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 22nd, 23rd, 24th, 25th and 26th days of February, the 1st, 2nd, 3rd, 4th, 5th and 9th days of March 2020 and the 4th day of November 2021, by the Coroner's Court of the said State, constituted of Anthony Ernest Schapel, Deputy State Coroner, into the death of Theo Nickolas Papageorgiou.

The said Court finds that Theo Nickolas Papageorgiou aged 27 years, late of 555 Cooltong Avenue, Cooltong, South Australia died at Cooltong, South Australia on the 24th day of January 2016 as a result of compression of the neck due to hanging. The said Court finds that the circumstances of his death were as follows:

1. Introduction

1.1. The deceased, Theo Nickolas Papageorgiou, was referred to as Theo during this inquest. Accordingly, I shall refer to him by his Christian name throughout these findings. Theo was last seen alive at about 10pm on Saturday night 23 January 2016. During the course of that evening Theo and his father, Mr Jack Papageorgiou, had been at the Renmark Club. After they returned to the family home at Cooltong, Theo was heard to say goodnight and he headed to bed. The next morning Jack Papageorgiou found Theo in one of the sheds on the property. Theo was hanging from a rope tied around his neck. Theo was cut down and CPR was commenced and maintained until the arrival of an ambulance. Unfortunately all efforts at resuscitation were unsuccessful. Theo was 27 years of age at the time of his death.

1.2. A post-mortem examination of Theo was conducted by Dr Neil Langlois who is a forensic pathologist employed by Forensic Science South Australia. Dr Langlois'

post-mortem report[1] was tendered to the inquest. It is plain from the report that the cause of Theo Papageorgiou's death was hanging which had caused compression of the neck and its various pathological consequences. Dr Langlois' report expresses the cause of death as '*compression of the neck in keeping with hanging*'. There is no doubt that the compression of the neck was in fact the result of hanging. Therefore it is appropriate to describe the cause of death as compression of the neck due to hanging. I so find.

1.3. Other relevant matters arising from the post-mortem examination include the fact that Theo was a large man and that he had the anti-psychotic drug, olanzapine, in his system. He was approximately 183 centimetres in height and 143 kilograms in weight as measured at post-mortem. These figures give rise to a BMI of 43 which signifies obesity. This matter is relevant insofar as Theo, already a large man, had gained a significant amount of weight in the period prior to his death. The weight gain was contributed to by his therapeutic use of olanzapine. Toxicological analysis of samples taken at post-mortem revealed that olanzapine was in Theo's blood at the time of his death, as was a small and insignificant alcohol concentration. Olanzapine had been prescribed for Theo in relation to mental health issues from which he had been suffering and in respect of which he was being treated. It is evident that the weight gain generated by olanzapine was another stressor for Theo.

1.4. It is obvious from the evidence that I heard in this inquest that Theo was solely responsible for the act of hanging that led to his death. No other person was involved in this incident or was present when it occurred. It is also clear that when Theo conducted the act of hanging he did so with an intention to end his own life. I so find.

2. Background

2.1. Theo's suicide in January 2016 followed many months of mental illness which had manifested itself at various times in paranoid and delusional ideation, manic behaviour and most recently with depression and expressions of hopelessness. He had been treated by various medical practitioners and had been seen by psychologists. In November 2015 he had been detained for a period under the Mental Health Act 2009 (the MHA). The detention had taken place in the Riverland General Hospital (the RGH) in Berri. The period of detention under what is known as a level 1 Inpatient Treatment

[1] Exhibit C2a

Order (ITO) was for a duration of six days. This was the only period of MHA detention to which Theo had been subjected prior to his death. There was no other period of hospitalisation, either on a mandatory or voluntary basis. However, as will be seen, there were a number of presentations to the RGH particularly in the days preceding Theo's suicide. None of those presentations had resulted in his admission to hospital. Issues have been raised in this inquest as to whether on any of those occasions Theo should have been admitted to hospital either on a mandatory or voluntary basis for treatment of the mental disturbance that he had displayed preceding and at the time of those hospital presentations.

2.2. Theo had also been under the care of the Community Mental Health Team (CMHT) at Berri which is an entity embraced by SA Health. This entity had become involved in Theo's care following his discharge from the detention that he underwent in the RGH in November 2015.

2.3. Since Theo's death there have been a number of investigations into the circumstances surrounding his death. This inquest has been one of them. The circumstances of Theo's death became the subject of an investigation conducted by the Office of the Chief Psychiatrist. That office made a number of findings and ultimately drafted a series of recommendations for change having identified a variety of shortcomings within the systems that had been responsible for Theo's care. The matter was also reviewed by Dr Brian McKenny who was the Clinical Director of Country Health SA Local Health Network (CHSALHN). Dr McKenny gave oral evidence in the inquest. Theo's medical and psychiatric care and the circumstances of his death have also been examined by an independent expert psychiatrist, Dr Maria Naso. This review was commissioned by the Office of the State Coroner. Dr Naso prepared a detailed report which set out her conclusions and opinions in relation to Theo's care both as a detained patient in the RGH and within the community. Dr Naso also gave oral evidence in the inquest. I shall refer to the findings and recommendations of the Office of the Chief Psychiatrist as well as to the conclusions and opinions of Dr McKenny and Dr Naso.

2.4. It is as well to begin the narrative relating to Theo in November of 2014. Theo revealed to his parents that he had been taking the prohibited drug '*ice*'. Theo said that he had experienced hallucinations and feared and that he needed help. Theo was taken by his parents, Jack and Poppy Papageorgiou, to the Emergency Department (ED) of the RGH. Theo told the medical practitioner on duty at the RGH ED that he had been using

amphetamines for about a year. A mental health examination was conducted and subsequent to this Theo had an appointment to see a general medical practitioner (GP) in Renmark.

2.5. On 17 November 2014 Theo attended the Renmark Medical Clinic and there, as it so happened, he consulted the same medical practitioner who had seen him at the RGH ED. On this occasion Theo told the doctor that he had been using crystal meth (ice) daily and that he became anxious when he had no access to the substance. He said that he had not used the drug since the day on which he had first presented at the RGH. He said that he had been feeling somewhat depressed but did not want a referral to any services.

2.6. For a period of time following these initial consultations, Theo consulted with Dr James McLeod who was a GP at the Renmark Medical Clinic. Ultimately he also consulted Dr George Dalamagas who was a GP at the Berri Medical Centre. Both Dr McLeod and Dr Dalamagas provided statements to the coronial investigation conducted by SAPOL and also gave oral evidence in the inquest. I will recite some of the more relevant features of Theo's interaction with those medical practitioners. I do so by way of setting the background to what was later to take place at the end of 2015 and the beginning of 2016 in respect of Theo's care. I do not believe it is necessary or helpful to embark upon a critique of the performance of either of those two medical practitioners in respect of their care of Theo.

2.7. On 19 November 2014 Dr McLeod saw Theo at the Renmark Medical Clinic. Theo told Dr McLeod that he had last used methamphetamines five days previously. Dr McLeod noted that Theo was presenting with hypomanic symptoms with possible psychotic features. Theo refused Drug and Alcohol Services South Australia (DASSA) intervention at this point.

2.8. Theo was again seen by Dr McLeod on 2 December 2014. On this occasion Theo reported decreased sleep and grandiosity in his thinking that included stated plans of purchasing all of Cooltong which is the district in the Riverland in which Theo lived and worked.

2.9. When Dr McLeod saw Theo again on 11 December 2014 Theo had improved. It was said that he had been off methamphetamines for a month. He had in fact engaged with a DASSA worker. In January 2015 Dr McLeod referred Theo to a psychologist. On

13 February 2015 Dr McLeod commenced Theo on quetiapine. Dr McLeod was of the opinion that Theo was still hypomanic after a long period of amphetamine use.

2.10. Dr McLeod also referred Theo to a psychiatrist, Dr Michael Warhurst. In the referral letter Dr McLeod reported that Theo appeared to be suffering from bipolar disorder with hypomania which appeared to have been triggered by methamphetamine use for a period of 12 months. Dr McLeod indicated that the quetiapine had not helped and that he was considering commencing a mood stabiliser for Theo. In this letter Dr McLeod indicated that he would detain Theo under the MHA if Theo's mental state deteriorated. In due course Dr McLeod received a letter from Dr Warhurst stating that Theo had declined the referral. It is not clear from the evidence as to why the referral had been declined. However, Theo was seen by a psychologist Ms Wakefield-Semmens whose opinion was that there was no evidence of psychosis but that Theo appeared to by hypomanic which might have been a personality trait. To my mind the evidence is clear that Theo was in fact experiencing psychosis at this time.

2.11. It is ironic in some ways that Dr McLeod formed a provisional diagnosis for Theo that ultimately, despite other later diagnoses that represented an over-simplification of his condition, would prove to be correct.

2.12. I have referred to Dr Dalamagas, a GP in Berri. Dr Dalamagas first saw Theo on 3 March 2015 when he commenced Theo on the antidepressant Effexor. The commencement dose was 75mgs which would ultimately be increased to 150mgs and then to 225mgs by the end of April 2015. There was an appointment on 28 May 2015 which was the last appointment with Dr Dalamagas until 12 October 2015, on which occasion Theo told Dr Dalamagas that he had stopped taking Effexor three weeks prior to that date. In the intervening period Theo had been apprehended by police and charged with serious traffic offences that had involved Theo driving dangerously and failing to stop when being pursued by police.

2.13. When Dr Dalamagas had seen Theo for the first time in March 2015 he had referred Theo for assessment by Dr Neeraj Gupta, a psychiatrist. Dr Gupta was a visiting psychiatrist with the Rural and Remote Mental Health Service. It was Dr Gupta who would ultimately detain Theo under the MHA in November 2015. Dr Gupta did not see Theo prior to that. As with the referral by Dr McLeod to Dr Warhurst, the evidence was not clear as to why Theo was not seen by Dr Gupta until November 2015 having

regard to the fact that he was referred several months earlier. In his oral evidence at the inquest Dr Dalamagas told the Court that Theo was not very keen on seeing a psychiatrist straight away although he had been open to the idea. Dr Dalamagas explained that he wrote the psychiatric referral because he was concerned about Theo but did not want to push Theo if he really did not want to become involved with a psychiatrist. Dr Dalamagas said that he was not detainable under the MHA. Theo was not suicidal and so Dr Dalamagas was not worried about Theo self-harming or harming anyone else. At the end of Dr Dalamagas' consult they decided that they would try medication first and to see how Theo responded.

2.14. On 13 November 2015 Dr Dalamagas wrote another referral, this time to a Dr Giri, another psychiatrist. When Dr Dalamagas saw Theo at the end of October 2015 he had realised that Theo had not seen Dr Gupta and was not getting better. As well, Theo had stopped taking his medication and so he decided to re-refer Theo for psychiatric care. In the event Theo would see Dr Gupta.

