, recorded as it was within the Department of Health CBIS computerised clinical record, was available in 2013 to clinicians during Mr Noakes' period of detention in the LMH prior to his death.

3.12. Dr Baker saw Mr Noakes on occasions in 2009 and 2010. A mental health plan was drawn up and there was a referral to a psychologist. Mr Noakes attended the psychologist on one occasion but failed to attend on a second occasion.

3.13. On 12 April 2010 Mr Noakes was brought into Dr Baker's practice by Ms Wyatt. In the preceding period Mr Noakes had apparently been doing reasonably well and was working

[4] Exhibit C13 page 157

again following the knee reconstruction. However, it was clear that underlying his apparent improvement was his renewed use of amphetamines. Dr Baker established that when Mr Noakes had resumed driving trucks he had stopped taking Olanzapine because it was effecting his ability to drive. Instead, he was now reliant on amphetamines to assist with that work. This was complicated by the fact that he was spending a lot of money in support of that habit.

3.14. In September 2011 Mr Noakes experienced another episode that required him to be hospitalised, this time at the LMH. On this occasion Mr Noakes had ingested a significant quantity of Olanzapine tablets which Mr Noakes himself described as being "*a lot*". On arrival at the Emergency Department on 24 September 2011 he was drowsy with slurred speech. A nursing note that is not reproduced in the computerised CBIS notes, but which was noted by hand within in the LMH progress notes, recorded that Mr Noakes had ingested a significant amount of Olanzapine "*with suicidal intent*"[5], although he denied a current intent. This note was apparently made on the evening of his arrival at the Emergency Department. Mr Noakes was placed under a Level 1 inpatient treatment order under the Mental Health Act. A further note that evening recorded that Mr Noakes himself had stated that he had been "*suicidal*"[6]. It appears that on the following day Mr Noakes was discharged from the LMH when the inpatient treatment order was not confirmed, a set of circumstances that would be replicated on the day of his death 17 months later.

3.15. The CBIS assessment summary in respect of the September 2011 episode was compiled by a member of the nursing staff, Ms Melody Kenneally. On the morning of Mr Noakes' death in February 2013, Ms Kenneally would be involved in Mr Noakes' management at the same hospital. In relation to the 2011 presentation, Ms Kenneally noted the ingestion of Olanzapine, Mr Noakes' difficulty with engagement and his threatening and aggressive behaviour. A psychiatrist, Dr Harvey, saw Mr Noakes for the purposes of the Mental Health Act examination. During the examination Mr Noakes told Dr Harvey words to the effect that the latter "*could not do anything so why bother*". He confirmed that he had taken a significant number of pills but had been stupid. Throughout the examination he repeatedly indicated that he did not want to speak meaningfully to clinicians. He did say, however, that he loved his daughter and he identified her as a

[5] Exhibit C14 page 215
[6] Exhibit C14 page 216

"*protective factor*". It appears that he had found the separation from his daughter difficult to manage. Although Mr Noakes reportedly said that he would not take another overdose, he made it clear that he did not want to talk about the circumstances of the then current episode. He repeated that he was angry with mental health services because they could not help him, and in this regard he pointed out that they had been unable to help a nephew by the name of Mark who a few months previously had hung himself in the Yatala Prison. The deceased person Mark would feature as the subject of a worrying Facebook post made by Mr Noakes the night before his death, a matter to which I will return. During his admission, as recorded by Ms Kenneally in the CBIS notes, Mr Noakes had reportedly identified a number of stressors including a relationship break up, financial issues, difficulty in gaining access to his daughter and his anger with mental health services in respect of his nephew Mark. He had denied current use of amphetamines and he denied current thoughts of self-harm. Dr Harvey's recorded impression is that Mr Noakes had presented with significant anger issues after what sounded like an impulsive overdose following an argument with his ex-partner. His lack of engagement with mental health services was noted by Dr Harvey, as was non-compliance with medical and nursing management at the hospital.

3.16. Dr Harvey noted that *"the client does have the ability to make decisions".* There is a note recorded by Ms Kenneally, "*Dr Harvey finds that there is a possibility he is depressed but he is unwilling for this to be explored, he is continuing to refuse to engage with mental health service. He denies current suicidal ideation and he is not threatening to harm anyone outside the ED*"[7]. The notation records that Mr Noakes' sister was present at the hospital during the 2011 examination. It appears that Mr Noakes was then living at his sister's premises at Smithfield.

3.17. The CBIS note relating to the September 2011 episode is incomplete in an important particular insofar as it neglected to record Mr Noakes' admission that he had taken the Olanzapine overdose with suicidal intent, an admission that seems to have been repeated to another clinician on the evening of 24 September 2011 and one which ought to have been accorded significant weight in assessing his risk of self-harm. Ms Kenneally's note in respect of the issue of suicidal ideation simply records that he denied a current suicidal ideation without reference to the fact that the precipitating event, namely the overdose,

[7] Exhibit 16 page 4

had been taken with such an intent. Why such an important detail would be omitted from a patient's history within a mental health agency document defies comprehension.

3.18. As indicated earlier, although in 2011 Mr Noakes had been detained pursuant to a Level 1 order, the order was revoked by Dr Harvey at the examination.

3.19. In June 2012 Mr Noakes presented to the Angaston Hospital having taken an overdose of Seroquel, an anti-psychotic. This episode did not find its way into the CBIS computerised record. On this occasion Mr Noakes was seen by his general practitioner, Dr Baker. Dr Baker told the Court that his recollection was that Mr Noakes had been experiencing difficulty with his back pain and had taken six 300 milligram tablets of Seroquel which he had cut in half before taking them. As these were slow release tablets the cutting in half would have allowed the active ingredient to be released more rapidly. I do not know whether Mr Noakes consumed all of the Seroquel tablets that he had in his possession. This would have been a matter worthy of exploration at the time. Suffice it to say he took a significant amount with a clear intention that it should affect him in a way that was not therapeutic. Dr Baker could not recall whether he had specifically asked Mr Noakes what his intention had been on this occasion, but Dr Baker recorded that Mr Noakes was "*sick of pain*". Mr Noakes was admitted to the hospital and was observed, but on this occasion was not detained pursuant to the Mental Health Act. There is reference in the notes to an incident involving Mr Noakes wanting to have a cigarette and breaching hospital security by going outside without permission. He had become very angry at staff and the incident had necessitated Police attendance. Mr Noakes' behaviour is described as unpredictable[8].

3.20. A number of conclusions were available to be drawn from Mr Noakes' longitudinal mental health history. Firstly, that he had a diagnosed major depressive illness that was never fully resolved and would re-emerge from time to time. Secondly, that while he despaired about his own situation and held little faith in the ability of the mental health services to help him, the most effective rapport with any medical practitioner had been established with his GP, Dr Baker. Thirdly, that his stressors were constant and not the subject of easy resolution. Fourthly, that he had a propensity to indulge in reckless behaviour in respect of his own wellbeing. And most importantly, there was strong

[8] Exhibit C15 page 29

evidence to suggest that he might not be averse to ending his own life as a means to escape his personal torment. These were all matters that a lay person could have deduced.

3.21. The events of 19 February 2013 would only serve to add to that bleak picture.

4. The events of 19 February 2013

4.1. According to Nicole Wyatt, in the week leading up to the 19 February 2013 Mr Noakes had been talking about suicide and stated that he did not want to feel like that anymore. Earlier in the week he had gone for a walk and upon his return stated that he had taken 8 Valium tablets and had wanted to walk in front of cars but had not done so because of the children.

4.2. Tuesday 19 February 2013 happened to be Nicole Wyatt's birthday and she went out to lunch. Mr Noakes stayed home. When she returned she discovered that Mr Noakes had consumed several cans of premixed alcoholic drinks. He told her that he had taken about 50 Valium tablets over the previous three days. He said that they were not helping him and that he was looking for something to stabilise his mood and to stop him from "*feeling so bad*".

4.3. Ms Wyatt describes an incident later that afternoon in which Mr Noakes grabbed a kitchen knife and held it to his throat. He said that he no longer cared about himself and that he did not want to feel like this anymore. There was a small cut on his neck where he held the knife. When Ms Wyatt ran to another room, Mr Noakes followed. Ultimately he became repentant about the knife and said that he had not wanted to frighten her or the children. He was crying and visibly upset. There was discussion about seeing Dr Baker at Angaston and, after much persuasion, Mr Noakes agreed to see Dr Baker, saying that he did not want to be locked up in a mental ward.

4.4. Prior to leaving for the Angaston Hospital Mr Noakes told Ms Wyatt that he wanted to go back to Adelaide to which Ms Wyatt pointed out that he had nowhere to stay. Mr Noakes said "*it doesn't matter, because I have something in my bag that will end it and nobody has to worry anymore*". Ms Wyatt then went to his bedroom, opened his bag and inside found a length of rope with a shackle attached to it. She confiscated the rope and hid it. If it was not obvious at that point, later that evening it would become crystal clear that Mr Noakes had acquired the rope with the intention of hanging himself.

4.5. Ms Wyatt's statement describes the journey from Renmark, firstly to Blanchetown to meet with her parents, and then on to Angaston. Nicole Wyatt's father drove the vehicle from Blanchetown to Angaston. About 2 kilometres out of Blanchetown Mr Noakes undid his seatbelt and then reached over and grabbed Ms Wyatt by the head and kissed her. He then opened the door of the vehicle and tried to jump from the moving vehicle. Ms Wyatt and her mother attempted to stop him from doing so. Her father braked heavily and stopped the car. Mr Noakes then got out of the vehicle and started walking down the middle of the road in a reckless manner. A truck that approached had to swerve to avoid hitting him. When Ms Wyatt and her parents caught Mr Noakes he was sitting on the side of the road. Eventually he walked to the car and told them to take him to the hospital, saying that they should have left him as he was sick of feeling the way he did.

4.6. Mr Noakes was conveyed to the Angaston Hospital where he was seen by Dr Baker.

4.7. About 7.20pm that evening Mr Noakes' sister, Ms Kilmartin, was browsing Facebook. She noticed that her brother Geoffrey Noakes had written on his Facebook page something along the lines of "*Won't be long Mark and I'll be seeing you*". Ms Kilmartin immediately became concerned as she interpreted this as a reference to the person Mark who had hung himself in Yatala. She believed that this was an indication that Mr Noakes was intending to join him by ending his own life. Ms Kilmartin made some telephone calls and no doubt would have been relieved to learn that her brother was going to be taken to the Angaston Hospital.

4.8. I have set out Mr Noakes' history in greater detail than what might normally be sufficient in a finding of this nature in order to emphasise the point that all of the information regarding Mr Noakes' longitudinal history as set out above, as well as that relating to his most recent behaviour and personal circumstances, was highly relevant to the question of Mr Noakes' continuing detention under the Mental Health Act in 2013 and was available to clinicians in the LMH if due enquiry had been made.