2.15. Theo would be detained under the MHA by Dr Gupta in late November 2015 and as a result Theo spent a number of days as an involuntary patient in the RGH until the revocation of the order on 30 November 2015. Theo was discharged from the hospital the following day on 1 December 2015. Elsewhere in these findings I will deal with some aspects of Dr Dalamagas' interaction with and care of Theo after his period of detention. Dr Dalamagas was cross-examined by Mr Plummer, counsel assisting, about his care in the period prior to Theo's detention in November 2015. The principal topic of cross-examination involved the fact that Dr Dalamagas did not receive information from Dr McLeod who had seen Theo earlier, particularly in relation to Dr McLeod's impression in November 2014 that Theo was mildly psychotic. Dr Dalamagas said in evidence that he still would have prescribed Effexor in any event because Theo was not psychotic when Dr Dalamagas had seen him in March 2015. Dr Dalamagas said that Theo might have been going through a psychotic episode when Dr McLeod had reviewed him in late 2014 but that if Dr Dalamagas had thought he was psychotic when he saw Theo, he would not have let him leave the clinic.[2] Dr Dalamagas did say in cross-examination that if Theo had presented to him as being psychotic he would have realised that he was not presenting with an episode of a '*first episode psychosis*'. Dr Dalamagas told the Court that he was aware from the RGH records that in November

[2] Transcript, page 161

2015 it was thought that Theo had presented with a first episode psychosis at that time, a diagnosis or impression that a psychiatrist would make of Theo while he was detained. However, Dr Dalamagas said it was obvious that Theo had been psychotic even prior to that.[3] Dr Dalamagas agreed that the grandiosity that Theo had displayed with Dr McLeod, that had included thoughts of buying the entirety of Cooltong and that he would conduct weed spraying with a jumbo jet, would be symptomatic of a person who was potentially suffering a psychosis.[4] In fact, Dr Dalamagas said that if he had known about that he would have given Dr McLeod a call to query why Theo had not received inpatient care as early November 2014, a full twelve months before he eventually did receive inpatient care.[5]

2.16. The point is that it seems reasonably clear that in late 2014 Theo had experienced psychotic and delusional thinking and this is so regardless of the impression that Dr Dalamagas formed in relation to Theo in March 2015 and subsequently. In any case, Dr Dalamagas had attempted unsuccessfully to secure psychiatric care for Theo in 2015. He said he would have expected Dr Gupta to have seen him within a three or four month period as a maximum.[6] Asked as to how important Dr Dalamagas had thought that it was that Theo see Dr Gupta, he said:

> 'It was very important because obviously his mental illness was going on for a while, he had declined Dr Warhurst, so there was a bit of an apprehension. Theo was thinking probably 'Should I go and see a psychiatrist or not?', but his mental state was showing that he was going through a lot at that stage and he wasn't getting better. So that's why I asked him to see the specialist from the first day'.[7]

It is difficult to argue with the validity of such an approach.

3. <u>Theo is detained under the Mental Health Act 2009</u>

3.1. The terms of the Mental Health Act 2009 (the MHA) are relevant in respect of the issues examined in this inquest. In November 2015 Theo was the subject of a level 1 Inpatient Treatment Order (ITO) made pursuant to section 21 of the MHA. Although the words '*detained*' and '*detention*' do not appear within the terms of section 21, it is convenient to refer to a person who is the subject of such an order as being detained or being in a state of detention. The order in Theo's case, which operated to detain him in a dedicated

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[3] Transcript, page 162
[4] Transcript, page 164
[5] Transcript, page 164
[6] Transcript, page 169
[7] Transcript, pages 171-172

mental health ward in the RGH known as the Integrated Mental Health Inpatient Unit (IMHIU), was imposed on 24 November 2015 by the psychiatrist, Dr Gupta. The order was confirmed on 25 November 2015 by a different psychiatrist, Dr Sarath Attanayake. As indicated above, the order which could have operated for a maximum period of seven days and therefore would have expired on 1 December 2015 was revoked on 30 November 2015 by Dr Attanayake. I will discuss the circumstances of the imposition and revocation of the ITO later in these findings.

3.2. The MHA provides for a structured tier of ITOs and Community Treatment Orders (CTO). An ITO as the name suggests, involves mandatory treatment of a person for a mental illness within an approved treatment centre. The treatment is administered to the person as a detained inpatient. A CTO involves the mandatory treatment of a patient suffering from mental illness where the treatment is administered within the general community. In this inquest we are concerned for the most part with ITOs.

3.3. A level 1 ITO unless earlier revoked expires at a time set out in the order but no later than seven days after the day on which the order is made. Upon the making of a level 1 ITO the patient must be examined by a psychiatrist or authorised medical practitioner within 24 hours of the making of the order. Upon completion of the examination the psychiatrist or authorised medical practitioner may confirm the level 1 ITO if satisfied that the grounds for it exist but must otherwise revoke the order. In any event a psychiatrist or authorised medical practitioner may revoke a level 1 ITO at any time either completely or impose a level 1 CTO in substitution.

3.4. A patient to whom a level 1 ITO applies may be given treatment for his or her mental illness or any other illness of a kind authorised by a medical practitioner who has examined the patient. The treatment may be given despite the absence or refusal of consent to the treatment.

3.5. If a level 1 ITO has been made or confirmed by a psychiatrist or authorised medical practitioner, a psychiatrist or authorised medical practitioner may, after further examination of the patient carried out before the order expires, make a further order for the treatment of the patient as an inpatient in an approved treatment centre. This further order is known as a level 2 ITO. A level 2 ITO may be made on the same grounds as a level 1 ITO. A level 2 ITO provides for a maximum period of detention of 42 days. Unless earlier revoked, a level 2 ITO expires at a time set out in the order and not later

than 42 days after the day on which the order is made. A psychiatrist or an authorised medical practitioner who has examined the patient to whom a level 2 ITO applies may revoke the order at any time either completely or may in substitution impose a level 1 CTO. As with a level 1 ITO, the patient may be given treatment for his or her mental illness or any other illness, and it may be given despite the absence or refusal of consent to the treatment.

3.6. A level 3 ITO may be made in respect of a person to whom a level 1 or a level 2 ITO already applies. It can be made on the basis of the same criteria as those upon which level 1 and level 2 ITOs are made but may only be imposed by the South Australian Civil and Administrative Tribunal (SACAT). In the case of an adult patient, a level 3 ITO can remain in force for a period up to 12 months.

3.7. It should be observed that a level 1 ITO may initially be imposed by a medical practitioner who is not a psychiatrist, such as a local GP working, say, in an ED in a country hospital or even in his or her office.

3.8. There is a similar tiered structure in relation to CTOs. Theo was not the subject of a CTO prior to his death. However, it is as well to record here that a person under a CTO may be given treatment for his or her mental illness which may be given despite the absence or refusal of consent to the treatment.

3.9. An ITO and a CTO were imposed having regard to a number of criteria based on the existence of a mental illness and a need to protect the patient or other persons from harm. I will deal more specifically with the criteria in a later section of these findings.

3.10. Theo was only subject to a level 1 ITO prior to his death. This is the ITO that I have referred to above.

3.11. The evidence at inquest was that the RGH in Berri was an approved treatment centre under the MHA. This was the hospital in which Theo was detained under the level 1 ITO. At the time with which this inquest is concerned, this hospital was only authorised to accommodate, detain and treat persons under a level 1 ITO. If a subsequent level 2 ITO needed to be imposed before the expiry of the level 1 ITO, it would have been necessary for the patient to be sent to and detained and treated in an approved treatment centre in one of the major hospitals in Adelaide. On my reading of the MHA there was no bar against the imposition of consecutive level 1 ITOs.

However, if a level 1 ITO was made within seven days after the expiry or revocation of a previous ITO applying to the same person, a review of the circumstances involved in the making of the consecutive level 1 ITO had to be conducted by SACAT. This is so pursuant to section 79(1)(c) of the MHA. SACAT, on a review, had various powers including the power to affirm, vary or revoke the consecutive level 1 ITO. There is no suggestion that the imposition of consecutive level 1 ITOs would have been appropriate in Theo's case. If any further detention under the MHA was required after the conclusion of the level 1 ITO it would have been more appropriate to have imposed a level 2 ITO and to have sent Theo to Adelaide. Elsewhere in these findings I have examined the issue as to whether there had been a need for Theo to have been the subject of detention beyond the eventual revocation of the level 1 ITO.

3.12. The background to Theo's detention under the level 1 ITO is supplied by his mother Mrs Poppy Papageorgiou in her affidavit.[8] She states that in October 2015 Theo started expressing some unrealistic ideas in respect of big projects. In November 2015 there were a number of incidents that she observed had a negative impact on Theo's disposition. These included Theo's spray plant being rammed by a fellow grower which caused damage. The tyres on his tractors had also been punctured. There had also been a traffic altercation involving his cousin's husband. On 14 November 2015 Theo appeared in court in relation to driving charges that I have referred to elsewhere in these findings. There had also been an approach by police to speak to Theo about a fire at Theo's cousin's husband's property. There was also an unsubstantiated accusation that Theo had lit the fire.

3.13. Theo's detention on an ITO occurred after Theo finally had a consultation with the psychiatrist, Dr Gupta, the visiting psychiatrist to the Riverland, on Monday 24 November 2014. Mrs Papageorgiou asserts in her affidavit that Theo appeared to be confused and was presenting differently on this occasion. He was rambling which was out of character. It is apparent from Mrs Papageorgiou's affidavit that Theo's parents and Theo himself did not expect that Theo would be hospitalised on this particular occasion and it is clear that Theo was, to put it mildly, unenthusiastic about the prospect of hospital admission.

[8] Exhibit C27

3.14. Dr Gupta, the psychiatrist, gave oral evidence in the inquest. The handwritten record of his consultation with Theo was also tendered.[9] Although Dr Gupta's notes do not form part of the RGH progress notes, there is in the RGH file[10] a letter written by Dr Gupta to the RGH ED explaining the basis of Dr Gupta's imposition of the ITO on Theo.[11] There is also a comprehensive letter that Dr Gupta wrote to Dr Dalamagas. This would be Dr Gupta's first and only consultation with Theo.[12]

3.15. It is evident from Dr Gupta's documentation that he took an extensive history from Theo.

3.16. In his oral evidence Dr Gupta told the Court that he could not explain the reason why there was a long gap between the initial referral by Dr Dalamagas and his seeing Theo in November 2015. As a visiting psychiatrist, Dr Gupta visited Berri on a limited number of times per year and was there for usually only two days at a time.

3.17. In his evidence Dr Gupta identified the typewritten letter that he wrote to Dr Dalamagas following his consultation with Theo. The letter is dated 24 November 2015. Dr Gupta told the Court that on 24 November 2015 Theo presented with symptoms that were mainly psychotic. He had grandiose and persecutory delusions. He was also irritable and guarded and did not want to participate completely in the interview. Dr Gupta formed the opinion that he was suffering from a psychotic episode or a psychotic illness which needed immediate attention and treatment. As to what may have underlay the psychosis, Dr Gupta said that he had a number of hypotheses in his mind including Theo's history of amphetamine use and the possibility that Theo may have still been using the substance at the time. Dr Gupta also thought there may have been an underlying mood disorder. However, the prominent picture was that of a psychotic episode. He formed the view that Theo needed inpatient treatment because he felt that Theo clearly had a mental illness. He was suffering from psychotic symptoms and because of these symptoms he was at risk of acting on the delusions that he harboured. Theo did not understand the impact or the risk that these symptoms presented. Dr Gupta particularly had in mind Theo's recent episode of speeding and failure to stop for the police and the failure to appreciate the risk involved. He also felt that Theo needed treatment, that he did not have insight into his symptoms and was not willing to

[9] Exhibit C26
[10] Exhibit C17
[11] Exhibit C17, page 94
[12] Exhibit C12, pages 71-73, Berri Medical Clinic notes

start the necessary treatment. In cross-examination Dr Gupta gave some further evidence about the basis of his decision to detain Theo. He emphasised that Theo had appeared threatening and guarded and had persecutory delusions. The recent episode of speeding where he did not stop for the police was symptomatic of his judgment having been impaired and that as a consequence he had put himself at risk or may have put others at risk because of those symptoms. It is not difficult to see why this is so, especially given that Theo's driving had put not only himself, but other road users possibly at risk. Dr Gupta added that Theo was not keen on voluntary admission as a patient. Thus Dr Gupta did not believe that there was any less restrictive option other than detention under an ITO. Dr Gupta also said '*…he didn't have the capacity to take decisions around this treatment, and that's why I felt he would fit in – he would meet the criteria for level 1 ITO and would need to be hospitalised, urgently*'.[13] I pause here to observe that capacity on the part of the patient to make decisions concerning the patient's treatment for a mental illness was not an element that needed to be satisfied for the imposition of an ITO under the MHA as it existed at the time with which this inquest is concerned, an issue that I will expand on in due course. However, it was clear that on any criteria, Dr Gupta's decision to detain Theo under the MHA was soundly based.

3.18. Other relevant matters that Dr Gupta recorded in his typewritten letter to Dr Dalamagas were that Theo's parents reported that in the previous three months Theo had become angrier and irrational and was not open to any discussion. He had been paranoid and delusional, had been talking about the Romanian or Russian Army and exhibited an apparent belief that they were going to come and support him. It was also reported that he had threatened some of his family members and that his parents were worried about Theo's safety. Theo's parents also reported that he had little insight into the fact that he had transgressed by his speeding offence. Dr Gupta also reported that when he had started talking about medication and the need for hospital admission Theo had become angry and had started threatening his parents. Other relevant matters recorded were that Theo did not report any suicidal or homicidal ideation but that he had poor insight into his illness and needed treatment.