5. Mr Noakes' detention and transfer to the Lyell McEwin Hospital

5.1. When Mr Noakes arrived at the Angaston Hospital he was recorded as experiencing suicidal ideation. His attempt to cut his throat with a knife and the incident during the car journey to Angaston were noted. He was given Olanzapine for agitation. Dr Baker attended at the hospital that evening where in addition to the information concerning the use of the knife and the incident on the way to the hospital he recorded that Mr Noakes

had been planning to hang himself, had bought a rope for that purpose and that the rope had been found in his bag. When Dr Baker gave evidence he told the Court that this presentation was quite different from previous presentations in that it was clear that Mr Noakes had actually been planning to hang himself as evidenced by the acquisition of the rope. This set of circumstances was to be distinguished from previous "*spontaneous off the-cuff*" events. This difference was a matter of concern for Dr Baker. He felt that Mr Noakes was at extremely high risk. At the time he examined Mr Noakes he was subdued, possibly due to the Olanzapine that he had been given earlier.

5.2. In his evidence before the Court Dr Baker made it plain that he was very concerned about Mr Noakes. Dr Baker formed the impression that Mr Noakes had concluded that his relationship with his partner Ms Wyatt was at an end. He described a number of losses in his life. There was also the matter of Mr Noakes' sister's change of circumstances which meant that Mr Noakes was no longer able to stay with her. After discussing matters with Mr Noakes Dr Baker formed the impression that Mr Noakes had given up on life[9].

5.3. One concerning matter that for Dr Baker also distinguished this from other earlier events concerning Mr Noakes was the fact that in the past his daughter had acted as a restraint from acting out on suicidal ideation. In January 2012 Dr Baker had recorded that his daughter stopped him from acting out on his occasional suicidal thoughts. What stood out for Dr Baker was that the one thing that had appeared to keep Mr Noakes going was his daughter but that Mr Noakes now held a belief that he might lose contact with and not have access to her. So as things currently stood on the evening of 19 February 2013 with Mr Noakes, the protective factor that his daughter may have provided was now complicated by Mr Noakes' evident belief that his relationship with his daughter was now seriously jeopardised. Thus the protective factor was of less significance. He said[10] "*I was really gravely concerned that that protective factor of his daughter potentially not being there was one of the things in his mind where that was perhaps why he felt like he'd given up*".

5.4. Dr Baker believed that Mr Noakes was at extreme risk of suicide[11] and was concerned about the potential loss of contact that Mr Noakes was going to experience with his

[9] Transcript pages 48-49
[10] Transcript page 50 line 32
[11] Transcript page 52

daughter as well as the loss of accommodation. It is difficult to come to any conclusion other than that Dr Baker's concerns were well placed.

5.5. Dr Baker believed that Mr Noakes was experiencing depression and that this was his current mental illness[12]. Dr Baker told the Court that the opinion of Dr Taylor, as contained within her comprehensive report in respect of the 2011 Olanzapine overdose incident, fitted with his own impression of Mr Noakes insofar as Dr Taylor's diagnosis was one of Major Depressive Disorder[13], a diagnosis supported by the fact that although Dr Taylor had been a resident medical officer when that original diagnosis had been made, there had been obvious input from the psychiatrist Dr Toh.

5.6. Dr Baker issued a Level 1 inpatient treatment order pursuant to the Mental Health Act 2009. This order was signed at 10:30pm that evening. This order would have ongoing effect for a period of 7 days. However, the Mental Health Act required firstly that Mr Noakes be accommodated and treated in a treatment centre which the Angaston Hospital was not. Secondly, section 21(5) of the Act required a psychiatrist or authorised medical practitioner to examine Mr Noakes within 24 hours of the imposition of the inpatient treatment order, with a decision to be made by that psychiatrist as to whether the order imposed by Dr Baker should be confirmed or revoked. If the order was confirmed in the first 24 hours, Mr Noakes would have to remain within the relevant treatment centre, in this case the LMH, for 7 days unless within that 7 day period the order was revoked at the discretion of a psychiatrist. The Act allows for a further period of detention beyond the 7 days depending on the circumstances.

5.7. The 24 hour period to which I have referred would have expired at 10:30pm on Wednesday 20 February 2013. Mr Noakes would be released from the LMH several hours prior to that.

5.8. Dr Baker carefully explained to the Court how he brought Mr Noakes within the terms of the Mental Health Act so as to enliven the provisions that permitted Mr Noakes' detention under the Act. I do not need to go into the precise detail of this, but I was satisfied of the accuracy of Dr Baker's opinion that Mr Noakes had a mental illness, that because of that illness Mr Noakes required treatment for his own protection from harm and that there was no less restrictive means other than an inpatient treatment order of

[12] Transcript page 57
[13] Transcript page 69

ensuring appropriate treatment of Mr Noakes' illness. Specifically, Dr Baker suggested that treatment for Mr Noakes could have consisted of a review of his medication within a psychiatric ward, access to psychologists and other mental health professionals in order to commence and develop insight that could be followed up on discharge and protection through his acutely suicidal period. Dr Baker persuasively argued that it would have been foolish to have kept Mr Noakes at the Angaston Hospital as a voluntary patient, his feeling being that in light of his evident plan to hang himself, Mr Noakes would abscond. He said "*I felt that if we went down the path of voluntary admission, that he would be a high risk of absconding and leaving the treatment setting*". Dr Baker told the Court that a community treatment order would not have been a *"wise choice"*[14] for Mr Noakes. It is hard to disagree.

5.9. I pause to observe that there is a certain irony in Dr Baker's view that the likelihood of Mr Noakes absconding from the Angaston Hospital as a voluntary patient was a matter that militated in favour of detention when the examining psychiatrist's opinion, as will be seen, would be that the probability of Mr Noakes absconding from the LMH militated in favour of his release.

5.10. I find that Dr Baker properly had regard to all of the matters that required consideration under the Mental Health Act for Mr Noakes' detention. Dr Baker could have come to no conclusion other than that Mr Noakes required the imposition of an inpatient treatment order. I find that Mr Noakes' detention was lawful and appropriate in all of the circumstances.

5.11. Dr Baker also gave evidence as to his hopes and expectations in respect of Mr Noakes' management once he was transferred to the LMH. He said that his expectation was that Mr Noakes would be reviewed by a psychiatrist. His hope was that he would be admitted so as to enable him to get through his period of acute suicidality. He believed that the circumstances surrounding Mr Noakes' case were such that this period would probably exceed 24 hours[15].

5.12. Dr Baker was not further consulted about Mr Noakes either in the next 24 hours or at all. Specifically, he was not consulted about the decision that would be made to discharge Mr Noakes from the LMH. He said that he was surprised ultimately to learn that Mr

[14] Transcript page 60 line 19
[15] Transcript page 61

Noakes had been sent home and that he had not been contacted for any additional information before this had taken place. In the witness box Dr Baker reiterated what he had said in his witness statement, namely that as Mr Noakes' long term treating doctor there should have been some discussion with him prior to any discharge. Dr Baker told the Court that he would have had no hesitation in sharing his opinions about Mr Noakes with any person from the LMH[16]. He said "*I would have been more than happy to impart that information*"[17]. There can be little doubt that Dr Baker specifically would have told an enquirer that he believed Mr Noakes was at extreme risk of suicide, that his current presentation and circumstances were adversely different from those of the past and that he should remain at the LMH as a detained patient. One would have thought that opinions such as these, coming from a medical practitioner who had known Mr Noakes in his professional capacity for a significant period of time, would have been accorded great weight.

5.13. Dr Baker prepared a letter of referral that accompanied Mr Noakes to the LMH. It was typed and written on the letterhead of the Angaston Medical Centre. As well, he telephoned the Rural and Remote Triage Service in Adelaide to advise them of Mr Noakes' detention and of his imminent transfer to Adelaide. His expectation was that this information would be made available to those managing Mr Noakes once he was established within the relevant Adelaide hospital.

5.14. The Rural and Remote Triage Service records are contained within the CBIS notes[18]. It is evident from this record that Dr Baker informed Rural and Remote Triage of Mr Noakes' anger management issues and amphetamine use as well as his failed attempted reconciliation with his partner due to drug use and the events of that night. Some of Mr Noakes' most recent history was also imparted including the fact that one of the triggers involved in Mr Noakes' attempted reconciliation with his ex-partner was that his sister had reconciled with her partner with the result that Mr Noakes' accommodation in her home had concluded and he had been required to move out. His ex-partner had taken him in until he found somewhere to live. Dr Baker explained that Mr Noakes had gone cold turkey in relation to his amphetamine habit, had felt suicidal for some time and that during the evening he had experienced a brain snap and had grabbed a knife. It was recorded that a rope had been located in his bag. The incident involving the car and truck

[16] Transcript page 61
[17] Transcript page 61 lines 24 and 25
[18] Exhibit C16 pages 9-11

on the way to Angaston was also described. Mr Noakes' thoughts of despair were also described, with the observation that there was no chance of reconciliation with his partner in light of the evening's events. The placement of Mr Noakes on an inpatient treatment order was also recorded. One matter that the record made plain was that Mr Noakes' accommodation outside hospital and in the community was an issue that was surrounded by uncertainty.

5.15. Dr Baker's letter[19] of referral used the words "*suicide attempt*" to describe the evening's events. It referred to Mr Noakes' attempt to cut his throat with carving knife in front of his ex-partner and five year old daughter. It also stated "*says he has been planning to hang himself, and had bought rope for this purpose*". The incident in which Mr Noakes threw himself out of the car and walked in front of a truck is also described. The salient features of that letter in my view are the unequivocal description of Mr Noakes' behaviour as having involved actual suicide attempts, the information that Mr Noakes had been planning to kill himself by way of hanging and that he had put things in place to enable that to occur, namely the purchase of a rope. In the course of Dr Baker's cross-examination there was a suggestion that it would have been helpful if his letter had pointed out that Mr Noakes had indicated that he would use the rope to hang himself specifically at his sister's premises, a matter that Dr Baker had not recorded at the time but which he later included in his witness statement to police. It is suggested that this was a fact that may have been of relevance in deciding whether to allow Mr Noakes to leave the hospital with the apparent intention to go that premises. But the letter made it perfectly clear that Mr Noakes had planned to hang himself, had taken a step of a very serious kind towards achieving that outcome and had attempted to kill himself by other means that day.

5.16. I do not believe that any criticism of Dr Baker is warranted. On the contrary, it is difficult to see what else Dr Baker could have possibly done in order to protect Mr Noakes.

6. A brief summary of Mr Noakes' admission at the Lyell McEwin Hospital

6.1. In this section I will briefly describe Mr Noakes' time within the LMH. In the following section I will examine those events in greater detail.

[19] Exhibit C15 page 12

6.2. Mr Noakes arrived at the Hospital by Ambulance at 12:17am on Wednesday 20 February 2013. He was seen by an emergency department registrar, Dr Boonstra. Dr Boonstra performed neither a mental health assessment nor a risk assessment. Mr Noakes stated that he just wanted to sleep. Dr Boonstra partially completed a document entitled "*Initial Mental Health Assessment Clinical Record*"[20]. The section that catered for an assessment of the patient's initial risk level was not completed. Proforma questions that were designed to assist in the determination of the *'patient's risk of harm to themselves should they leave the hospital'* were also not completed. These questions addressed general topics that included background risk factors and current risk factors. This document would never be completed at any stage prior to Mr Noakes' discharge from the hospital.

6.3. It appears that Mr Noakes slept until the following morning when he was seen by nursing staff. Other than the superficial, nursing staff failed to develop a meaningful rapport with Mr Noakes whose behaviour and demeanour was aggressive and overtly unreasonable.

6.4. Although Dr Baker's letter and the notes compiled by the Rural and Remote Triage Service were available to clinical staff within the emergency department, no further information was sought about Mr Noakes from any person including his partner, members of his family or Dr Baker.

6.5. In accordance with the requirements of the Mental Health Act Mr Noakes' psychiatric examination took place at the hands of Dr Dennis Liu, a psychiatrist. This examination commenced at about midday and occupied approximately 45 minutes. It took place in the presence of a locum mental health nurse, Mr Huxter. At the conclusion of the examination Dr Liu revoked the Level 1 inpatient treatment order. Mr Noakes was referred to services including Drug and Alcohol Services South Australia (DASSA) who had a representative at the hospital. Mr Noakes declined to consult the DASSA representative before he left the hospital. He left the hospital by taxi at approximately 1:20pm.

6.6. At no stage was any enquiry made by LMH staff as to whether Mr Noakes had any firm accommodation arrangement in place.

6.7. In the period during which Mr Noakes was admitted to the LMH it is difficult to identify any therapeutic benefit to him.

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[20] Exhibit C14 pages 33-36

7. The course of Mr Noakes' management at the Lyell McEwin Hospital

7.1. I have already referred to Dr Boonstra. Dr Boonstra's involvement with Mr Noakes was minimal having regard to the time at which he arrived in the Emergency Department, Mr Noakes' general lack of co-operation and his desire merely to sleep. I accepted her evidence that in effect she was in no position to have completed the Initial Mental Health Assessment Clinical Record, as the information that required its completion would not have been immediately available in the middle of the night. Furthermore, it was not unreasonable for Dr Boonstra to assume that because Mr Noakes had been detained only a matter of hours ago his ongoing risk would continue to be seen as high. Dr Boonstra had nothing further to do with Mr Noakes and she completed her shift at approximately 8:30am the following morning. I would add here that Dr Andrew Champion who is the Clinical Director of the Mental Health Service at Noarlunga Hospital and who has independently reviewed the whole case, was not in any way critical of Dr Boonstra's handling of the matter for the reasons that I have identified in this paragraph.

7.2. On the morning of 20 February 2013 Mr Noakes was awake within the Emergency Department and was seen by a registered mental health nurse, Ms Melody Kenneally. As seen earlier Ms Kenneally was the nurse who had placed on the CBIS computerised record the account of what had transpired in 2011 when Mr Noakes had been detained in the LMH in respect of the Olanzapine overdose.

7.3. Ms Kenneally commenced her shift at 7:00am on 20 February 2013. When she approached Mr Noakes she unwittingly addressed him by the wrong surname. Mr Noakes' reaction was angry and irrational. As a result, Ms Kenneally stepped aside and allowed another nurse by the name of Matt Huxter to attempt to develop a rapport. The only two mental health nurses on duty were Ms Kenneally who was a full time employee of the Hospital and Mr Huxter who was a locum. Ms Kenneally explained that this number of mental health nurses on duty was standard. Ms Kenneally also explained that in the normal course of events there would be an interview with the patient that might occupy an hour or an hour and a half but there was no interview in this case. It is difficult to find evidence that before the psychiatrist Dr Liu examined Mr Noakes, there had been any meaningful exchange between Ms Kenneally and Mr Noakes or between Mr Huxter and Mr Noakes.

7.4. Ms Kenneally would again see Mr Noakes just prior to his leaving the hospital. She walked him to the taxi rank. Ms Kenneally eschewed any suggestion that she was Mr Noakes' assigned mental health nurse. She denied that she had any responsibility to conduct a risk assessment of a patient under an inpatient treatment order unless the person's order was confirmed which in this case did not happen.

7.5. Similarly, Ms Kenneally avoided any suggestion that nursing staff such as herself had any responsibility to complete the Initial Mental Health Assessment Clinical Record, and in particular the section that deals with the specific issues designed to address the patient's risk of harm to themselves should they leave the hospital.

7.6. At this point it is convenient to describe in some detail the purpose of that document. The section involving risk of harm if a patient were to leave the hospital includes two broad sections entitled "*Background Risk Factors*" and "*Current Risk Factors*". The questions posed need to be answered 'yes' or 'no'. The answers are circled or ticked in a proforma manner. The background risk factors section includes reference to such matters as previous self-harm, history of mental disorder, history of substance abuse, ongoing social/emotional/financial stressors and ongoing social isolation. All of those matters are manifestly relevant to a patient's risk of self-harm should they leave a hospital. And they were relevant to the issue as it affected Mr Noakes. In his case there had been episodes of previous self-harm, a history of diagnosed mental disorder, a history of methamphetamine abuse, ongoing social stressors in respect of his relationship with his partner and his young daughter and the potential for social isolation having regard to those matters as well as to the uncertainty surrounding his accommodation and his employment. As to current risk factors, the questions concerned the presence or otherwise of active suicidal intent, whether there was a safe supervised disposition location and insight into current condition. In Mr Noakes' case the reality was that if he had no active suicidal intent on the morning of 20 February 2013, he certainly had such an intent the day before and indeed had harboured what appears to have been an ongoing plan to end his own life. Whether Mr Noakes had a safe disposition location was in reality uncertain. It is evident that Mr Noakes was lacking in insight. Either he was in denial in relation to his difficulties or was downplaying them in order to leave the hospital and carry out his plan. His lack of co-operation was manifest, as was his disinterest in seeking help. For instance, he did not avail himself of the opportunity of seeing the DASSA representative before leaving the hospital. A proper and fully informed

assessment of Mr Noakes, as would have been required for this document to be completed, would have painted a very bleak picture in respect of the risk of harm were he to leave the hospital. One would not have needed to be a mental health nurse or physician to come to such a conclusion.

7.7. This document was no mere formality to be filled in at the discretion or whim of clinicians. This was a form that was designed to ensure that pertinent questions and issues were addressed in respect of a patient in the hospital, either voluntary or detained. The document seems to be tailor made to address the needs of a detained patient where the question of whether or not that patient should leave the hospital needed to be considered. No person within the Lyell McEwin Hospital took ownership of the task of ensuring that the form was completed and that the issues that the form required to be addressed were addressed. When Ms Kenneally was specifically asked in her evidence whether that part of the document under consideration would normally be completed, she said that it was normal practice for it to be completed. She said that she was not sure why a doctor had not done so in this case. She asserted that nursing staff do not *"touch this document at all. This is a medical officer's document"*[21]. One would observe, though, that much of that section of the document devoted to risk factors relates to factual matters that would not require the expertise of a medical practitioner to be established and recorded.

7.8. Ms Kenneally told the Court that she would have been aware that Mr Noakes had been a patient of the LMH in September 2011 and that she would have gained a better view of the matter from her review of collateral information from CBIS. She acknowledged that she would have noted her own involvement in that matter because her name was on the document that recorded it, but she told the Court that she did not recall Mr Noakes as having been at the hospital on that previous occasion.

7.9. As to the question of the securing of collateral information about a patient that might be obtained from family and acquaintances, a matter that has been acknowledged for some time and repeatedly emphasised in coronial findings as important in respect of the assessment of the psychiatric patient, Ms Kenneally stated that the obtaining of such information was a common practice "*where possible*"[22]. She went so far as to say that

[21] Transcript page 283 lines 13-14
[22] Transcript page 293 line 8

the practice was "*a general rule of thumb*"[23]. In the opinion of the Court this constituted a wholly inaccurate description of what was required by way of obtaining important information from sources that could readily be tapped in Mr Noakes' case from his partner or his general practitioner. It will be noted that Nicole Wyatt's telephone number was set out in Dr Baker's letter of referral. As well, it was clear that the medical practitioner who had detained Mr Noakes, the practitioner who had written the letter of referral and the practitioner who was the patient's usual GP was one and the same person, namely Dr Baker of the Angaston Medical Centre. Ms Kenneally stated that as to whether or not collateral information was obtained from outside sources, "*depended on the workload within the Department*"[24]. She said "*I believe that as part of normal process for a search of collateral we would attempt to contact next of kin, or significant others for collateral. Why it didn't happen, I can't explain*"[25]. She also stated that it was not usual practice to contact the detaining medical practitioner at discharge except by way of faxing the doctor the patient's discharge management plan, a matter that rather suggests that the detaining doctor is presented with a fait accompli[26].

7.10. Ms Kenneally could not sensibly explain the astonishing omission from her CBIS account of the 2011 Olanzapine overdose incident that Mr Noakes had admitted that he had taken the overdose with suicidal intent.

7.11. The Court also heard from the other mental health nurse, Mr Huxter. Mr Huxter had very little if anything of a therapeutic nature to do with Mr Noakes. He did manage to develop something of a rapport with Mr Noakes, at least insofar as he did manage not to antagonise him further, and apparently for that reason was asked to attend the psychiatrist's examination of Mr Noakes. Mr Huxter suggested that normally a patient like Mr Noakes would also be reviewed by a nurse, such a review including an examination of the patient's current mental state and a discussion about the reasons for their presentation, discharge planning and the like. He did say that this would not always be undertaken prior to the consultant psychiatrist's examination. Whether it occurred would depend on the workload within the Emergency Department. In any event, Mr Huxter said that Mr Noakes *"wasn't on my patient load"*[27] and that he did not have an in

[23] Transcript page 293 line 11
[24] Transcript page 294 line 33
[25] Transcript page 296 lines 4-7
[26] Transcript page 296
[27] Transcript page 120 lines 12-13

depth knowledge of his matter. What Mr Huxter learnt about Mr Noakes appears to have emanated from Dr Liu's examination.

7.12. Mr Huxter believed that Mr Noakes had a plan to live with his sister. In his evidence before the Court he said that this was a positive factor[28]. Mr Huxter said that if he had seen the reference in the Rural and Remote Triage record that Mr Noakes had been required to move out of his sister's premises, he would have wanted to speak with that sister as he would have been quite concerned, or even more concerned than he already was, about Mr Noakes. He agreed that after a high lethality suicide attempt it would have been *"certainly a good idea"*[29] to contact a person who was said to be in a position to accommodate the patient, at least to make sure that the person was happy to do so. However, he did not see his own role as involving such an enquiry. He said that Mr Noakes had not been assigned to him, and so he supposed that the responsibility of contacting such a person would have fallen either to Dr Liu or Ms Kenneally[30]. The note that Mr Huxter placed on the CBIS record following Dr Liu's examination stated categorically that Mr Noakes would now be staying at his sister's premises. This was a matter that was highly uncertain and no attempt had been made to verify whether that was the case or not.