3.19. Dr Gupta's recorded plan included the suggestion that Theo would benefit from antipsychotic medication such as risperidone and that he may also need

[13] Transcript, page 200

benzodiazepines initially to control his agitation. Dr Gupta did not book any further appointment with Theo at that stage but indicated in his letter that he would be happy to review Theo again if required. As will be seen, late in the piece an appointment with Dr Gupta was made to see Theo but it was overtaken by Theo's death.

3.20. Evidence was given about a chance encounter between Dr Dalamagas and Dr Gupta in Berri during the week of Theo's period of detention between 24 November 2015 and 30 November 2015. The encounter occurred outside Dr Dalamagas' home when Dr Gupta was walking with Dr Attanayake, another psychiatrist. Theo's admission to the hospital was discussed that day. The thrust of the conversation was that Theo was floridly psychotic. And yet he would be discharged from the hospital within a matter of only days.

3.21. Dr Gupta was cross-examined by Mr Apps of counsel for Theo's parents. Dr Gupta told Mr Apps that he did not recall when he had discovered that Theo was discharged from the hospital, but was asked by Mr Apps whether the discharge had surprised him. Dr Gupta responded by saying that it depended on the origin of Theo's presentation. If his psychosis had been drug induced, he would not have been surprised that he had become better within a week. However, if it was not a drug induced psychosis one would have expected a longer admission, although he said he could not be sure about that. I pause to observe that the evidence strongly suggests that whatever the origin of Theo's psychosis, by November 2015 it could not reasonably have been viewed as a temporary drug induced psychosis at that point in time.

3.22. As will be seen in the following section, Theo's mother stayed with Theo during his admission and detention in hospital. In his evidence Dr Gupta acknowledged that this was not a common practice. Dr Gupta said that he had no knowledge that this was going to take place and could not recall whether he knew anything about that at the time of Theo's admission. He had not seen this happen in Australia. Asked as to what his attitude to this would have been, Dr Gupta said he would have taken a neutral stance on it.[14] He acknowledged that there could be benefits as well as difficulties with such an arrangement and further acknowledged that staff in the hospital may not have been used to having family members staying with their patients. As will be seen, there was

[14] Transcript, page 210

very little evidence to suggest that Theo developed any kind of therapeutic relationship with staff in the RGH during the course of his involuntary admission.

3.23. Dr Gupta told the Court that he did not return to Berri until the week following Theo's death.

4. Events following Theo's placement on a level 1 ITO

4.1. Theo was placed under the level 1 ITO on Tuesday 24 November 2015. He occupied one of six dedicated mental health rooms at the RGH in Berri. It was not a closed ward. The room was of a sufficient size that it could accommodate a person other than the patient. In this case Theo's mother, Mrs Poppy Papageorgiou, stayed in the room for the duration of her son's occupancy. The evidence suggested that this arrangement was by no means routine or necessarily desirable in cases of patients detained under the MHA, either in the country or in the city.

4.2. Elsewhere in these findings I have indicated that a level 1 ITO must be reviewed within 24 hours of its imposition. The review must be conducted by a psychiatrist and will result either in the confirmation or the revocation of the ITO. A level 1 ITO unless revoked, operates for seven days. If any further detention is required, a level 2 ITO which operates for a maximum period of 42 days, is generally imposed. The same criteria for imposition apply. At the time with which this inquest is concerned the RGH did not accommodate patients under level 2 ITOs. A person detained under such an Order would have needed to be sent to an approved treatment centre in the city which would consist of a mental health ward in a tertiary hospital. The facility in the RGH was an open ward arrangement, albeit one that could involve the locking of doors. However, if a truly closed detention environment was called for, the Riverland facility would not have been suitable and the patient would have needed to be sent to Adelaide where mental health wards had closed ward capabilities. That would be so regardless of whether or not it was a level 1 or level 2 ITO that had been imposed on the patient.

4.3. Against that background Theo's time in the RGH under a level 1 ITO comes to be considered.

4.4. Following Theo's admission to the ward, he was examined by Dr Nosa Efeovbokhan, a local GP. The relevant entry in Theo's clinical progress notes[15] was timed at 4:31pm

[15] Exhibit C17

on 24 November 2015. Dr Efeovbokhan conducted a mental health examination. He noted in the progress notes that Theo was agitated, loud and sweaty. Theo exhibited rapid conversation and was noted not to have made sense. He had an elevated affect and was quite paranoid. He was noted to have delusions of grandeur. He suggested among other things that nothing could harm him. He asserted that he could set off metal detectors simply with his hand. He was noted to have poor insight and nil suicidal ideation. Theo is recorded as having refused bloods being taken from him. A nursing note timed at 10pm that day recorded that Theo said that he did not want to be there and at one stage had left the unit to go the ED as he wanted to speak with a doctor. He was unable to understand why he was being detained and was recorded as being '*extremely agitated*'. It was noted at this point that Theo's mother was going to stay with him at Theo's request and that a bed had been arranged for her. It is recorded here that Theo's parents supplied '*collateral*', meaning collateral information which is a term used to describe information about a mental health patient as to their longitudinal history and other relevant contemporary matters such as might be supplied by a patient's family members and associates. The note does not record what the collateral information imparted by Theo's parents consisted of. It is noted that Theo did not want to engage with staff and that he was telling them that he wanted to be discharged. Theo spoke to his parents in Greek.

4.5. Theo's ITO was confirmed by Dr Attanayake, a local psychiatrist, the following day, 25 November 2015. Dr Attanayake received his basic medical degree in Sri Lanka in 1995. In 2006 he completed his training to become a psychiatrist and worked within a Sri Lankan hospital. In 2008 he moved to Australia. Arriving in Australia, he began working in the North/North Eastern suburbs of Adelaide with the Northern Mental Health Service. He worked in the Mildura Base Hospital for one and half years before moving to the Riverland in early 2015, at which time he began working at the RGH Mental Health Unit as a consultant but with distant supervision. At that time Dr Attanayake was not a Fellow of the Royal College of Psychiatrists. He only obtained that Fellowship in early 2018. As I understood the evidence, it was for this reason, possibly among others, that Dr Attanayake required supervision. Dr Attanayake explained that he worked within the IMHIU in Berri which was the six-bed mental health inpatient facility within the RGH in Berri. He was also the most senior clinician within the Berri CMHT. Leaving aside the role played by visiting psychiatrists, Dr Attanayake was the sole medical practitioner for the Riverland Mental

Health Services. At that time there had been a request made for, or at least discussions surrounding, securing the services of a junior medical practitioner to work with Dr Attanayake. However, this did not eventuate until after Dr Attanayake left the Riverland. Dr Attanayake said, '*So I was the only doctor where I had to do consultant work as well as junior doctor*'.[16] In my view Dr Attanayake was overwhelmed in the position he held in the Riverland, a situation not of his making.

4.6. Dr Attanayake made a handwritten record of his review of Theo on 25 November 2015 within the progress notes. I will deal with Dr Attanayake's care of Theo in more detail elsewhere in these findings. However, at this point it is worth describing the salient matters that Dr Attanayake noted at his review. It is evident that Theo's attitude had not altered from the day before. Dr Attanayake's recorded observations included that on examination Theo engaged satisfactorily but became angry and emotional when he heard that he needed to be in hospital. He shouted at his mother for making things worse. He exhibited delusions of persecution with grandiosity. Dr Attanayake noted that he had no suicidal ideation or thoughts to hurt other people. He had poor insight and impaired judgement. Dr Attanayake noted that Theo ultimately agreed to stay in the unit and that he would '*behave well*' rather than going to a closed bed environment.

4.7. Dr Attanayake recorded his impression of Theo as that involving a '*first episode psychosis*'. Dr Attanayake's management plan included placing Theo on a waiting list for a closed bed, which of course would have needed to be in Adelaide, but with the rider that Theo could stay in the RGH unit if he settled. Also, part of the plan recorded by Dr Attanayake was as follows, '*minimise parents time c̄ him*'. The evidence would suggest that this recommendation was not observed.

4.8. Dr Attanayake provided a witness statement dated 22 January 2018.[17] He also gave oral evidence in the inquest. In his oral evidence Dr Attanayake expanded upon Theo's paranoid delusions and grandiosity. Dr Attanayake said that Theo was clearly having paranoid delusions that involved him suggesting on a number of occasions that he was scared of the police and government and felt that he would be killed, a delusion that was supported by evidence of his having recently evaded police after speeding. He believed that the police and government were after him. There was also evidence in the form of Theo not drinking hospital water such that his father had to bring water

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[16] Transcript, page 235
[17] Exhibit C28

from home. Similarly, he was initially reluctant to eat hospital food. As a result, food was brought in by his parents. As far as grandiosity was concerned, Dr Attanayake told the Court that Theo harboured grandiose delusions in which he believed he had special powers that could help farmers in the area. He also suggested that Jesus Christ was his grandfather.[18]

4.9. On the same day a mental health social worker spoke to Theo's mother and father. While this was taking place Theo came into the room and was loud; he was telling his parents they had to stay with him and were not to leave. Attempts on the part of the social worker to talk directly with Theo were met with Theo talking over her. The social worker recorded that Theo seemed to think that he had special powers and that he knows what people are thinking. A nursing note timed at 3:10pm recorded that Theo had been quite loud and was frustrated at being kept in hospital. He had initially refused his medications and had become quite aggressive and more angry. He ultimately accepted olanzapine medication. It was specifically recorded by the nurse that Theo was aware that he was required to take his medication as he was on a level 1 ITO and indicated that he was '*willing to take medications why* (sic) *he is an inpatient*'. Later that same day in the early evening he was reported as feeling normal and was no longer angry.

4.10. A nursing note compiled on the morning of 26 November 2015 records that Theo's mother had slept overnight in the room. Theo had been observed to be asleep on all routine hourly checks overnight. A nursing note timed at 4pm recorded that Theo stated that his mood was good and that there was nothing wrong with him. He later stated that it was not right that he was there. His speech was recorded as being of normal volume and articulate but became pressured when he was speaking to his psychiatrist. When engaged in conversation, apparently with the nursing staff, Theo started describing conspiracies about the Army and the South Australian Government. He exhibited delusional thinking about knowing the names of persons murdered prior to his birth and about his having been alive 2000 years ago. The content of his delusions were '*around death and dying*'. It is recorded that according to Theo and his parents he had entertained these thoughts for approximately 12 months. His insight was recorded as being poor as was his judgment, the additional matter recorded being that he did not recognise that he had any problems. He was recorded as becoming cross and stating

[18] Transcript, pages 240-249

that he was not going to take any medication. The nursing note records that Dr Brian McKenny was asked to review Theo and that this remotely occurred at 1pm. It was recorded that Dr McKenny refused to grant Theo leave. He is recorded as being paranoid about the water and about what the nurses were writing down.

4.11. A nursing note timed at 10:30pm on 26 November 2015 recorded that delusions were still evident in that Theo claimed that he controlled the rain and owned the water. Mrs Papageorgiou indicated that she would stay that night.

4.12. On the morning of 27 November 2015 Theo greeted staff in a pleasant manner at 6:25am. Later that day it was recorded in a nursing note timed at 1:30pm that Theo's delusional thoughts had not been rigorously assessed in the morning so as not to upset or stir him up. It is recorded that he expressed paranoia when staff asked him questions and was particularly paranoid about food and water although he does eventually eat and drink both. It is recorded, '*Theo continues to have little insight into his situation*'. Although he was cooperative with care and treatment, he had an underlying irritability. It is recorded that he did not wish to stay but understood the conditions of the ITO. One observed improvement was that Theo was coming out into the communal area and eating his meals. Theo complained that his medications were affecting him and that he did not need them. He refused the suggestion that his mother could go home that night. A nursing note later that evening and timed at 8:45pm recorded that Theo had been a little more relaxed during that shift by comparison to the shift of the previous day. Less irritability was noted. It was recorded that he had attended to his personal hygiene needs. Staff engaged with him superficially and he was responsive. It is recorded that he said that he was '*exempt from normal people*' in relation to blood results that showed abnormal triglycerides.