7.13. Mr Huxter said that he did not have any knowledge of previous attempts at self-harm made by Mr Noakes[31].

7.14. Mr Huxter did not know that Mr Noakes had a diagnosed mental illness[32].

7.15. Mr Huxter was not asked to contact Mr Noakes' ex-partner, his sister with whom he said he would be staying nor Mr Noakes' general practitioner for further information[33].

7.16. Mr Huxter said that he did not have time to go back through Mr Noakes' history and previous entries in the records[34].

7.17. Mr Huxter suggested that the Initial Mental Health Assessment Clinical Record would be filled in after the arrival of the patient[35]. In order to complete that document one would

[28] Transcript page 130 line 18
[29] Transcript page 139 line 31
[30] Transcript page 139 line 140
[31] Transcript page 127 line 26
[32] Transcript page 131 lines 31-32
[33] Transcript page 132
[34] Transcript page 134
[35] Transcript page 143

have to examine collateral information about the patient[36]. He specifically said that there would be an expectation that the background risk factors and current risk factors sections within that document would be completed and that it would be all the more important for this to be undertaken in the case of a detained patient[37]. He acknowledged that the information that would be required to complete those parts of the document might not necessarily come from the patient him or herself and that the patient in any event might have every reason to withhold that kind of information. He acknowledged that an external source might well have to be the origin of such information. Mr Huxter suggested that his recollection was that at the Lyell McEwin Hospital the document was usually completed by the general medical nursing staff on admission. In any event, he agreed that the necessary enquiries would have to be made if a document could not be completed overnight. He suggested that this obligation would fall to the day shift nursing staff being the general medical nursing staff[38]. He acknowledged that it would be more appropriately be completed by a mental health nurse[39]. Whereas Ms Kenneally would divest nursing staff of such a responsibility, Mr Huxter readily conceded that nursing staff did have an obligation in respect of the completion of the document. I prefer Mr Huxter's candour on this issue. Mr Huxter said that he was not aware that the document had not been completed in Mr Noakes' case[40].

7.18. As to the Mental Health Act examination by Dr Liu, Mr Huxter told the Court that it did not enjoy a propitious start in that Mr Noakes at the outset was outwardly hostile towards Dr Liu. Mr Huxter described the hostility as involving slurs to the effect that he wanted to talk to an 'Aussie' and not an Asian. Mr Huxter's impression was that Dr Liu had found Mr Noakes slightly intimidating at the time[41]. During the course of the examination Mr Huxter interpreted the events of the previous night as having involved "a situational crisis"[42] with suicidal ideation. He agreed with counsel assisting that Mr Noakes' actions had involved a high lethality suicide attempt. Mr Huxter would use that expression in the note that he placed on the CBIS record. Mr Huxter's overall impression of Mr Noakes is summarised in the following answer given by Mr Huxter:

"Yeah, he felt that his issues had resolved. He had a plan to go and live with his sister and he explained his context the night before, something that had been I think his ...

[36] Transcript page 143
[37] Transcript page 144
[38] Transcript pages 145-146
[39] Transcript page 146
[40] Transcript page 147
[41] Transcript page 128
[42] Transcript pages 126 lines 28-29

had been brewing for a long time. He had some relationship instability and some problems and he felt that that culminated that night and yeah, a lot of his actions he explained was because of being intoxicated with alcohol."[43]

This impression was far more benign than the reality of the matter.

7.19. Mr Huxter's note in the CBIS record is relatively brief. It records that Dr Liu revoked the Level 1 inpatient treatment order due to "a change in risk status". Emphasis is placed on Mr Noakes' stated assertions that he no longer had suicidal ideation. It recorded that Mr Noakes was eager to leave the hospital and that he continually reassured staff that he was no longer suicidal and that the previous day's events were the end result of relationship dysfunction and his poor coping capacity with stress and anger management.

7.20. It is fair to say that Mr Huxter had only the most superficial appreciation of Mr Noakes' history and current personal circumstances and that his involvement with Mr Noakes was at the shallowest of levels. Mr Huxter was brought into the matter in order to attempt to establish the rapport that Ms Kenneally had failed to establish. He was more or less a chaperone in Dr Liu's examination.

8. Mr Noakes' Level 1 Inpatient Treatment Order is reviewed

8.1. Mr Noakes' Level 1 inpatient treatment order was reviewed by Dr Dennis Tianming Liu who is a psychiatrist. Dr Liu obtained his ordinary medical degrees in China. He obtained his specialist psychiatric qualification from the Royal Australian and New Zealand College of Psychiatry in 2007. Dr Liu has a PhD in medicine that was completed at the University of New South Wales in 1993. The speciality for his PhD was something other than psychiatry. Dr Liu is the clinical leader of community psychiatry at Salisbury. He told the Court that he has been working in the Mobile Assertive Care Team in the Northern Community Mental Health Services and he also provides support to the Lyell McEwin Hospital psychiatric services which includes consultation liaison and covering for inpatient services. He also provides support to the Emergency Department for examinations under the Mental Health Act. He is a senior lecturer at the University of Adelaide. I accepted Dr Liu's evidence as to his qualifications and regarded him as an expert in the field of psychiatry.

[43] Transcript pages 128-129

8.2. It is first necessary to describe the task that confronted Dr Liu as outlined by the Mental Health Act 2009. Section 21(5) of the Act requires a psychiatrist or authorised medical practitioner to examine a patient who is the subject of a Level 1 inpatient treatment order within 24 hours of the making of the order. After the completion of the examination the psychiatrist may confirm the order if satisfied that the grounds referred to in subsection (1) exist for the making of a Level 1 inpatient treatment order, but otherwise must revoke the order. The grounds referred to in subsection (1) are the grounds upon which a Level 1 inpatient treatment order would be imposed in the first instance by the original medical practitioner. I would observe that if a psychiatrist revokes the Level 1 inpatient treatment order it would not necessarily imply that the grounds for the original imposition of the order had not been made out. Rather, the psychiatrist looks at the whole matter afresh and considers whether the grounds for the making of a Level 1 inpatient treatment order exist at the time of the examination, regardless of whether or not the original order had been appropriately imposed.

8.3. I set out the Section 21(1) and (2) in full:

> (1) A medical practitioner or authorised health professional may make an order that a person receive treatment as an inpatient in a treatment centre (a ***level 1 inpatient 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 is no less restrictive means than an inpatient treatment order of ensuring appropriate treatment of the person's illness.
>
> (2) In considering whether there is no less restrictive means than an inpatient 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 or in compliance with a community treatment order.

Section 21 goes on to state clearly that a medical practitioner forming an opinion in respect of the matters set out above may do so on the basis of his or her own observations together with any other reliable and relevant evidence[44]. No doubt such other reliable and relevant evidence could include the patient's documented mental health history,

[44] Section 21(2) of the Act

recent behaviour, the opinions of other medical practitioners and information from family members and acquaintances. It will also be seen from use of the expression 'may make an order', that the imposition of an inpatient treatment order is discretionary notwithstanding that the criteria for the imposition of the order have been met. The same discretion applies in respect of a psychiatrist's confirmation of the order[45].

8.4. The confirmation of a Level 1 inpatient treatment order by a psychiatrist does not necessarily mean that the patient must be detained for a period of 7 days. This is due to the fact that Section 21(7) allows for the revocation of a Level 1 inpatient treatment order at any time, that is to say even after the order has been confirmed within the first 24 hour period.

8.5. Dr Liu gave oral evidence at considerable length. He identified the handwritten notes that he made at the time of Mr Noakes' examination[46]. The document runs to two and a half pages, the salient features of which, as recorded by Dr Liu, are a description of Mr Noakes long history of 'dysthymia' with no 'consistent major depressive symptoms' and no 'evidence of psychosis'. The document fails to acknowledge the previous diagnosis of a major depressive disorder. Rather, the document records a situational crisis, an anti-social personality disorder and an alcohol related suicide attempt. I would observe that I have not seen any reference in Mr Noakes' historical records to any diagnosis or impression of dysthymia or of an anti-social personality disorder.

8.6. There is specific reference in Dr Liu's notes to Mr Noakes' plan *"to stay with his sister and try to reconnect with his children"*. It has already been seen that both aspects of this plan were surrounded in uncertainty.

8.7. It is of telling significance that although the notes speak of a high lethality suicide attempt under the influence of alcohol after an argument with his wife, the note mentions nothing about a plan on the part of Mr Noakes to end his life as indicated by his acquisition of a rope and his statements to his partner. There is also no specific reference in the note to previous acts of self-harm including, notably, the Olanzapine overdose with suicidal intent.

8.8. Dr Liu told the Court that his examination took about 45 minutes. Asked as to why he did not include within his notes reference to a past diagnosis of a major depressive

[45] Section 21(5)(d) of the Act
[46] Exhibit C14 pages 37-39

disorder, Dr Liu said that he could have documented more but that at the time he had been *"quite rushed"* and had been an hour late for his outpatient clinic. He said that he was *"rushed in documentation"*[47]. The other reason he made no reference to depression was that he did not totally agree with that previous diagnosis. I will return to that matter in a moment. When specifically asked whether time pressures had impacted upon the thoroughness of his assessment of Mr Noakes, Dr Liu gave the following answer:

> *"Not much impact on my engagement with him and I did spend about - in total probably about three-quarter of an hour to discuss issues with Mr Noakes. If I had a lot more time then perhaps I will do the rest of assessment, which I believe at the time it could be done in the community. But in the emergency department I felt at the time is not the best place to collected* (sic) *those* (sic) *information".*[48]

8.9. In my opinion this answer evidences a flawed approach on the part of Dr Liu. One would legitimately ask what it was that would have constituted the *'rest of'* Dr Liu's assessment. The more worrying question which might remain unanswered is what impact the *'rest of assessment'* may have made on his assessment as a whole. Dr Liu appears to have assumed that a full and proper assessment of Mr Noakes could be completed once he was released into the community, without giving proper consideration as to whether or not a full and proper assessment completed in the hospital may have resulted in Mr Noakes not being released at all.

8.10. Dr Liu told the Court that he had access to the CBIS notes, to Dr Baker's referral letter and to the triage documentation from the Rural and Remote Triage Service. It is clear that Dr Liu made no further enquiry, or caused any further enquiry to be made, about Mr Noakes' accommodation arrangements should he leave the hospital. Dr Liu did not speak with or make any attempt to speak with the medical practitioner who had imposed the inpatient treatment order in the first instance. Dr Liu stated in fact that "*all the relevant information will be in the clinical notes including the electronic casenote. So I go through those casenotes to identify any relevant issues*"[49].

8.11. Dr Liu told the Court that he characterised Mr Noakes' most recent actions of the day before as being a highly aggressive, potentially lethal act from an impulsive man. He suggested that Mr Noakes' intention was more an expression of his anger than an actual intention to end his life. This characterisation, at a pinch, might have taken on legitimacy

[47] Transcript page 226
[48] Transcript page 229 lines 10-17
[49] Transcript page 162 lines 20-23

had those particular actions been viewed in isolation, but they took on a completely different flavour when one had regard to the fact that Mr Noakes had harboured an ongoing plan to use a rope to hang himself and had acquired the means to do so. Dr Liu was asked the following question and gave the following answer:

"Q. When someone then tells their doctor that they have a plan to hang themselves and that they have bought the rope with which to do it, that cannot be seen as an impulsive suicide attempt, can it.

A. Yes ... the context, he had - looking at the history, there was quite a significant deterioration of his mental - the relationship at the time and he was very unhappy and in the past when he was in those situation he tend to have suicidal ideation. And he, at the time, told his partner he had a rope, after he actually - from my memory actually his ex-partner took his knife away from him and then he told her that he had a rope and he also wanted to kill himself. So, this is in the context from when at the time I assess him and he actually calmed down and he made it quite clear, and that was no longer the case[50]*."*

In that answer Dr Liu appeared to demonstrate a reluctance to accept that Mr Noakes' impulsive acts of self-harm the day before needed to be viewed in the wider context of a desire and plan on Mr Noakes part to end his own life. The answer also evinces a belief on Dr Liu's part that unquestioning acceptance of Mr Noakes' assertions that he no longer desired to kill himself was appropriate if not mandated. This acceptance needs to be examined against Dr Liu's somewhat startling assertion that patients do not often lie[51]. While an acceptance of the truth of a patient's story might be appropriate when the patient is examined clinically from a purely therapeutic viewpoint, the same cannot be assumed in the context of the section 21(5) examination of a detained patient who well knows that his or her liberty, and the consequent ability to carry out a suicidal intent, depends on the outcome of the examination. It is worthwhile observing that there is nothing in the Mental Health Act, the Mental Health Regulations nor the Inpatient Treatment Orders Statement of Rights that compels the revelation to the patient of the purpose of a 24 hour review. In his evidence Dr Champion suggested that there are possible natural justice considerations that might come into play here, but one would think that human nature dictates that when the suicidal patient bent on release has an appreciation of the nature of the review exercise, his or her responses to questions that are relevant to the outcome of the examination are going to be more guarded than otherwise. In Mr Noakes' case there was absolutely nothing to suggest to Dr Liu that Mr Noakes' assertions of a lack of any

[50] Transcript page 210 lines 23-38
[51] Transcript page 205 line 8

further intent to harm himself were sincere and genuine. In this regard, if Dr Liu had spoken to the doctor who had imposed the detention in the first instance, namely Dr Baker, he may have learnt that there was a real question mark over Mr Noakes' ability to be accommodated at his sister's premises, to which he said he intended to go, and most significantly may also have learnt of Mr Noakes' stated intent to hang himself at that premises. It is also worthwhile observing that in considering the veracity of Mr Noakes' denials of intent to self-harm, he was not naïve to the process involved in a section 21(5) examination. In 2011 he had undergone the same process. That examination had involved the strikingly similar outcome of his being released after he had made denials of an intent to self-harm in the face of earlier admissions that he had taken the overdose with suicidal intent, a matter that never made its way onto the CBIS record.

8.12. Dr Liu's faith in the accuracy of what Mr Noakes said about himself also has to be viewed against the fact that on several occasions during the course of Dr Liu's evidence he emphasised that Mr Noakes had a capacity to make decisions for himself[52]. If Dr Liu meant by this that a person such as Mr Noakes, who notwithstanding the fact that he had recently indulged in reckless behaviour that had placed his own life in danger, had the capacity to decide what was in his own best interests, he appears to have been guided in a way which was of limited value. There is nothing in the Mental Health Act regarding the patient's ability to make decisions for him or herself. If all the other elements necessary for detention are present, a patient's capacity to decide matters for themselves in the face of an ongoing serious risk of harm to themselves could hardly be determinative.

8.13. Likewise, considerations such as that articulated by Dr Liu, namely that if detained, Mr Noakes would probably abscond and do so in a worse state than that in which he had entered the facility[53], is also a matter of limited relevance when one considers that a detention is an acute protective mechanism and a state whereby a person who is at risk of absconding should not be allowed to do so. It is idle to say that if all of the elements for detention are satisfied one would nevertheless refrain from imposing an inpatient treatment order on the basis of a strong perception that the patient might abscond. This is akin to saying that it is no use imprisoning any criminal who for whatever reason is likely to escape. For Dr Baker, the likelihood of Mr Noakes absconding as a voluntary

[52] Transcript pages 182, 183, 184, 203 and 247
[53] Transcript page 183

patient was a matter that spoke more of the need to detain. I have no hesitation in concluding that if all essential elements of Mental Health Act detention are established, Dr Baker's approach to the risk of absconding would generally have to be preferred. Had Dr Liu contacted Dr Baker and had raised with him the likelihood of Mr Noakes absconding as a relevant factor, the immateriality of that in Mr Noakes' case may have been made apparent to him.

8.14. There are other matters connected with Dr Liu's approach that are questionable. Dr Liu believed that Mr Noakes had a long history of dysthymia. He held this belief despite the fact that dysthymia had not featured as part of Mr Noakes' longitudinal history. Moreover, it was an impression or diagnosis that conflicted with an already existing historical diagnosis of a major depressive illness. In any event, as Dr Liu conceded, dysthymia is a mild form of depressive illness and it is recognised within DSM-IV[54]. He acknowledged that dysthymia is an illness or disorder of the mind[55]. For the Court's part there seems little doubt that dysthymia could be regarded as a mental illness for the purposes of the Mental Health Act and is one for which acute episodes could be the subject of inpatient treatment[56].

8.15. As for the impression of an anti-social personality disorder, this diagnosis had likewise never been part of Mr Noakes' longitudinal history. Dr Liu acknowledged this[57]. Dr Liu told the Court that this disorder is characterised by a person's recurrent pattern of dealing with stresses and life issues by way of impulsive behaviour and emotions that are difficult to deal with and a by tendency to act aggressively towards others. As well, they sometimes also fail to conform to common social rules and norms[58]. There was little evidence of that in Mr Noakes' character and personality. Curiously, Dr Liu agreed that in a clinical context a person with an anti-social personality disorder might exhibit an outwardly charming and convincing persona where the reality is that the person is manipulating clinical staff and even fellow patients[59]. Dr Liu was therefore asked whether he had given any thought to the possibility that when Mr Noakes had said that he was no longer suicidal, and had given his assurances that he would not attempt to commit suicide if he left the hospital, he was manipulating Dr Liu. To that Dr Liu said:

[54] Transcript page 173
[55] Transcript page 256
[56] Transcript page 255
[57] Transcript page 250
[58] Transcript page 249
[59] Transcript page 250

"*A.* *That is a possibility but at that time when I assess him I didn't feel - I sincerely didn't feel that he was lying to me.*"[60]

Again, Dr Liu seems to have placed great faith in the veracity of what Mr Noakes was saying to him.

8.16. I have already referred to the fact that there is nothing in Dr Liu's notes about the acquisition of the rope and Mr Noakes' intentions in respect of it. When Dr Liu was cross-examined about this aspect of the matter he could not provide a convincing answer to specific questions as to whether or not he had even asked Mr Noakes about the rope and his intentions in respect of it. Dr Liu said that he was compelled to admit that he could not remember whether he had specifically asked Mr Noakes about the rope, but said that he had asked him generally about his plans and his intention to commit suicide. He agreed that questions such as *"have you ever had a plan to hang yourself?"* and *"did you buy a rope for the purpose of hanging yourself"* were necessary questions for Mr Noakes to have been asked and that they could have been answered yes or no. Asked as to whether he did ask those very questions of Mr Noakes, Dr Liu said that he could not remember but suggested that those questions were in effect posed somewhere in the overall context of his suicide assessment in that he asks patients whether they have any specific plan to kill themselves and how long those intentions have been existence[61]. Asked as to why in an examination of this type he would not ask the specific and pointed questions I have identified, he said:

"*A.* *I couldn't remember whether I ask or not and I believe I would ask those questions, but in the similar context, whether it's specific in those words I can't remember, but as I said the specific question he wouldn't answer in detail.*"[62]

Dr Liu was asked whether if he had asked Mr Noakes if he had bought a rope to hang himself and he had said yes, his answer would have changed the whole complexion of his examination[63]. Dr Liu said it would have. On the other hand Dr Liu agreed that if Mr Noakes had said no, that would have been an indication that Mr Noakes had been lying to him and might have led him to doubt his veracity in general[64]. When Dr Liu was asked whether he agreed that the question *"have you bought a rope to hang yourself with"* was one of the most important questions Mr Noakes could have been asked in the

[60] Transcript page 251 lines 10-12
[61] Transcript page 213
[62] Transcript page 213 lines 32-36
[63] Transcript page 214
[64] Transcript page 214

examination, Dr Liu agreed, and when confronted again as to whether he had asked Mr Noakes the question, he said *"I can't remember"*[65].

8.17. Dr Liu's notes say nothing of the rope topic at all. The only conclusion that the Court can draw is that Dr Liu never asked those specific questions of Mr Noakes. I so find. Either an affirmative or negative answer to those questions would have been of some significance on Dr Liu's own admission. How any proper assessment of Mr Noakes could have been conducted without those specific questions being asked is a matter that is difficult to understand.

8.18. As to the Facebook post concerning the possibility of Mr Noakes joining Mark in the afterlife, Dr Liu knew nothing of that and acknowledged that if he had known of it he would have explored the issue with Mr Noakes. It is easy to see why. Dr Liu agreed that the Facebook post may have affected his impression that Mr Noakes' actions of the day and night before, both at Renmark and on the road to Angaston, were merely impulsive acts[66]. It will be remembered that the untapped source of the information concerning the Facebook post was Mr Noakes' sister whose premises was that to which Mr Noakes said he would go and be accommodated in if he left the hospital. Had those assertions been explored, and in particular if Mr Noakes' sister had been contacted about the accommodation issue at least, it would seem highly likely if not inevitable that she would have mentioned the Facebook post to the person from the Lyell McEwin Hospital who made the enquiry of her. This is one way in which the gathering of collateral information can be seen as an essential and intrinsic part of any examination under section 21(5) of the Mental Health Act. And there was also Dr Baker's information that suggested that Mr Noakes' intention to hang himself would be carried out at the sister's address. One is now left to wonder whether Mr Noakes' sister would have been hesitant about accommodating Mr Noakes even if the accommodation had been available on a short term basis, and whether as a result, Mr Noakes would have been allowed to leave the hospital. These are not mere speculative matters that one can conjure up in hindsight. These represent valid and necessary enquiries that ought to have been made at the time. The Initial Mental Health Assessment Clinical Record that was required to be completed dictated the making of such collateral enquiries. It will be remembered that the form was never completed. No other efforts of securing collateral information were made.