4.13. A nursing note recorded at 6:20pm the following day, 28 November 2015, stated that Theo presented as more relaxed on interaction and was smiling on several occasions. He continued to deny any hallucinations but did have fixed delusions about continuing to eat more so that his grandfather, that is his father's father, would remain alive. He continued to voice frustrations about being in hospital. On this day it appears that a psychiatrist by the name of Dr Lattanzio agreed, remotely from Adelaide, that Theo could have four hours leave that day and on the following day. Theo indicated that he was happy with this and that he had guaranteed to comply with the conditions of leave

and would return to the ward. It is recorded that Theo left at 1pm and returned at exactly 5pm. Theo reported that his leave had gone well.

4.14. The record for 29 November 2015 suggests that Mrs Papageorgiou had stayed overnight in the ward with Theo. A nursing note timed at 1pm recorded that Mrs Papageorgiou had attempted to give Theo space so he could communicate with the nursing staff. Although he was cooperative with nursing care it was difficult to engage him therapeutically. He was monosyllabic when staff asked him questions. The nursing note of 29 November 2015 also records Theo's lack of insight. It is also recorded as follows, '*Theo informed nursing staff that he was going home tomorrow, after he met the doctor*'. This assertion by Theo proved to be somewhat prophetic in that the following day he would meet Dr Attanayake and the ITO would be revoked with the result that he went home the following morning. The basis of Theo's belief that he was going home the following day after he met the doctor is unknown, but as things were to transpire his confidence was not misplaced. A later nursing note that day recorded that he had been out on day leave and had found it to be very productive as he had been able to mow the lawns. It is recorded that he was happy to take his medications.

4.15. At 11am the following day, 30 November 2015, Theo was seen by Dr Attanayake with his parents. Dr Attanayake noted that his most recent leave had gone well and so he allowed Theo six hours leave. It is recorded that Theo would return at 4:30pm when he would be reviewed again.

4.16. Later on 30 November 2015, he was again seen by Dr Attanayake. Dr Attanayake's handwritten note suggests that Theo was not suicidal, not aggressive and was calm and settled with minimal paranoia and grandiosity. His insight was recorded as being '*quite partial*' and that his judgment was '*improved*'. Dr Attanayake recorded his impression as acute psychiatric episode, first episode psychosis. He recorded that he would revoke the ITO and that Theo would have '*overnight leave*'. He also recorded a plan that Dr Gupta would follow up and that Theo would be discharged the following day if his leave went well. The ITO revocation document times the revocation as having occurred at 4:30pm. Thus, technically speaking, Theo did not need overnight leave. A nursing note timed at 7:50pm recorded a '*noted improvement*' in his overall mental state examination from admission and that he had gained some insight into the reason for his admission. It was recorded that Theo recognised that his medication had helped his

thoughts and that he agreed to continue taking his medication. It was specifically recorded that a CTO as an alternative measure in order to deliver treatment, would not be required at present.

4.17. Theo left the ward at 6:15pm with his family and returned the following morning at 8am with his mother. It is recorded that on discharge there was no current thought of harming himself or others. The content of his conversation remained superficial with some grandiosity concerning his business plans. He was guarded overall. He denied any hallucinations. It is recorded as follows:

> 'Insight – developing some insight, where his thoughts are clearer with medication.'

Theo refused to complete a care plan, stating that he had lots of goals and plans and that he is '*ok*'. It was not established whether any of Theo's '*goals and plans*' were realistic or were entirely grandiose and a figment of his imagination. In any event he was discharged.

4.18. As to the fact that Theo's parents were in the ward with Theo for significant periods, Dr Attanayake in his oral evidence told the Court that this had generated concern with his staff. He felt that Theo could have engaged better with staff without his parents' presence. That said, Dr Attanayake opined there had been certain positive elements to their presence, given that Theo was severely unwell with the risk of aggression, violence, absconding, not taking medication and not engaging with treatment.[19] Notwithstanding those positive elements Dr Attanayake told the Court that there could have been more therapeutic engagement.[20] As to Dr Attanayake's note in the clinical record that staff should minimise the parents' time with Theo, Dr Attanayake told the Court that it would have been helpful for Theo to have undertaken some activities on the ward but that these might have been hindered by the presence of his family. As well, it would have facilitated Theo having space that would have enabled staff to have engaged in some of the activities in which Theo could have taken part.[21] The evidence suggests that in fact, the relationship between Theo and the nursing staff was never developed to any significant or therapeutic degree.

4.19. One matter of particular note is that Dr Attanayake told the Court that part of his plan had been to place Theo on a waiting list for a bed in a hospital in Adelaide if one had

[19] Transcript, page 244
[20] Transcript, page 245
[21] Transcript, page 245

become available. Theo's reaction to this contingency had been one of anger, especially when it was suggested that he was going to stay longer in Berri. And this was so given that Theo had an apparent expectation that he would be returning home the day after Dr Attanayake's review. When asked by me whether on 25 November 2015 when he reviewed Theo it had been his preference at that point that Theo go to Adelaide to be accommodated in a closed ward, Dr Attanayake suggested that it was a potential plan if Theo did not settle.

4.20. I have described Theo's presentation during his period of detention in perhaps greater detail than one normally would to illustrate that he was clearly, and profoundly, mentally unwell. His care was hindered by the inability of staff to properly engage with him. The reality was that no proper impression of Theo could have been gained in the time available. The suggestion that Theo was well enough to be discharged from hospital would be met with the somewhat wry observation by Dr Naso, the independent psychiatrist who reviewed Theo's care, that a significant improvement in his well-being in the space of only six days would have been a '*miracle*'. For my part it is not difficult to see why Dr Naso would say that. More of that later.

5. **Theo's discharge from the ITO**

5.1. As seen in the previous section Theo's discharge was facilitated by Dr Sarath Attanayake. In his oral evidence Dr Attanayake confirmed that at the RGH they could not accommodate involuntary patients beyond the seven days of a level 1 ITO and were not able to administer level 2 ITOs. As well, the facility did not have a high dependency unit. It was only an open ward. Although a patient who was required to be on a level 2 ITO would have to be sent to Adelaide, a patient could remain at Berri beyond the seven-day detention period of a level 1 ITO as a voluntary patient. They would remain in the IMHIU if that was the case. In fact, Dr Attanayake suggested that as a voluntary patient the average length of stay in the ward was approximately nine days.

5.2. As indicated in the previous section Dr Attanayake was the medical practitioner who had confirmed Theo's ITO on 25 November 2015 after he had been detained by the visiting psychiatrist, Dr Gupta, the day before. In his witness statement Dr Attanayake asserted that when he spoke to Theo on 25 November 2015 he found him to be unwell, psychotic, had very poor insight and was refusing to take medication. Although

Dr Attanayake understood that Theo had been experiencing delusions for about 12 months prior to his consultation, he would make a diagnosis of first episode psychosis, a diagnosis which does not seem consistent with an understanding that Theo had been having delusions for a significant period of time prior to November 2015. As well, it is known through the evidence of Dr McLeod and Dr Dalamagas that Theo was probably psychotic in late 2014 and early 2015.

5.3. In the previous section I have described the interaction between Theo and Dr Attanayake during the course of Theo's six-day detention. In his witness statement Dr Attanayake asserts that the ITO was revoked on the sixth day because Theo appeared to be well and that both he and his family were happy for him to go home. Dr Attanayake asserts that Theo was compliant with his medication, there were no risks to him or to his family and there was no reason why he should not go home. He also asserted that the fact that Theo had an '*overnight leave pass*' allowed him to trial a home coming before he was discharged. This had gone well to the extent that it made Dr Attanayake more comfortable in discharging Theo home. I do note, however, that Dr Attanayake had revoked the ITO even before Theo had his so-called leave pass.

5.4. Dr Attanayake states that in his opinion Theo was suffering from a first episode psychosis. He explained in his statement that this is an umbrella term that is used when a young person presents for the first time as they generally do not know if the person's symptoms and condition will develop into something more long term or whether it is a one-off episode caused or triggered by other contributing factors.

5.5. Asked by his counsel, Ms Cliff, as to why he revoked the ITO as opposed to allowing it to run its full seven days, Dr Attanayake said that he believed that Theo was not further detainable; he said that clinicians attempt to be the least restrictive as possible. He also regarded it as '…*good validation for the patient*' in the sense that Theo would be happy to be a voluntary patient and had agreed to return to the hospital. He said:

> 'I gave him more empowerment and validation and it's also a trial if he did not return, we can be more stringent as with the use of the Mental Health Act by putting him on an order, I can easily put him on another order and bring him back to the hospital if he didn't come back. So it was approved for me to believe that he can be managed in the community'.[22]

[22] Transcript, page 249

Dr Attanayake added that compared to the way in which Theo had presented originally, his mental state examination and his risk assessment were now good. Theo's risk was not such that he should be kept on an ITO. He had '*reasonable capacity, considering the four criteria in the Mental Health Act, I thought he was good to be voluntary patient*'.

5.6. In the event, as seen above, Theo did return the following day to the hospital and was then discharged. He was not admitted as a voluntary patient. I have seen no evidence to suggest that further hospitalisation as a voluntary patient was seriously considered. I doubt whether Theo would have agreed to that in any event given his braggadocio of the day before that he would be leaving when he saw the doctor.

5.7. To digress in the narrative for a moment, Dr Attanayake is in fact incorrect where he said that he could easily have placed Theo on another Order if he had not returned to the hospital on the morning of 1 December 2015 after his leave. Although there is no legal bar against the imposition of consecutive level 1 ITOs, as observed earlier, if a level 1 ITO is made within seven days after the expiry or revocation of a previous level 1 ITO a review of the circumstances involved in the making of the second level 1 ITO must be conducted by SACAT which would add to the difficulty of the measure that Dr Attanayake said he contemplated. It will also be recognised here that a level 2 ITO would have involved Theo being sent to Adelaide which was a matter that Theo no doubt would have resisted with some vehemence considering his reaction when he was detained in the first instance. That said, if Theo needed to be sent to Adelaide, he should have been sent to Adelaide regardless of his own attitude in my view.

5.8. I will have more to say also regarding Dr Attanayake's observations about Theo having reasonable '*capacity*' considering the '*four criteria*' in the MHA. This, as will be seen, would have been an erroneous approach had it been a matter that was in truth taken into account by Dr Attanayake.

5.9. Dr Attanayake also told the Court that although Theo was actually discharged from the hospital, he considered it a transfer of care to the community.[23] There was also the prospect of Theo following up with his GP. As will be seen, the care that Theo would receive in '*the community*' was inconsistent and largely ineffectual.

[23] Transcript, page 250

5.10. Dr Attanayake also told the Court that he believed that he had discussed Theo's case with Dr McKenny or Dr Mosler, senior psychiatrists in Adelaide, given that Dr Attanayake was still under supervision and that they would routinely discuss patients who required discussion. Dr Attanayake said that he did not think that these discussions had resulted in any suggested different way of managing Theo and that his management plan was agreed to.

5.11. Dr Attanayake prepared a discharge summary in relation to Theo. In the event this summary did not make its way to Theo's GP until 17 December 2015 which was more than two weeks since Theo's discharge.

5.12. Asked by Ms Cliff as to whether during the course of Theo's admission he had been aware that he had experienced delusions around death and dying, Dr Attanayake said that he had been made aware of that from nursing entries in the progress notes and also from discussions about Theo's delusions. However, Dr Attanayake suggested that these delusions did not reflect any plan, intent or ideation for Theo to kill himself or to harm himself. That said, Dr Attanayake stated that he could not exactly remember when it was that he had explored this issue with Theo although it could have been on the last day that he saw him in hospital which was 30 November 2015. I asked Dr Attanayake whether in fact he had explored the issue of delusions personally with Theo at all or whether he had done so simply with the nursing staff in a second-hand manner. To this Dr Attanayake said that he could not recall that clearly. He said '*…sometimes, we elicit things we are not direct, but indirect*'.[24] I asked Dr Attanayake whether he would have specifically asked Theo as to the nature of his beliefs or of the thoughts that he was experiencing about death and dying. Dr Attanayake said that he does do that. Asked as to whether he had so on this particular occasion, Dr Attanayake said:

> 'I explored about this delusions where he was talking about his previous lives, but through that I got the clinical judgment, clinical feeling, that he was having delusions, which are - delusions can be related to anything, but that doesn't mean that he was - that's not a clinical judgment; that doesn't mean that he was suicidal.'[25]

I do not see anything in Dr Attanayake's handwritten notes of 30 November 2015 about that topic.