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[65] Transcript page 214 line 22
[66] Transcript page 216

8.19. As to the Olanzapine incident in 2011, there was nothing in Dr Liu's notes about that at all.

8.20. In the event I found it difficult to understand whether Dr Liu had in fact, at the time of the examination, come to a decision whether or not the detention provisions within the Mental Health Act had been enlivened. Dr Liu did agree that his impression of dysthymia was one which would qualify as a mental illness for the purposes of the Act. He agreed that the mental illness required treatment in order to protect Mr Noakes from harm[67]. He also agreed that there was no guarantee that Mr Noakes would receive the necessary treatment in the community. He also agreed that the prospects of Mr Noakes obtaining treatment for his illness on a voluntary basis were questionable[68]. He said that at the time he did not believe that a community treatment order would have been granted by the Guardianship Board[69]. When asked if he had considered whether Mr Noakes should have been kept in the hospital for a few more days and monitored, he said:

> *"A. Well, at the time, I didn't consider that he should be kept for a few days in the hospital because, as I said, when I assess him and his situation - well, his mental state has come down and had I kept him against his will and if he had intention to lie to me and he will do the same thing to the inpatient doctor and there will be no further ground to detain him. And so most likely he will be released immediately."*[70]

Dr Liu did acknowledge that if the order had been confirmed it would have provided the Lyell McEwin Hospital staff with the necessary opportunity to gather further information about Mr Noakes that would have consisted of approaches to Mr Noakes' general practitioner, his ex-partner and his sister[71]. If such an opportunity had been taken, and the important collateral information about Mr Noakes had been gathered, it is difficult to see why it was inevitable that *'the inpatient doctor'* would have considered that there were no grounds to further detain Mr Noakes. I would add here that this examination was conducted at a time considerably less than 24 hours since the inpatient treatment order had been imposed by Dr Baker. It would be understandable, but not always clinically appropriate, if the timing of a Mental Health Act 24 hour examination was frequently aligned with the commitments and convenience of the examining practitioner. One suspects that to be the case. It was also suggested in effect by the expert Dr

[67] Transcript page 256
[68] Transcript page 257
[69] Transcript page 257
[70] Transcript page 258 lines 22-29
[71] Transcript pages 258-259

Champion[72], that a section 21(5) examination is regarded more as a forensic exercise required by law than a therapeutic or protective one, if so, another undesirable set of circumstances. Be all that as it may, I accept in this case that Dr Liu had other commitments that pressed him for time, and that both this pressure and the timing of the examination were possibly not of his making, but the fact of the matter was that there were many hours left before the 24 hour examination deadline would be reached. Although an examination by a medical practitioner as soon as possible following the admission of a detained patient is clearly desirable, there is no express legal requirement that an examination pursuant to section 21(5) of the Act, and the confirmation or revocation of the inpatient treatment order, all have to be completed at the earliest opportunity within the 24 hour period. Although I did not hear argument on the topic, I would be strongly inclined to the view that neither the Act's 'Guiding Principles' in section 7, nor any other part of the Act, even impliedly mandate such a requirement. While accepting the principle that services under the Act should be provided in the least restrictive way and environment[73], the requirement that services should be designed to bring about the best therapeutic outcome for the patient[74] would appear to be an overarching one, especially given that the provision of those services is the core object of, and reason for the existence of, the Act[75]. And the fact that there is a numerical deadline at all, and one which may be exceeded if it is not practicable for the examination to be carried out within the 24 hour period[76], would imply that the examination may be carried out at any time within that 24 hour period. It is difficult to escape the conclusion that in Mr Noakes' case there would have been sufficient time for the necessary collateral enquiries to have been made if the examination and decision to revoke had been delayed for that purpose. It is therefore difficult to escape the further conclusion that this examination and revocation was premature and conducted with unnecessary haste. I would also add that it would be highly inappropriate for the scheduling of the examining psychiatrist's professional or personal commitments to take precedence over the therapeutic and protective needs of a patient.

8.21. Having examined Dr Liu's evidence carefully, I can see no assertion within it to suggest that at the time of the examination the requirements in the Mental Health Act for the

[72] Transcript page 350, Exhibit C21 page 9
[73] Section 7(1)(b)
[74] Section 7(1)(a)
[75] Section 6(a)(i)
[76] Section 21(5)(c)

confirmation of an inpatient treatment order were not satisfied. Within Dr Liu's witness statement[77] there is an assertion that he did not think that Mr Noakes had a treatable Axis I mental illness of major depression, acute psychosis or mania. He asserts that Mr Noakes' presentation was due to a situational crisis as well as anti-social personality pathology. Yet within his oral evidence Dr Liu suggested that dysthymia was an illness that would have qualified Mr Noakes for an inpatient treatment order, and at no stage did Dr Liu ever suggest that the original imposition of the order by Dr Baker had been inappropriate. Rather, Dr Liu appears to have succumbed to an uncritical acceptance of Mr Noakes' questionable assertions and assurances that he would not harm himself if released.

9. The Evidence of Dr Champion

9.1. I have already referred to Dr Champion. Dr Andrew Robert Champion is a consultant psychiatrist. He obtained his basic medical qualification in 1989 from the University of Adelaide. He became a Fellow of the Royal Australian and New Zealand College of Psychiatrists in 1996. Dr Champion has worked at Glenside Psychiatric Hospital, at the Queen Elizabeth Hospital's Cramond Clinic, at the Noarlunga Hospital and with both the Child & Adolescent Mental Health Service and Southern ACIS. Since 2006 he has been the Clinical Director of the Mental Health Service at the Noarlunga Hospital. Dr Champion has sat on the Nurses Board and on the Adelaide Metropolitan Mental Health Service Incident Review Committee which was a body that examined adverse events including completed suicides. Dr Champion currently sits on the Morbidity and Mortality Committee for the Southern Adelaide Local Health Network and has participated in a number of root cause analyses that are structured examinations of adverse events including completed suicides.

9.2. Dr Champion was asked to provide an independent expert assessment of Mr Noakes' care in the last 24 hours of his life. He compiled a report[78] and gave oral evidence at the Inquest. I accepted Dr Champion's evidence as to his qualifications and regarded him as an expert in the field of psychiatry.

[77] Exhibit C20
[78] Exhibit C21

9.3. Dr Champion was not critical of Dr Boonstra nor Dr Baker. He agreed that Dr Baker's imposition of the inpatient treatment order was appropriate[79].

9.4. In his oral evidence Dr Champion spoke about the nature of Mr Noakes' mental illness. Dr Champion opined that on his reading of the clinical record relating to the June 2008 episode the diagnosis of a major depressive disorder had been a reasonable one. He believed that the duration and severity of Mr Noakes' distress was consistent with such a disorder. As well, the likelihood of a recurrence would have been high, with recurrence after more than two episodes almost being inevitable[80]. As to his view of Dr Liu's questioning of that diagnosis, Dr Champion said that while it is legitimate for a psychiatrist in Dr Liu's position to question a previous psychiatric diagnosis, he was not convinced that a 45 minute assessment provided sufficient information to discharge or revise a previous diagnosis. And although in Mr Noakes' case Dr Champion believed that dysthymia was a legitimate inclusion as a differential diagnosis, he thought it was premature to dismiss the previous diagnosis of depression merely on the basis of a 45 minute interview[81]. In any event Dr Champion pointed out that dysthymia is a less severe and more prolonged form of depressive disorder which can co-exist with a major depressive disorder[82]. As well, according to Dr Champion, dysthymia is a mental illness for the purposes of the definition of 'mental illness' in the Mental Health Act. I see no reason to depart from that assessment as a matter of law or fact. As to anti-social personality disorder, Dr Champion was of the view that although there was a history of impulsive behaviour going back some years, there was not the usual evidence of a lack of remorse or conscience that is central to a diagnosis of anti-social personality disorder, a profile that in any event had not been explored by Dr Liu. Dr Champion told the Court that Mr Noakes' racial provocation would not be a proper basis for such a diagnosis. Such a diagnosis would have required the clinician to step back and examine the longitudinal history of the patient, as distinct from relying on the degree of irritation or affront that the patient might engender during an interview.

9.5. In the Court's opinion the important aspect of Dr Champion's evidence concerning diagnosis is his evidence that the Mental Health Act did not require a full diagnosis of depression. He agreed that in order to invoke the Mental Health Act one would not

[79] Transcript page 335
[80] Transcript page 324
[81] Transcript page 353
[82] Transcript page 354

necessarily have to embark upon a complete DSM-IV analysis and conclude that the patient was suffering from major depression. As well, Dr Champion also acknowledged that in many cases due to the poor level of engagement of the patient, it was simply not possible to do this[83]. Dr Champion stated that due to a number of factors including a failure to consider major depression criteria in terms of sleeping and appetite, he could not be certain that on the 19th and 20th of February 2013 Mr Noakes had been suffering from a major depressive disorder. However, what was clear was that Mr Noakes was exhibiting a depressed mood, he had a clear sense of despair as articulated to Dr Baker when he was detained, and had provided a clear description of suicidal thoughts for at least a fortnight[84]. Dr Champion added that the presence or absence of a major depressive episode was not the central determining factor in deciding the appropriate course of action at the time. If the diagnosis of dysthymia was correct, it was a DSM-IV diagnosis and that would have been sufficient to invoke the Act in any case.

9.6. In the opinion of the Court the evidence is overwhelming that when Mr Noakes was examined by Dr Liu, he had a mental illness for the purposes of the Act, whatever label was placed on his condition.

9.7. Dr Champion told the Court that the purpose of hospitalisation in a case such as Mr Noakes might simply be to have enabled him to survive the existing crisis, to establish a level of engagement and to manage short term agitation. As well, a purpose to be served would to be to increase the likelihood that the individual might subsequently engage with outpatient treatment. In Mr Noakes' case, Dr Champion did not believe that there was sufficient evidence of safety in discharge to outpatient treatment. Dr Champion believed that there were grounds to consider the possibility that Mr Noakes' crisis had not passed and that the possibility for harm remained. It had not been possible to establish that any of the stressors in his life that had led him to the point where he had been detained the day before had resolved. As well, over many years, he had a history that demonstrated a proneness to impulsive behaviour[85].

9.8. As to the issue regarding the likelihood of Mr Noakes absconding, a matter that Dr Liu believed was relevant, Dr Champion told the Court that he believed that it is legitimate to consider whether compelling a person to remain in hospital under the Mental Health

[83] Transcript page 360
[84] Transcript page 359
[85] Transcript page 361

Act might damage the chance of future engagement.[86] Dr Champion interpreted Dr Liu's evidence to imply that in his judgment there could only have been one way in which things could have turned out had he confirmed the order, that is to say adversely. Dr Champion observed that such a conclusion does not necessarily accord with clinical experience. He also pointed out that in any case it was not inevitable that a detained patient would be accommodated in a locked psychiatric ward. He described a variety of measures available within an open ward that would both mitigate the rigours of detention and promote proper care and scrutiny of the patient.