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[24] Transcript, page 257
[25] Transcript, page 257

5.13. Asked by his counsel, Ms Cliff, as to why he had decided that community-based follow-up was the appropriate option for Theo, as distinct from asking him to stay as a voluntary patient on the ward, Dr Attanayake said that Theo did not want to stay any longer as a voluntary patient and that his family were happy to take him home. And Dr Attanayake added, '*...he was not further qualifying for ITO*'. Dr Attanayake also suggested that further hospitalisation would have been traumatic for Theo especially having regard to the fact that he would have needed to send him to Adelaide which of itself would be traumatic for him, and there could have been significant resistance from Theo.[26] However, Theo would only have needed transfer to Adelaide as a detained patient. He could have been admitted as a voluntary patient at the RGH in Berri.

5.14. In cross-examination by Mr Apps of counsel for Theo's parents, Dr Attanayake was questioned about the accuracy of his diagnosis of Theo, which was that of a first episode psychosis. Dr Attanayake continued to insist that there was no evidence of Theo having experienced hypomanic, manic or psychotic episodes to the extent that he had needed or required hospitalisation.[27] In my view he was wrong about that. There was plenty of evidence of previous psychosis if the trouble had been taken to consult GPs who had seen Theo a year earlier, particularly Dr McLeod.

5.15. During cross-examination by Mr Plummer of counsel assisting, Dr Attanayake reiterated he had spoken to his supervisor in Adelaide about Theo and whether it was appropriate for Theo to be discharged. Dr Attanayake said that there was no disagreement with his plan including the decision to discharge Theo. He said that he was fairly certain that there had been no recommendation from either Dr McKenny or Dr Mosler for Theo to be transferred to Adelaide. He believed that he had discussed the revocation of Theo's ITO with them. Dr McKenny refuted that claim in his oral evidence.

5.16. Asked by Mr Plummer, as to when Dr Attanayake had actually started contemplating discharging Theo, Dr Attanayake said:

> 'It could have been from the time maybe third day or second, third day, fourth day, because he was settling and it is very, very unusual and it could be a very unusual practice for me to send him to Adelaide, and I am pretty sure everyone in the team, including Dr McKenny, and everyone could have agreed that I am discharging him with proper community mental

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[26] Transcript, page 260
[27] Transcript, page 293

> health follow-up and other follow-up in the community, which is the best practice for a young man like Theo.' [28]

5.17. It is difficult to see how discharge of Theo could have been contemplated as early as the second or third day given his presentation.

5.18. Dr Attanayake disagreed with the suggestion put by Mr Plummer that having told Theo that if he '*behaved*' as an inpatient at Berri he would not be sent to a closed bed in Adelaide, Theo may have masked his symptoms so as to prevent his being transferred. To this Dr Attanayake asserted that the observations of Theo and his clinical assessment of him gave rise to objective evidence of improvement in his mental state as well as in relation to his risk assessment.[29]

5.19. Dr Attanayake was cross-examined by Mr Plummer about the content of Theo's risk assessments during his period of detention. In particular, Dr Attanayake was questioned about recorded assertions by nursing staff that Theo was difficult to assess as the client was not engaging as he was preoccupied about going home and wanting to be discharged. This issue was recorded on 25 November 2015 which was the day on which Dr Attanayake first assessed Theo. Again, on 28 November 2015, it was recorded in the Consumer Risk Assessment[30] that Theo had a bland effect when discussing his delusions. As well, the content of his conversation remained superficial unless encouraged. Theo was recorded as having delusional thinking and was guarded. When asked how he was, he engaged only superficially. It was recorded on this day that Theo had voiced delusional thinking about knowing the names of persons murdered prior to his birth and of having been alive 2000 years ago. The content of his delusions were '*around death and dying*'. He indicated a belief that to keep his grandfather alive he needed to eat bigger portions himself. Specifically in relation to the risk assessment of 28 November 2015 and whether Dr Attanayake had been aware that nursing staff were having difficulties with Theo presenting as guarded, he said that considering the overall clinical picture Theo had not been fully open at any point. He said:

> 'But that guardedness is accepted due to his paranoia he was suffering from ... to a young man presenting for the first time, having a, you know, middle class social background, with shame and everything to be here on the ward. He mentioned to the nursing staff a couple of times 'Don't tell anyone that I'm here'. So he was actually probably, when he

[28] Transcript, page 322
[29] Transcript, page 329
[30] Exhibit C18, page 55

> was getting better with the insight, he might be thinking of his reputation which is very sensible'.[31]

The same presentation of guardedness was recorded on 29 November 2015. It was also recorded that it was difficult to engage with Theo therapeutically. To this Dr Attanayake asserted that his guardedness was not objective evidence upon which he could decide that Theo had not improved sufficiently to warrant his being discharged.[32] Dr Attanayake said that they do not keep patients on the ward only until they are 100% better. Rather, when they have improved sufficiently to be managed in the community their care is transferred to the community. Theo was open enough with Dr Attanayake himself that he could be discharged.[33]

5.20. Dr Attanayake was questioned about Theo's boastful and prophetic assertion on 29 November 2015 that he would be going home the following day after he had met the doctor. Dr Attanayake was asked as follows:

> 'Q. My question is, what would have given him any confidence that he would be going home after he saw you.
>
> A. I'm sorry I can't comment on that.
>
> Q. Is this some evidence, possibly, that he intended to manipulate you or deceive you, by saying things that would encourage you to discharge him.
>
> A. I agree that Theo did not like to be in the hospital since admission. Having said that, there's no, any indication as to why we should not be discharging him after the - by this date. Generally, the staff here would tell me 'Sir, don't send this patient home', if they were also having major concerns about not having enough resolution ... symptoms, or whether there was any risk. Because this is a multidisciplinary setting especially, these nurses are very good at picking that kind of things up and they would let me know, 'Sir we should not send this person home'. I didn't hear anything from them either, not only from my other colleagues.' [34]

5.21. The discharge summary[35] which was not received by Dr Dalamagas until 17 December 2015 refers to the initial belief that Theo needed accommodation in a closed ward but that he was able to be maintained on an ITO with a proper medication regime. Additionally, it was recorded that Theo and his family did not want him to be transferred to Adelaide and that this reluctance had worked as motivation for him to remain calm

[31] Transcript, page 335
[32] Transcript, page 336
[33] Transcript, page 336
[34] Transcript, page 342
[35] Exhibit C17, page 51 and Exhibit C12, page 31

in the inpatient unit at Berri with an awareness that he would be transferred to Adelaide if he became aggressive.

5.22. Within the discharge summary there is a management plan as devised by Dr Attanayake which included a number of measures that were to be administered in the community. In large, part this was directed towards Theo's GP, Dr Dalamagas. Suggested measures included that the GP should consider psychology. As well, it was contemplated that Dr Gupta, the visiting psychiatrist, would follow up with Theo and that Dr Attanayake himself, as resident psychiatrist in the Riverland, would perform a post discharge review in two weeks. A nurse identified as Michelle Hogan, a case manager from the CMHT in Berri, would follow up with Theo as well. It was also stated that Theo's diagnosis should be clarified as time went by. Theo was discharged on olanzapine, 10mg, twice a day.

5.23. Mr Plummer questioned Dr Attanayake about the difficulty involved in Theo possibly being transferred to Adelaide. Dr Attanayake was asked whether there was a general reluctance to send patients to a closed ward in Adelaide. To this Dr Attanayake said:

> 'It's a good question. I think I need to explain that because at that very - IMHIU was established, started to treat the patients in their area near their home with the families, and secondly, sending someone to Adelaide is not easy. There's always bed pressure; people are waiting in - even if he was - even in this situation, if Theo was sent to Adelaide, it is a matter of sending Theo to the Royal Adelaide Emergency Department, not to the closed ward direct, and then waiting for a bed in a closed ward. Before that, there's very complex logistics around transport with significant risk when someone was to be sent under ITO, against their wishes, because patients become aggressive, especially with a big built man like Theo, it could have been a disaster.' [36]

Nevertheless, Dr Attanayake acknowledged that at one point he had in fact placed Theo on a bed waiting list in Adelaide for a closed ward.[37]

5.24. In cross-examination Dr Attanayake continued to insist that Theo had not been psychotic at an earlier point in time, or at least information to that effect had not been made available to him.[38] Dr Attanayake acknowledged that as of 25 November 2015, when he first saw Theo, it would have been important for him to have known of

[36] Transcript, page 353
[37] Transcript, page 355
[38] Transcript, page 356

information that had been in the possession of Theo's GP's from 2014. Dr Attanayake said:

> 'It could have been perfect and ideal if I had this information. Having said that, with the presentation Theo had to the hospital, which was the first presentation to the specialised mental health services, there's no - ... history of previous mania or hypomania.' [39]

Dr Attanayake also acknowledged when questioned by me that the gathering of collateral information was a very important component when dealing with a person who may or may not require detention under the MHA. In acknowledging this Dr Attanayake said:

> 'Yes, collateral information is important but there is limitation as to what we can gather.' [40]

The observation needs to be made in the light of that answer that there were fecund sources of collateral information in the form of the records and opinions of Theo's GPs and his parents. The obtaining of information from Theo's GPs was not merely '*ideal*' or something to have been undertaken in a perfect world. It was an essential element in Theo's evaluation and treatment and a matter that has been commented upon in coronial inquiries in the past as well as in mental health policies and guidelines.

5.25. Dr Attanayake agreed with the proposition that if Theo had experienced a psychotic episode at the end of 2014, and had then presented a year later with possible psychosis with delusional thinking, it would indicate that Theo was prone to relapse. In many ways it is astonishing that Dr Attanayake would not have been made aware of Theo's complete mental health history since the end of 2014. It was readily available. Theo had seen two GPs in the community in relation to mental health episodes. One would have thought that proper enquiry would have established that Theo had exhibited psychotic if not hypomanic behaviour in the recent past. As well, it would have revealed that he had been referred to a psychiatrist Dr Warhurst in the first instance and had failed to take up that appointment. Mr Plummer cross-examined Dr Attanayake as follows:

> 'Q. No, but when you reviewed Theo on the 25th you were not aware of that were you, that there were symptoms of mania in the year prior to you seeing him.
>
> A. I wasn't.

[39] Transcript, page 358
[40] Transcript, page 358

Q. But it would have been important for you, I suggest, in accessing Theo to know that information. Do you agree with that.

A. Yes.' [41]

Dr Attanayake, however, was at pains to say that he did not think he missed much about Theo because when Theo presented to him he was, to Dr Attanayake, not manic. He said that in any event even if he had known of Theo's history, the treatment and management plan would have been the same. The expert evidence suggested that this approach was questionable.

5.26. I have earlier in this section referred to Dr Attanayake's references to Theo's '*capacity*'. Throughout Dr Attanayake's evidence, including when questioned about why it would not have been appropriate to have placed Theo under a CTO when he next saw Theo on 16 December 2015[42], Dr Attanayake suggested, among other factors, that he had not found any evidence of impaired capacity in Theo. When asked by me as to what the significance of capacity was, Dr Attanayake suggested it was capacity to make decisions about the following up of his treatment within the community. In his evidence he referred more than once to the need for '*all four criteria*' within the MHA to be fulfilled. As far as the elements that are required for intervention under the MHA are concerned, Dr Attanayake acknowledged that if Theo were not to take his medication, which he required in respect of treatment for his mental illness, he could have relapsed. He also acknowledged that Theo required treatment for his own protection from harm, be it physical, mental or otherwise.[43] He agreed that Theo might suffer a deterioration of his mental illness had he not undergone treatment.[44] It is to be observed that the harm contemplated within the MHA from which a person might need protection, includes harm involved in the continuation or deterioration of the person's condition. Dr Attanayake acknowledged that having regard to Theo's episode at the end of 2014 there would have been a significant risk of relapse upon discharge in December 2015 and that to ameliorate that risk Theo would have needed to comply strictly with the treatment that he was prescribed and would have needed to refrain from taking any drugs apart from those prescribed for him.[45] Nevertheless, Dr Attanayake insisted that when he discharged Theo he was confident that Theo would accept and comply with

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[41] Transcript, page 360
[42] Transcript, page 365-366
[43] Transcript, page 373
[44] Transcript, page 373
[45] Transcript, page 375-376

the necessary treatment and that he would attend appointments, engage with the CMHT and other primary health professionals in the community. Dr Attanayake insisted, '*there was no evidence to say that he would not*'.[46]

5.27. In my view, Dr Attanayake misjudged Theo. Theo was no better at the end of his period of hospitalisation than he had been at the start. Theo's longitudinal history, had it been properly evaluated, demonstrated that he was profoundly mentally unwell and would be prone to relapse.