9.9. Dr Champion said that there was evidence in Mr Noakes' case that supported the confirmation of the inpatient treatment order and the imposition of a brief period of hospital treatment. Dr Champion stated that the passage of time by itself can have a calming and therapeutic effect for a person presenting in suicidal crisis. A brief hospital admission often provides an opportunity for family and friends to offer support, reassurance and practical solutions for the person. Another intervention that could be offered is the short term use of medication to manage agitation and arousal, and it is also possible for therapeutic conversations with clinical staff to take place.[87]

9.10. There are a number of aspects surrounding the decision to discharge Mr Noakes which Dr Champion believed were questionable. He suggested that the episode in 2011, in which an inpatient treatment order had been lifted by Dr Harvey, had involved a very different situation from that which confronted Dr Liu. In 2011 there had been tangible and meaningful support for Mr Noakes. Dr Champion pointed to the fact that on that occasion a sister and a friend had been present, that they had been made aware of follow-up plans and that they would have been able to provide support. In contrast, in the 2013 episode no such person had been present during Mr Noakes' examination. Accordingly, there had been very little evidence of the support that would have been required once Mr Noakes came to be discharged. What possible support there was, in the form of accommodation, was questionable, or at least needed to be further questioned.

9.11. Dr Champion also referred to the character of Mr Noakes' most recent self-harming behaviour consisting of the placing of the knife to the throat, the jumping from the vehicle and placing himself in the path of a truck, which was not to be characterised as *"simply*

[86] Transcript page 363
[87] Transcript page 365

a dramatic gesture"[88], and the obtaining of the rope which, in the context of contemplating suicide for the previous two weeks, implied a degree of planning. In Dr Champion's opinion the combination of all three matters indicated *"an extreme suicidal risk"*[89].

9.12. Dr Champion expressed the very firm opinion that Dr Liu should have explored with Mr Noakes the question of his obtaining of the rope. He said:

> *"so a premeditated act of obtaining access to a high lethality means of suicide, I don't think it's something that can be safely overlooked. I don't think one can accept Mr Noakes' willingness to dismiss or not discuss that topic"*[90]

Dr Champion was there referring to Mr Noakes' asserted lack of willingness to speak about that particular aspect of his presentation. Dr Champion told the Court that the topic of the acquisition of the rope was absolutely central to the assessment of suicidal risk. Dr Champion believed that in light of the fact that this was an element that increased the severity of suicide risk, it would have been a significant omission for Dr Liu not to have explored that issue specifically with Mr Noakes. My view is that Dr Liu for whatever reason refrained from asking Mr Noakes' specifically about the rope and his intentions in respect of it. I thus accept Dr Champion's criticism of Dr Liu in that regard.

9.13. Dr Champion was of the view that even in a busy emergency department there would have been an opportunity to make the necessary collateral enquiries from next of kin such as Ms Wyatt, whose telephone number had been provided by Dr Baker, and possibly from other members of Mr Noakes' family as well. Asked specifically as to whether Dr Baker should have been contacted, Dr Champion agreed that was so, given that Dr Baker was the person who had detained the patient. Key issues to have been explored with Dr Baker would have been how concerned the latter had been about his patient and how different Mr Noakes' most recent behaviour had been from his usual behaviour. Dr Champion states in his report that it is possible that knowledge of Dr Baker's extreme level of concern might have influenced Dr Liu's willingness to take at face value Mr Noakes' assertions that he was no longer feeling suicidal. I would accept that as a matter of logic Dr Liu ought to have been so influenced. Although Dr Champion did not believe that there should be a statutory requirement that as part of a Mental Health Act

[88] Transcript page 333
[89] Transcript page 334 lines 2-3
[90] Transcript page 351 line 3

examination the psychiatrist must communicate personally with the practitioner who had imposed the inpatient treatment order in the first instance, he suggested that there was nevertheless a need for the medical practitioner to be contacted and that the value of such a communication needed to be reinforced.[91] Dr Champion believed that the strongest reason for the general practitioner being contacted was that that practitioner may know things that the psychiatrist does not know.[92]

9.14. As to Mr Noakes' assertions and assurances of a lack of suicidal intent, Dr Champion suggested that current good intentions as expressed during a review of an inpatient treatment order do not speak to what might happen after the person leaves the hospital. He said:

"The person might be completely sincere but the evidence is that they can behave impulsively when distressed and their behaviour can change in a volatile or unpredictable way."[93]

As to the acceptance by Dr Liu of Mr Noakes' denials of an actual suicidal intent, Dr Champion stated that if the patient's behaviour is intrinsically lethal, the risk to that person is in any event identical regardless of intent[94]. Dr Champion was asked by me to pass comment on the desirability or otherwise of a person being able to avoid confirmation of a Level 1 inpatient treatment order by a deliberate lack of engagement or by inducing in the mind of the examining psychiatrist the unquestioning acceptance of denials of suicidal ideation. Dr Champion's view is that such denials could not be given weight without also giving proper consideration to recent behaviour, to a past history of mental illness, to the patient's proneness to impulsivity and to the presence or absence of substance abuse which are all equally as relevant[95].

9.15. Dr Champion also expressed an opinion about the failure to seek collateral information about Mr Noakes. Dr Champion suggested that during the course of the morning there had been an opportunity for a member of the mental health team to interview Mr Noakes. This could have been undertaken for a number of purposes including firstly, that it would have provided an opportunity to build on the referral information. Secondly, it would have represented an opportunity to actually engage the patient in a conversation that was therapeutic as distinct from the psychiatrist's statutory assessment which was an exercise

[91] Transcript page 345
[92] Transcript page 346
[93] Transcript page 357 lines 9-12
[94] Transcript page 356
[95] Transcript page 357

designed principally to determine whether or not the patient should be compelled to remain as a detained patient.

9.16. Finally, Dr Champion was asked whether in his view Mr Noakes' death was preventable. Dr Champion said:

> *"A. In the short term, yes, I think there were grounds to confirm the ITO, I think there were grounds to offer a brief hospital admission and I think it's reasonably likely, based on my experience of observing the trajectory of other men presenting in suicidal crisis, that his issues might have resolved to the point, when he left hospital after admission, that he didn't go on to take his own life in the short term."*[96]

I should add that in his report Dr Champion expressed the view that the long term risk of future suicidal crises would have remained moderately high that Mr Noakes may have reached another suicidal crisis at a future stage. I accepted Dr Champion's evidence in its entirety. I preferred Dr Champion's evidence to that of Dr Liu where the evidence of the two psychiatrists conflicted. I have given due consideration to the fact that Dr Champion did not examine Mr Noakes. However, to my mind Dr Champion's evidence more closely accorded with common sense and a proper understanding of the human condition. For example, I have assigned great weight to Dr Champion's evidence that Mr Noakes' plan in respect of the use of a rope to hang himself was a matter that required specific exploration with Mr Noakes and that it would have been a significant omission for that not to have occurred in the course of a section 21(5) Mental Health Act examination such as this. Such conclusions would accord with common sense and one's experience of life. I was satisfied on the balance of probabilities, and to a very high degree of satisfaction, that Dr Liu did not specifically explore that issue with Mr Noakes and that he should have done so.

10. Suicide Risk Assessment Guidelines

10.1. In the course of his evidence, Dr Champion produced to the Court a document promulgated by the New South Wales Department of Health entitled "Suicide Risk Assessment and Management – Emergency Department"[97]. The asserted copyright belongs to the New South Wales Department of Health and is dated 2004. A similar South Australian document is now in existence.

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[96] Transcript page 373 lines 17-24
[97] Exhibit C17

10.2. The New South Wales document contains advice as to the assessment of suicide risk as well as to the management of the suicidal patient. It has a specific section relating to the discharge of a patient from an emergency department into the general community. It is surprising that a document as easily understood and followed as the New South Wales document can be was not in existence in South Australia at the time of these events.

10.3. The salient features of the New South Wales document are an emphatic identification of a number of matters that are relevant to the assessment of suicide risk including an assessment of the person's mental status in terms of hopelessness and despair, recent interpersonal crises and recent suicide attempts. The document also identifies as a risk factor a lack of social support network and makes specific reference to family cohesion as a protective factor against suicide. The document also places significant emphasis on the need on the part of those assessing suicide risk to consider the availability of collateral information such as might be obtained from medical records, members of the patient's family, accompanying persons and other health providers. There is also reference to identifying current thoughts of suicide and the need to establish with the patient whether the patient has any current plan of suicide or has access to lethal means of carrying out that plan.

10.4. There are also many common sense matters that the document would require addressing. These include a consideration of the triggers for recent self-harm or suicide attempts and whether the precipitating factor is still present or not. When read as a whole, the document make it reasonably plain that in assessing current suicide risk the patient's asserted current intent is but one matter to be taken into consideration with all other relevant matters. Included in other such matters are a need to consider impulsivity, drug abuse, child custody issues and, relevantly as far as this Inquest is concerned, the ability to complete the assessment of the patient and the ability to obtain collateral information. The document suggests that an inability to carry out either task might generate low risk assessment confidence.

10.5. As far as management of the patient is concerned, the document states *"a person assessed to be at immediate risk of suicide should never be left alone".*

10.6. As to discharge from hospital to the community, the document does not purport to deal specifically with the scenario of legislative detention, but appears to relate to discharge from an emergency department regardless of the status of the patient. In general the

document advises *"when the person's risk can be revised down to low risk or no foreseeable risk, levels of care can be safely and appropriately reduced and the person can be assessed for discharge to the community"*. The document then goes on to describe certain requirements that need to be met before a patient can be discharged from the emergency department into the community. Such requirements include but are not limited to the need for a comprehensive suicide risk assessment to have been conducted and ensuring that the person being discharged has a means of returning home or to suitable accommodation. Both of these issues were relevant in Mr Noakes' case. The document also requires the following:

- That prior to leaving the emergency department the patient and where appropriate their family must be provided with information about how to access urgent help including a 24 hour contact telephone number and they must be provided with written confirmation of a follow up appointment;

- Significant support people must be contacted including the patient's general practitioner and family and friends about potential suicide risk and about follow up arrangements that have been made.

I observe that nothing of the kind occurred in Mr Noakes' case.

10.7. The South Australian document[98] is entitled "Guidelines for Working with the Suicidal Person – Shared Learning in Clinical Practice". Dr Liu told the Court that this document was originally released in a manner that saw little attention drawn to it such that most of his colleagues would not have known of its existence. In his report Dr Champion stated that the guidelines were released in late 2012 but were not distributed with accompanying training about their use, and that it was possible that mental health staff, as well as general hospital staff, would not have been familiar with them. In his oral evidence he confirmed that the document was released with no accompanying communication or training package such that mental health staff would not have been aware that it represented an expected standard of assessment and care. It was Dr Champion's firm view that training packages should routinely be put in place when guidelines of this nature are released. He said:

"*A.* *Very much so. Unfortunately there's a history of this in mental health services. I don't know if other branches of health are more rigorous in how they roll out*

[98] Exhibit C18

> *policies and procedures but a number of new tools and electronic mental health records, care plans within those documents were released for use by staff and that the training was mostly about data entry rather than how to meaningfully consider and critically analyse the information that should be used. This policy suffered a similar fate. So yes, there should be communication and there should be training.*"[99]

10.8. The South Australian document cites more or less the same matters that the New South Wales document cites and also places some emphasis on the need for the obtaining of collateral information, particularly from the family or support person. It suggests collateral information *"should always be sought as part of the reassessment of suicide risk"*. It also refers to the reports of this Court as having made it very clear that collateral information is a source of information that is frequently ignored by clinicians. In his evidence Dr Champion suggested that this document could place even greater emphasis on the obtaining of collateral information[100].

10.9. The South Australian document deals with the requirements for transfer of care. The relevant section is intended to address both transfer of and discharge from care within an emergency department. Under this topic the requirements include ensuring that there are contact details for the patient and for those supporting them within the community including the patient's general practitioner. There is one particular requirement which addresses the situation in which a general practitioner, psychologist, private psychiatrist or other therapist has been working with the patient. In such a case the requirement is that those persons should be spoken to before the patient leaves the emergency department or where that is not possible, on the day they are next available. Another requirement is that all collateral contacts should be documented including unsuccessful efforts to obtain ancillary information from those contacts.

10.10. The document contains a number of imaginary scenarios and practice tools that describe certain clinical situations for analysis and discussion. There is only the one oblique reference to Mental Health Act detention or revocation[101]. There is no scenario that deals with a section 21(5) Mental Health Act 24 hour examination. In fact within this 37 page document there is only the one specific reference to the use of the Mental Health Act 2009[102]. The document states:

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[99] Transcript page 372 lines 10-20
[100] Transcript page 373
[101] Scenario 4 page 28
[102] Page 19 left column

"*The use of the Mental Health Act (2009) may be necessary in the following instances to enable the continued observation and safety of the person:*

- *if suicidal thoughts or verbal intentions are persistent and intense; or*
- *the self-harming is serious in nature; or*
- *there is evidence of serious mental disorder or illness.*"

In my view, these three criteria should not be considered as exhaustive. For instance, one would have thought that the harbouring of an obvious plan to self-harm would be worthy of specific mention.

10.11. It is plain that these guidelines within South Australia were long overdue in their implementation and promulgation, particularly having regard to the fact that a similar document had been available in New South Wales for many years.

11. Conclusions

The Court reached the following conclusions.

11.1. On 19 February 2013, Mr Geoffrey Noakes was correctly assessed by his general practitioner, Dr Ben Baker, as being at extreme risk of suicide. Dr Baker correctly took into account Mr Noakes' current presentation, his most recent behaviour and his longitudinal mental health history. In particular, Dr Baker gave the appropriate measure of consideration to Mr Noakes' stated plan to hang himself with a rope that he had acquired for that purpose.

11.2. I find that the inpatient treatment order imposed by Dr Baker on Mr Noakes pursuant to the provisions of the Mental Health Act was appropriate in all of the circumstances and was lawful.

11.3. Mr Noakes was lawfully conveyed from the Angaston Hospital to the Lyell McEwin Hospital where he was admitted and detained pursuant to the inpatient treatment order. Other than Dr Baker's letter of referral and the notes made by the Rural and Remote Triage Service pursuant to Dr Baker's telephone call, no other information was obtained about Mr Noakes' most recent behaviour and demeanour. A document part of which was intended to address the risk of self-harm to a patient in the event that the patient left the

hospital was not completed. It should have been completed prior to any review of the inpatient treatment order.

11.4. The section 21(5) examination of Mr Noakes commenced at about midday on 20 February 2013. It was conducted by Dr Liu who is a psychiatrist. Nursing staff had failed to establish any meaningful rapport with Mr Noakes prior to the commencement of the examination. Furthermore, no collateral information was obtained in respect of Mr Noakes. In particular, there was a significant omission to conduct the following, namely an enquiry of the detaining doctor, Dr Baker, as to his views concerning the prospect of discharge of Mr Noakes from detention, a lack of due and proper enquiry of members of Mr Noakes' family as to his accommodation circumstances were he to be discharged from hospital, a lack of due and proper enquiry made of members of Mr Noakes' family, including his estranged partner, concerning their opinions as to whether Mr Noakes ought to have been discharged from detention.

11.5. The enquiries that I have identified in the previous paragraph should have been made prior to the examination conducted by Dr Liu. If there had not been enough time for those enquiries to have been made prior to the commencement of the examination, the examination should have been postponed. The examination seems to have been conducted at a time with Dr Liu's professional commitments in mind. Dr Liu was pressed for time when he conducted the examination. As a matter of law, the examination did not have to be conducted and completed until 10.30pm on the evening of 20 February 2013. The examination was conducted and completed well before that deadline occurred. Had the examination been postponed, the necessary enquiries for the obtaining of collateral information could have been made.

11.6. I find that the fact of the matter was that as of 20 February 2013 Mr Noakes was still at an extreme risk of suicide.

11.7. I find that the examination by Dr Liu was sub-optimal and that the decision to discharge Mr Noakes from the Lyell McEwin Hospital was flawed. Dr Liu did not give sufficient weight to the fact that Mr Noakes had harboured a recent plan to hang himself with a rope that he had acquired for that purpose. Moreover, Dr Liu's examination was conducted in the absence of due and proper enquiry made in respect of collateral information about Mr Noakes. Dr Liu should have communicated with Dr Baker before any decision was made to discharge Mr Noakes. I find that Dr Liu gave undue weight to

Mr Noakes' current denials of suicidal intent and failed to give due consideration to the possibility that Mr Noakes' motivation in maintaining those denials was to avoid further detention under the Mental Health Act. I also find that Dr Liu gave undue weight to the possibility that Mr Noakes might abscond if detained.

11.8. In the Court's opinion there was material available concerning Mr Noakes upon which a conclusion could have been drawn and that all of the elements required for the confirmation of the inpatient treatment order were established. Accordingly, it was open for Dr Liu to have confirmed the order. The evidence demonstrates, and not just in hindsight, that Dr Liu should have confirmed the order.

11.9. I find that Mr Noakes should not have been discharged from the Mental Health Act inpatient treatment order and should not have been allowed to leave the Hospital in the early afternoon of 20 February 2013.

11.10. I find that Mr Noakes' death could have been prevented at least in the short term if due, proper and fully informed consideration had been given to the confirmation of the inpatient treatment order and if the order had been confirmed. His best shot at ultimate salvation had been right there within the Lyell McEwin Hospital. However, just as it is impossible to identify or even quantify with precision the many lives that are undoubtedly saved by the intervention of the mental health services, it is impossible to say with complete certainty whether Mr Noakes' suicide would have been prevented in the long run.

12. Recommendations

12.1. 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.

12.2. I make the following recommendations directed to the Minister for Health and the Chief Executive Officer of the Department of Health and Ageing, Minister for Mental Health and Substance Abuse and the Chief Psychiatrist:

12.2.1. That psychiatrists and authorised medical practitioners who regularly conduct examinations pursuant to Section 21(5) of the Mental Health Act 2009 be advised of or reminded of the following:

- That an examination pursuant to Section 21(5) of the Mental Health Act 2009 should be regarded as an exercise that is designed to bring about the best therapeutic outcome for the detained patient and that it is not merely a statutory forensic exercise.

- That a detailed explanation of the purpose of a section 21(5) examination and of the possible outcomes of an examination does not necessarily have to be provided to the detained patient at the outset and that in some circumstances it may be considered undesirable for such an explanation to be so provided.

- That for an inpatient treatment order to be confirmed on the basis that the patient has a mental illness, the existence of a strict DSM-IV diagnosis is not necessarily the determinative consideration.

- That an examination should be conducted not at the first opportunity that suits the commitments or convenience of the psychiatrist or other mental health staff, but be conducted at a time which is clinically and therapeutically appropriate having regard to the presentation of the detained patient and the extent of the information about the patient that has been gathered to date.

- In circumstances where it is not practicable for an examination to occur within 24 hours of the making of an inpatient treatment order, that pursuant to Section 21(5)(c) of the Mental Health Act 2009 an examination may be conducted at a time greater than 24 hours since the making of the order. The revocation of an inpatient treatment order should not occur merely because 24 hours has elapsed since the making of the order. Examining psychiatrists should be advised that if the necessary information about the patient has not been made available within 24 hours of the making of the order, or there are other circumstances that have prevented or curtailed a proper and fully informed review of the order, consideration should be given to the question whether it has or has not been practicable for the examination to have occurred within that 24 hour period.

- The need to gather collateral and corroborative information relating to a detained patient should be reinforced. That in any event, the section 21(5) examination of an inpatient should not be scheduled or carried out until all necessary collateral or corroborative information has been sought and provided, and until the document entitled "*Initial Mental Health Assessment Clinical Record*", or the current equivalent of that document, has been completed.

- That an examination should not be scheduled or carried out until such time as mental health staff within the relevant institution have had an opportunity to conduct an interview and assessment of the detained patient.

- That an examination should not be conducted or completed until the medical practitioner who has originally imposed the inpatient treatment order has been consulted. The revocation of an inpatient treatment order in any event should not occur before the detaining medical practitioner has been consulted and the views of that practitioner have been considered.

- That due and proper enquiry should be made to establish the accommodation arrangements and other supports relating to the detained patient before any discharge of the patient occurs.

- That psychiatrists should assess with a critical mind the detained patient's denials of a current suicidal intent, and to take into account any previous statements made by the patient in respect of such an intent as well as plans to carry out such an intent, and also to take into account that denials of suicidal intent may be engendered by a desire to be released from detention so as to enable the patient to act upon the undisclosed suicidal intent.

12.2.2. I further <u>recommend</u> that all prior acknowledgements of suicidal ideation and/or suicidal intent made by a patient during a period of detention should be recorded within the CBIS record.

12.2.3. I further recommend that the South Australian Guidelines for Working with the Suicidal Person again be promulgated to all mental health service providers in South Australia together with the necessary and appropriate training.

12.2.4. I further recommend that the South Australian Guidelines for Working with the Suicidal Person include as a de-identified educational scenario a description of the circumstances that surrounded the detention and presentation of Mr Noakes. The Guidelines should also contain a specific section relating to examinations pursuant to Section 21(5) of the Mental Health Act 2009.

Key Words: Psychiatric/Mental Illness; Suicide

In witness whereof the said Coroner has hereunto set and subscribed his hand and Seal the 13th day of July, 2016.

Deputy State Coroner