6. The CMHT and Dr Attanayake's review of Theo on 16 December 2015

6.1. Theo's relationship with the CMHT following his discharge had an unfavourable start. Two nurses from the CMHT visited the Papageorgiou home on 9 December 2015. The precise details of this encounter are disputed as between the staff members, Ms Hogan and Ms Curtis on the one hand, and Mrs Papageorgiou on the other. It is not necessary to resolve that dispute. It is common ground that Theo was asked to sign consent forms in relation to his treatment and that he refused to sign them. The reasons for the CMHT's insistence that Theo sign such forms was not at all clear to me. Equally, Theo's intransigence in refusing to sign them is also not explained except perhaps on the basis that it was in keeping with his general paranoia and was also consistent with his having refused to sign documentation when discharged from hospital on 1 December 2015. The Chief Psychiatrist in his review report has commented adversely on this aspect of Theo's management.

6.2. As foreshadowed in Dr Attanayake management plan, Dr Attanayake reviewed Theo at the outpatient area of the hospital on 16 December 2015. This would be the last occasion on which Theo was seen by Dr Attanayake or any other psychiatrist. Dr Attanayake would proceed on leave over the Christmas/New Year period and would be replaced by a locum psychiatrist by the name of Dr Dham who, as will be seen, did not see Theo despite Theo's acute presentation approximately a month later on 14 January 2016 at the RGH and despite the fact that Dr Dham was on duty at the hospital on that occasion. The next psychiatric appointment would be scheduled for 27 January 2016. That would have involved Theo being seen by Dr Gupta. However, Theo's death intervened.

[46] Transcript, page 374

6.3. Dr Attanayake made typewritten notes of his examination of Theo on 16 December 2015[47]. He saw Theo with Ms Hogan, a registered nurse with the CMHT.

6.4. Dr Attanayake recorded that on this occasion Theo presented well but reported side effects from the olanzapine medication. The side effects were reported as weakness, lack of energy, sore joints, feeling bloated and feeling a bit low. Theo had also gained 5 kilograms in weight. Weight gain is a known side effect of olanzapine. Nonetheless, Theo reported that he had been compliant with the medication. During the course of this consultation Dr Attanayake would alter Theo's medication. I will come to that in a moment.

6.5. Dr Attanayake recorded that there was no overt evidence of psychosis, mood disorder or anxiety. Theo denied using any drugs.

6.6. Dr Attanayake recorded that Theo had no homicidal or suicidal thoughts or delusions. His insight was recorded as being poor and his judgment was fair. The impression recorded by Dr Attanayake was that in the context of a recent psychotic episode which was probably drug induced, Theo '*at this stage*' was not psychotic, He recorded that the primary psychosis needed to be further clarified using the first episode psychosis model. Dr Attanayake still appears to have been wedded to the view that Theo was suffering from a first episode psychosis.

6.7. As to the recorded Plan, olanzapine was ceased and another medication namely aripiprazole 15mgs mane was ordered. As part of the plan it was also envisioned that Dr Dalamagas would follow-up and that Ms Hogan, who was described as Theo's '*case manager*', would discuss early morning signs and a crisis plan.

6.8. Dr Attanayake also recorded that Theo might require a depot medication if he became unwell again and if his compliance was poor; a CTO would preferably be avoided having regard to the least restrictive strategies for a young man who lived with his supportive parents.

6.9. Theo would be on aripiprazole until 28 December 2015 when he was prescribed olanzapine and lorazepam. In the early hours of the morning of 28 December 2015 Theo presented at the RGH with his mother and was seen by a Dr Mohamad Nuruzzaman. Theo reported that he had switched medications from

[47] Exhibit C12, page 29

olanzapine to aripiprazole and since then had experienced sleeping difficulties, was breathless and was stressed in relation to his upcoming court case. As a result Dr Nuruzzaman telephoned the Rural and Remote Mental Health Team and spoke with a psychiatric nurse. The advice was that Theo be given olanzapine and lorazepam to relieve his anxiety and shortness of breath and that he should be observed. Theo's symptoms subsided and he was discharged. This recommended change of medication was intended only to be temporary in order to deal with Theo's reported symptoms. However, from that point forward Theo took olanzapine and lorazepam on an ongoing basis until his death. The continuation of olanzapine and lorazepam appears to have been contributed to by Dr Dalamagas at an appointment on 30 December 2015 with Theo forming the belief that this regime was intended to be ongoing. There appears to have been an expectation following his 28 December 2015 presentation, that Theo would receive psychiatric evaluation regarding the change of medication. This did not take place. There is no evidence that anything, or at least anything immediate, was arranged in that regard. When Dr Attanayake was interviewed as part of the Chief Psychiatrist's review he stated that had he known of the 28 December presentation he would have considered increasing the aripiprazole or trying a different antipsychotic rather than returning to olanzapine.

6.10. Dr Attanayake told the Court that he believed that his last day at work was 31 December 2015. Shortly before that a member of the CMHT, Ms Curtis who was also about to go on leave, had mentioned to him that Theo was not tolerating aripiprazole. Dr Attanayake's view was that Theo should therefore revert back to olanzapine. He asserted in his oral evidence that he had told Ms Curtis that this was his view but that Theo should again be reviewed by a psychiatrist. Dr Attanayake said that the review he contemplated might be undertaken by Dr Gupta or by his locum while he was on leave, or even by Theo's GP. In the event the medication change was not immediately documented which Dr Attanayake told the Court he regretted. He accepted that this had been his responsibility.[48] Dr Attanayake believed that he left instructions for either Dr Gupta or Dr Dham to see Theo which as we know did not occur. Specifically, Dr Attanayake asserted that in a handover to Dr Dham he had specifically mentioned that Theo needed a review of medication. Dr Attanayake's preference appears to have been that Dr Gupta should see Theo as he had seen him in the past.[49] In his written

[48] Transcript, page 272
[49] Transcript, page 274

handover to Dr Dham which was emailed to her on 1 January 2016 he described Theo as having a '*first episode psychosis*'.[50] He stated that Theo needed a review of medications and that if Dr Gupta had the capacity to see Theo, Dr Dham would not need to see him. Such a vague arrangement was almost inevitably going to result in confusion and delay. In the event, no psychiatrist would see Theo. The appointment with Dr Gupta did not eventuate because of Theo's death.

7. Theo's presentation at the RGH on Thursday 14 January 2016

7.1. The background to Theo's presentation is described in the affidavit of Mrs Papageorgiou which was tendered to the Court.[51] Mrs Papageorgiou noticed what appeared to be an improvement in Theo's condition between 1 and 4 January 2016. Theo had seen a psychologist, Dr Field, in relation to a medico legal report in respect of his traffic matter. As well, he had been seen Dr Dalamagas on 7 January 2016. However, on about 9 January 2016 Mrs Papageorgiou noticed a change in Theo's demeanour. He started expressing deep regret in relation to a range of things which had happened over a number of years. Theo was apologising to his father about those things. Mrs Papageorgiou became concerned about Theo's state of mind. Theo said that he did not like the thoughts that he was having. The following day he continued to express regret about things that he had done and was very down on himself. Mrs Papageorgiou states that she was terribly concerned. Theo's worrying symptoms continued into the following day.

7.2. A scheduled meeting with Ms Hogan of the CMHT for 12 January 2016 was not kept. Ms Hogan said that she had been in Waikerie and was not able to make the appointment. Mrs Papageorgiou was extremely disappointed by this as she had major concerns about Theo's mindset and wanted to discuss the changes that Theo had been experiencing. Another meeting was not scheduled until 19 January 2016.

7.3. Theo appeared to deteriorate further on Wednesday 13 January 2016. Mrs Papageorgiou describes him as being more anxious and distressed than she had ever seen him. He said that he was scared. For the first time ever Theo expressed to Mrs Papageorgiou what sounded to her like suicidal thoughts. He said to his father words to the effect of '*let me go*'. He said he wanted to go into a deep sleep. He also

[50] Exhibit C23
[51] Exhibit C27

said that he wanted to see his grandparents, both of whom had died during the previous 18 months. Theo said to his father that he could not cope and could not do it anymore. He was repeatedly apologising to his parents. He lay in their bed as they tried to comfort and reassure him. Mrs Papageorgiou asserts that she and her husband '*had Theo under 24 watch*' which I took to mean a suicide watch.[52]

7.4. Theo was in a similar frame of mind the following day, Thursday 14 January 2016. He was expressing the same thoughts as the day before, telling his parents that he wanted to go with his grandparents. He described a headache at the front of his head. Mrs Papageorgiou rang Dr Dalamagas and told him about Theo's condition. Dr Dalamagas told her to take Theo to the RGH ED where he would meet them.

7.5. Theo was taken to the hospital during the morning. Dr Dalamagas was not able to attend. However, Theo was seen by a local duty doctor, Dr Vishal Mahajan, who as it happened worked in the same clinic as Dr Dalamagas.

7.6. It will readily be seen from Mrs Papageorgiou's account, which I accept, that she was a source of highly relevant collateral information about Theo that would have been available to anybody who saw Theo that day.

7.7. Dr Mahajan's clinical notes record that Theo was brought in by his parents.[53] Theo's arrival time noted on the Non-Admitted Unplanned Patient Attendance Record.[54] was 11:20am and he is noted to have been by the doctor at 11:35am. The recorded reason for attendance is '*Suicidal Ideation?*'. It was also recorded on the same document that Theo had been sent to the ED by Dr Dalamagas for a mental health review and that Dr Dalamagas was contacted by Theo's parents as '*PT is suicidal*'.[55] The Patient Admission Form[56] recorded as the reason for Theo's admission, '*Suicidal Ideation*'.

7.8. A Mental Health Risk Assessment[57] executed by Dr Mahajan recorded that Theo had '*ideas to harm himself*'. His risk assessment in relation to self-harm was ticked as both '*low*' and '*moderate*', as was his risk assessment in relation to suicidality.

[52] Exhibit C27, paragraph 95
[53] Exhibit C17, page 11
[54] Exhibit C17, page 13
[55] Exhibit C17, page 14. PT is an abbreviation for patient
[56] Exhibit C17, page 8
[57] Exhibit C17, page 19-20

7.9. Dr Mahajan recorded that Theo presented with a history of racing thoughts in his mind and that he was not able to control these thoughts. There is no recorded detail as to what those thoughts were and in particular whether they involved suicidal ideation. However, as seen above, he recorded that Theo had ideas to harm himself. As well, it is recorded that Theo thinks that somebody was putting thoughts in his mind; again those thoughts are not detailed. Dr Mahajan has recorded that Theo had a sad mood/affect. It was also recorded that Theo expressed no hallucinations or '*illusions*' and that he had insight with '*ok*' judgment.

7.10. Dr Mahajan recorded that the ideas to harm himself were '*mild to moderate*'. The plan of management included that registered nurse, Mr Tony Guscott, should assess Theo and that Theo wanted to attend his GP with his parents. It is recorded that he was ultimately sent away that day in the custody of his parents.

7.11. Dr Mahajan gave oral evidence in the inquest. Asked by Mr Apps of counsel for Theo's family as to what Dr Mahajan had meant by Theo's risk of self-harm as being low to moderate, Dr Mahajan answered as follows:

> 'So for that, like, because of his previous mental health history and aggressive thoughts in his mind and previous history of, like, schizophrenia, so I was of the opinion that, yes, he has - but he was not giving any direct information to me that he wants to harm himself or he wants to kill himself. So my assessment was that he has, like, low to moderate risk of having suicide so that's why I called the mental health unit to assess him more because they are the expert in that one.' [58]

Dr Mahajan added that he had expected the mental health unit to recommend a plan for Theo's management which they would follow. As to whether Theo would be hospitalised, Dr Mahajan said that this would have depended upon the assessment of the mental health unit. In the event, after his consultation with Theo Dr Mahajan spoke to Mr Guscott and asked whether Theo needed to be admitted to hospital. Mr Guscott had said words to the effect that '*No, Theo would be seeing his local GP*'.[59]

7.12. In cross-examination by Mr Plummer, counsel assisting, Dr Mahajan said that he expected that as a matter of routine the mental health risk assessment and the mental state examination documentation would be provided to the mental health team. However, his own progress notes would not be provided.[60] Dr Mahajan stated that the

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[58] Transcript, page 562
[59] Transcript, page 563
[60] Transcript, page 569

information included in the progress notes was not made available to any entity outside of the ED.[61] That would, if true, appear to be an astonishing state of affairs especially where both the ED and the mental health team were all under the same roof. Dr Mahajan explained that, similarly, the notes after he had been admitted as a detained inpatient in the previous November were not available to the ED staff. The entity that operated the ED, namely River Doc's, which was an emergency service provided by private doctors in the Riverland, was a different entity from that which operated the rest of the hospital including the IMHIU. That said, if Dr Mahajan had wanted to access the patient's notes including the ITO progress notes from that admission he could have requested a file to be brought from central storage. However, Dr Mahajan said that because the mental health team were seeing him in any event and that Theo was well known to them, they should have had all of their notes from Theo's previous presentations. Accordingly, Dr Mahajan did not see the need to call for any mental health notes from the past. In addition, any decision that was to be made in relation to Theo's care and management would be made by the mental health team. This included whether or not Theo would again be placed under an ITO having regard to his suicidal ideation. He regarded the mental health team as the experts in this type of assessment.[62] Dr Mahajan made this assertion;

> 'I'm not expert. I'm GP working in the ED so I don't have mental health like background or psychiatric background for any post - graduation or any like further studies in that. So they have all the experts over there. They have a psychiatrist. So the decision was to be made by them not by me.' [63]

With respect, this is an example where clinicians refrained from dealing with the situation at hand, in this case Theo's acute suicidal presentation, because he was due to be seen by others. As will be seen a reluctance to grasp the nettle and the lack of cohesion between clinicians involved in the evaluation of a patient's acute circumstances was a matter that Dr McKenny in particular would comment upon unfavourably.

7.13. Mr Plummer also closely questioned Dr Mahajan about Theo's thoughts as had been described to him and as had been recorded by him in the progress notes. Dr Mahajan acknowledged that the racing thoughts that Theo was not able to control were thoughts

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[61] Transcript, page 570
[62] Transcript, page 573
[63] Transcript, page 573

of self-harm.[64] Dr Mahajan said he was not told whether Theo had contemplated any particular method of suicide or self-harm, say by way of drug overdose or driving a car into a tree, but when asked as to whether he had asked Theo if he had contemplated various methods of suicide, Dr Mahajan claimed that when assessing suicide risk they normally ask about a plan. If the patient acknowledged that he or she did have a plan then in those circumstances they would ask about the nature of the thoughts. He said that Theo did not tell him whether he had any plan. He did not ask Theo about suicide methods and repeated that he did not do so because Theo had not expressed any plan. When asked by me as to why one would not ask that question given that it might elucidate whether the thoughts of suicide were genuine, serious or otherwise, Dr Mahajan said:

> 'So ideas, there are like ideas and plan. Ideas are like few type of ideas and irrational thoughts and plan is like what is considered as more serious for suicide risk. But he had some thoughts about that, but I didn't like ask him whether he wants to like commit suicide by hanging or by any other methods. So it was not asked, anything like that.' [65]

7.14. When questioned by me, Dr Mahajan again acknowledged that he had interpreted the thoughts that Theo could not control were thoughts of harming himself. He also acknowledged that Theo was in a persistent state in which he was thinking of harming himself.[66] Asked as to whether thoughts of harming himself meant possible suicide, Dr Mahajan acknowledged that this could be so. The following passage of evidence was then given:

> 'Q. Would it surprise you then that the mental health unit, when they examined him the same day, after you, detected no suicidal thoughts.
>
> A. I don't have those papers with me. I couldn't see those papers at the time.
>
> Q. No, but would it surprise you that he told them, or told Guscott, that he had no suicidal thoughts, he having told you that he had.
>
> A. Yes. He had, yes.
>
> Q. Well it would have been fairly important then for Mr Guscott to have seen your own notes.
>
> A. Yes.
>
> Q. Or even have spoken to you perhaps.
>
> A. Yes.' [67]

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[64] Transcript, page 575
[65] Transcript, page 576
[66] Transcript, page 578
[67] Transcript, page 578

I will deal with the evidence of Mr Guscott in a moment. In response to questions from Mr Plummer, Dr Mahajan added that if the mental health team wanted more information than was contained within the mental state examination documentation they could have asked him for it.[68]

7.15. After the evidence of Dr Mahajan, it was obvious that there had been a lamentable disconnect between him and the mental health team. That was confirmed by the evidence of Mr Guscott. I turn to that evidence in a moment. As superficial as Dr Mahajan's assessment was, given the limited role he perceived himself to have had, it at least would have given rise to what in my view was an appreciable perception that Theo was at risk of self-harm had the issue then been competently explored by the '*experts*'.

7.16. Mr Anthony John Guscott is a registered psychiatric nurse of considerable experience. He has worked in various positions in South Australia and the Northern Territory. He has particular expertise in disaster responses and suicide postvention. Ultimately he took up a position with the Rural & Remote Mental Health Service at Glenside in metropolitan Adelaide. In January 2016 he was working in the Riverland as a locum replacing another nurse who was on leave. Mr Guscott had also worked for the Emergency Triage Liaison Service (ETLS) as their bed coordinator. The ETLS is the metropolitan emergency contact arm of the Country Mental Health Service. It operates as an emergency mental health telephone number for country access. It is available on weekend days when local consultant psychiatrists are not available. In January 2016 at Berri Mr Guscott's role was as the clinical program coordinator. This role involved providing clinical assessment of clients in the inpatient unit and for people who attended the ED of the RGH. He also supported nursing staff in the mental health inpatient unit. Mr Guscott explained that this unit had only opened some months previously. This had meant that there were a number of new staff members who were relatively inexperienced in their roles. Mr Guscott's position also contained a role in supporting the CMHT as a lead clinician. However, as a locum he was only in Berri for a limited period of time. According to Mr Guscott, many of the clinicians in the region who had been there for many years knew his job better than he did. He said '*So whilst I was there in that role I guess it was more of a mentoring than a clinical lead role*'.[69]

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[68] Transcript, page 579
[69] Transcript, page 394

7.17. Mr Guscott saw Theo after Dr Mahajan had seen him. Dr Palavi Dham, who is a psychiatrist, was on duty at the hospital that day. Dr Dham was also a locum practitioner. She was filling in for Dr Attanayake who was on leave. Mr Guscott told me that he only spoke briefly with Dr Dham about Theo that day. Dr Dham would not see Theo herself at all. As I understood Mr Guscott's evidence, the psychiatrist on duty would not routinely provide acute care to a patient unless admitted as an inpatient. Dr Dham's duties that day would have consisted of seeing community-based patients which I took to mean seeing them on a scheduled basis. I will deal with her evidence separately. Mr Guscott explained that the usual process was that the patient would be seen by him as the CPC and that he would assess the patient and refer him or her if required. Mr Guscott told the Court that when he briefly spoke to Dr Dham before seeing Theo, Dr Dham indicated to Mr Guscott that she was not keen on Theo's mother accompanying him if he required inpatient admission. Mr Guscott had established that there was in fact a bed available for Theo should he have required admission.

7.18. The CMHT nurse, Ms Hogan who also had contact with Theo prior to Mr Guscott seeing him, provided some information to Mr Guscott. Mr Guscott was also aware that Theo had been seen by Dr Mahajan but was only provided with limited documentation. Mr Guscott said that the only note he had from the ED was '*the ED admission document*'.[70] He identified the 'NON-ADMITTED UNPLANNED PATIENT ATTENDANCE RECORD' as a document that he had seen. He said he could not recall seeing the Risk Assessment. Later in his evidence he acknowledged that he read Dr Mahajan's assessment, but then denied that he had seen Dr Mahajan's notes.

7.19. Mr Guscott made some handwritten notes during his consultation with Theo. He spoke to Theo for about 20 to 25 minutes. To begin with, Theo's parents were present. However, although Mrs Papageorgiou gave Mr Guscott some background information, Mr Guscott was unable to elicit any information firsthand directly from Theo himself. Theo would consistently defer to his mother. Mr Guscott therefore asked Ms Hogan to usher Theo's parents from the room so that he had '*…some clear space with Theo to get a clear assessment*'.[71]

7.20. I now turn to Mr Guscott's assessment. Mr Guscott told the Court that he made handwritten notes of his consultation with Theo that were written into a notebook that

[70] Transcript, page 398
[71] Transcript, page 400

he no longer possessed. However, tendered to the Court was a three-page typewritten document that purports to record an emergency assessment of Theo by the Riverland mental health team. Mr Guscott referred to this document during his testimony. It was revealed during the course of his evidence that this document was created on Monday, 25 January 2016 which was after Theo's death. Mr Guscott said that he used his handwritten notes to create this document. He stated that as far as he could recall, the typewritten document was an accurate rendition of his original handwritten notes. The typewritten document ultimately made its way onto the Country Mental Health Service casenotes for Theo.[72] Mr Guscott had some difficulty explaining why he had not compiled the typewritten document prior to 25 January 2016 except to suggest that he had been side-tracked by the need to compile an assessment for Dr Dalamagas who was scheduled to see Theo later that day. Mr Guscott conceded that the unavailability of the typewritten record in the first instance meant that there would have been a less than optimal communication with the CMHT regarding his review of Theo.

7.21. As to the detail of his review after Theo's parents had left the room, Theo identified the stressor that had precipitated his presentation as being the breakdown in the repair of a storm drain for the second time. He said that he had been feeling pressure in his head since then and that he had been thinking too many things. As to suicidal ideation, Mr Guscott recorded that Theo said that there had been times when he had suicidal thoughts but that he did not entertain them at the present. He denied any specific plans for suicide. The note states, '*Currently denies suicidality*'. As to the assessed level of risk of suicide or self-harm, Mr Guscott noted that this was '*Medium-frequent, limited intensity and duration.*' I am not certain what that was intended to convey given that there are other entries in the notes to the effect that Theo was not currently experiencing suicidal ideation although he had done so in the past. This aspect of the review seems to be at odds with information that was in the possession of Theo's parents and at odds also with the recorded reasons for Theo's presentation that day which was suicidal ideation. This as the principal reason for Theo's presentation at the ED had been recorded in a number of different documents, including notes prepared by Dr Mahajan where it was recorded that he had ideas to harm himself. The impression created by the record made by Mr Guscott gives an altogether more benign impression of Theo

[72] Exhibit C16, pages 16-18

than had been displayed when assessed by nursing staff and by Dr Mahajan. As well, it conflicted with his most recent condition as perceived by his mother.

7.22. According to the note made by Mr Guscott, throughout this interview Theo was watching the time. It was said that he had an appointment with Dr Dalamagas at 2pm. Theo became more restless and less attentive as time progressed. By the end of the interview all rapport had been lost. Theo had become agitated. In fact, according to Mr Guscott the interview was curtailed. It ended at 1:40pm, ostensibly to enable Theo to attend the appointment with Dr Dalamagas. The reality was that the appointment was not until 3:50pm. Where Mr Guscott gleaned the time of 2pm from is not satisfactorily explained in the evidence, except to the extent that this time was probably given to him by Theo whose main objective was to end the interview as soon as possible.

7.23. There is no record of Mr Guscott having explored the issues identified by Dr Mahajan such as Theo's presentation with racing thoughts in his mind with no ability to control those thoughts. Theo's ideas to harm himself as expressed to Dr Mahajan do not appear to have been explored except to the extent that Mr Guscott recorded no current suicidal ideation - which in fact is the polar opposite of what Theo told Mahajan.

7.24. There are a number of references in Mr Guscott's retrospective typewritten record about the possibility of inpatient admission. Mr Guscott recorded that he discussed with Theo the option of an inpatient admission without Theo's mother being present. Mr Guscott recorded that Theo stated that he wanted to stay with his parents and did not want to come into hospital. Another entry is to the effect that Theo was offered inpatient admission but that both he and his parents were reluctant to accept that. There is a dispute about that which I will come to in a moment. Theo's parents in their oral evidence totally rejected this. Mr Guscott also recorded that Theo had an appointment with a psychologist on 20 January 2016 in Adelaide which in fact was the case. The parents had arranged that and would ensure attendance. Mr Guscott recorded that Theo's risk was '*low at present*'.

7.25. In cross-examination by Mr Apps, Mr Guscott acknowledged that he had read Dr Mahajan's assessment including references to racing thoughts and not being able to control those thoughts. As well, Mr Guscott acknowledged that he knew that Theo had said that he had ideas to harm himself and that Theo believed that someone was

putting thoughts into his mind. It is also observed that Dr Mahajan had assessed Theo as having ideas to harm himself that were mild to moderate. Mr Guscott said in evidence that this would indicate that Theo needed further assessment. However, he stated that at the time he assessed Theo he did not detect that he was entertaining ideas that were mild to moderate ideas to harm himself. He agreed with the proposition that Dr Mahajan had gained a different perspective from him about Theo.[73] Mr Guscott stated that during his interview he believed that he was under time constraints due to the looming appointment with Dr Dalamagas. He said that in normal circumstances the assessment would have taken an hour to an hour and a half. In the event it took 20 to 25 minutes. He did not think to contact Dr Dalamagas to postpone his appointment so as to enable him to have more time with Theo. To digress, the acknowledgments that he read Dr Mahajan's assessments do not seem to sit well with Dr Mahajan's evidence about the CMHT not having access to River Doc's ED records.

7.26. Mr Guscott was asked by his own counsel Ms Cliff about whether or not he had considered detaining Theo under the MHA. Mr Guscott said that he had recently been accredited with the necessary statutory power to do so. Mr Guscott said that he did not believe that Theo fulfilled the criteria under the Act; in particular he could not establish any suicidal ideation or intent. He said that the history since his previous admission had been '*somewhat sketchy*'.[74] In addition, Theo had very supportive parents and an appointment later that day with his GP who had been seeing Theo over a period of time. As well, there was the appointment with his psychologist the following week. He said that later that day he told Dr Dham that in his opinion Theo was not detainable under the MHA and that Dr Dham accepted that.[75]

7.27. Mr Apps of counsel for Theo's family, put to Mr Guscott a number of matters based upon Theo's recent utterances to his parents that were objectively suggestive of significant suicidal ideation. They included whether Theo had expressed thoughts of joining his grandparents who had died recently, whether he had given up hope and had had enough. Mr Guscott said that if he had been told that Theo had entertained thoughts of joining his dead grandparents, it would have alarmed him such that it would have

[73] Transcript, page 420
[74] Transcript, page 407
[75] Transcript, page 407

caused a need for further review and assessment and a need for him to stay, at least overnight, for observation.[76]

7.28. In his evidence Mr Guscott said that he would have been much happier if Theo had been admitted as a voluntary patient but that Theo had rejected this. He said that he may have told Theo that if he was to be admitted as an inpatient he could not have a parent there with him, although he could not specifically recall saying that. This of course would have been consistent with Dr Dham's view as earlier told to Mr Guscott. He could not recall saying to Theo's parents that it would be beneficial for Theo to be admitted to hospital as a voluntary patient but that he had refused. He did not recall suggesting to them that his personal view was that admission, even on a short voluntary basis, would be beneficial.[77]

7.29. In a valiant attempt by Mr Plummer, counsel assisting, to clarify what ED documentation Mr Guscott had or had not seen, Mr Guscott responded that he did not see Dr Mahajan's type-written progress notes. I am not certain how that denial lives with earlier assertions he had made in his evidence that he had read Dr Mahajan's assessment concerning racing thoughts. Be that as it may, Mr Guscott accepted that '*…with the benefit of hindsight*' [78] he should have spoken to Dr Mahajan about his assessment of Theo. He accepted that there appeared to be a difference between the way that Theo presented to Dr Mahajan compared to the way he presented to him. This was yet more evidence of the lamentable disconnect between the RGH ED and the mental health services.

7.30. Finally, when Mr Guscott was closely questioned about possible intervention under the MHA, he appeared to express the belief that the harm contemplated within the Act involved harm to the patient or to other persons and suggested that it was his understanding that there had to be an element of physical self-harm or the possibility of the same before the MHA was triggered.[79] However, it was pointed out to him that the protection from harm under the legislation could include harm involved in the continuation or deterioration of the person's condition. Mr Guscott acknowledged that for the MHA to be applied to a patient, suicidal ideation was not necessarily required. He also acknowledged that in a letter that he wrote to Dr Dalamagas that afternoon and

[76] Transcript, page 421
[77] Transcript, page 427
[78] Transcript, page 445
[79] Transcript, page 446

which he hand-delivered to Dr Dalamagas' office, Theo had been behaving normally that morning but that his mental state had deteriorated swiftly and he had been brought to hospital.[80] There is no mention in this document about anything connected with possible admission of Theo to hospital. The assertion that Theo had rejected admission seems to have only been documented for the first time in Mr Guscott's ex post facto typewritten record of 25 January 2016, made after Theo's death.

7.31. Following his assessment of Theo, Mr Guscott again spoke to Dr Dham. I now turn to Dr Dham's evidence.

7.32. Dr Dham is a psychiatrist who originally had worked with Country Health until May 2015. She moved to Canada in June 2015 but then, remarkably, in January 2016 she returned from Canada to the Riverland for the sole purpose of performing three weeks' locum cover for Dr Attanayake during his leave. Dr Dham stated that Dr Attanayake had provided her with an emailed '*handover*'.

7.33. Dr Dham did not see Theo on 14 January 2016. However, she spoke to Mr Guscott about him. She told the Court that Mr Guscott said that Theo had presented with anxiety attacks and suicidal ideation but denied any specific suicidal intent or plans. No psychotic, manic or hypomanic symptoms were described. Dr Attanayake had mentioned in the handover that Theo would need a medication review but interpreted the instruction as meaning that this would be performed by Dr Gupta when he next returned to the Riverland at the end of January 2016. As seen elsewhere, the handover did state that if Dr Gupta had the capacity to see Theo she would not need to see him. Dr Dham did not regard an immediate medication review to be a priority, and she had many crisis patients within the inpatient unit. She suggested that it was not an essential thing for her to have seen Theo adding '*…there was nothing that alerted any red flags for me*'.[81] As will be seen in a moment, there would have been red flags if Dr Dham had been properly briefed.

7.34. However, having detected through her conversation with Mr Guscott that Theo's presentation was apparently different from what it had been in November 2015, Dr Dham thought that they should be looking to put him on a mood stabiliser. She said that she would have preferred him to be an inpatient so he could be observed.[82]

[80] Exhibit C12, page 74
[81] Transcript, page 588
[82] Transcript, page 589

However, Dr Dham described something of a stumbling block to admission. She understood from Mr Guscott that his opinion was that he did not fulfil the criteria for admission under the MHA because there were less restrictive means of managing him than detention. Nevertheless, she understood that there was a bed that could be made available for voluntary admission. The stumbling block was that Theo's mother would want to stay with him which she regarded as a very unusual request. As far as Dr Dham was concerned, it was not feasible. And so, she said that it would not be appropriate to have Theo's mother staying with him; in any case the ward was an open ward where families spent much time with their patients on the unit. Dr Dham suggested that she remembered Mr Guscott saying that the issue had been discussed and that a proposal without Mrs Papageorgiou's attendance was not acceptable to the Papageorgious. In addition, the nurse Ms Hogan had suggested that during the admission in November they had not been able to establish a rapport with Theo and that it had been felt that the presence of Mrs Papageorgiou had interfered with his treatment. Unfortunately, Dr Dham did not speak with any members of Theo's family or Theo. She said that she trusted Mr Guscott's judgment. When asked by her counsel Ms Cliff as to whether it had been an option for her to review Theo herself, she said:

> 'No, in hindsight when I look, I wish I did, but there was a lot of work at that time and I was completing inpatient admissions and my letters from review. What Tony was describing, he did not ask me for a psychiatrist review. I did not feel at that point that this was something I should be leaving all my work to go out. I thought we still had - and Michelle Hogan was going to see him on the 19th so I thought that was in itself a safety net and I wasn't aware of any changes to Theo's medications or any difficulties in the past before I had spoken about him. So I was thinking from my point of view I thought okay, we have a plan, we can see how it goes. If it doesn't go well, we can bring him back and then he was going home with his mother who would be monitoring his medication. They clearly told me he is not using drugs at that point. There was no other risk concerns that were raised with me so I thought that was okay, that we could try that option as a first option.' [83]

7.35. Once again, rather than dealing with the matter at hand, it appears that reliance seems to have been placed on Theo being seen at an appointment in the future.

7.36. Dr Dham suggested that lorazepam should be added to Theo's medication and that perhaps the dosage of olanzapine could be split across the day. This would in reality

[83] Transcript, pages 592 -593

be the sole measure that Theo was subjected to at that attendance. It was hardly the comprehensive medication review that had become necessary.

7.37. Dr Dham said that from what she knew about Theo she suspected that he had bipolar disorder because of two very distinct and different presentations. However, because she had not assessed the patient herself it was difficult for her to gain any confirmation of that. Rather, she thought that this would be an assessment that would be investigated over time.[84] Dr Dham added that if lithium had needed to be prescribed for Theo for possible bipolar illness, this would be something that a psychiatrist would have to manage and titrate.

7.38. Dr Dham was cross-examined extensively by Mr Apps and Mr Plummer, and in particular about what could properly be characterised as the red flags that Dr Dham says she did not see. Dr Dham stated that the details of Dr Mahajan's mental health assessment were not conveyed to her.[85] Dr Dham could not recall that it had been said that Theo could not control his thoughts of self-harm. If it had been reported to her that the thoughts that he could not control had been suicidal thoughts, this would have concerned her.[86] She said also that uncontrolled thoughts could hardly have been described as thoughts that were '*fleeting*', an expression that she believed had been used by Mr Guscott, and coincidentally an expression that Dr Dalamagas had utilised at one point. Asked specifically as to whether she would have recommended that Theo be admitted to hospital if she had known about Theo's uncontrolled thoughts, she said:

> 'I already recommended that it would [be] preferable to have him admitted in hospital because sometimes it's difficult to get a full assessment, even though Tony felt there was none. I already kind of recommended that as a first option. It was more about whether we should be forcing him to get admitted in hospital, that he didn't have the capacity to make that decision.' [87]

It will be observed here that Dr Dham also seemed to be of a view that Theo's capacity to make decisions was a relevant consideration. Dr Dham's answer above prompted me to ask her whether having uncontrolled thoughts of self-harm would have meant

[84] Transcript, page 593
[85] Transcript, page 598
[86] Transcript, page 599
[87] Transcript, page 599

that her view that Theo should be admitted would have been reinforced. She said it would be reinforced and escalated in her mind '…*definitely*'[88], adding:

> 'That if it is uncontrollable means he is really struggling with that, and so the admission becomes more of a priority. Yes, it would definitely escalate the risk for me if it was mentioned as uncontrolled.' [89]

7.39. Asked by Mr Apps as to what had caused her not to pursue her original preference for admission of Theo, Dr Dham said that they could only recommend admission and not force it. That his mother could not stay with him was not the real issue. She had understood that this was what they had wanted but that she could not provide that at that point in time. Therefore, admission was a decision for the family to make.[90] Mr Apps suggested that if admission as a voluntary inpatient had been her preference and that if there had been uncertainty about Theo's admission, she should have spoken to the parents herself. To this Dr Dham suggested that she believed that the CMHT knew the Papageorgiou family well and that the team had been in the best position to have the necessary discussions with the family.[91] Dr Dham said that she did not have the time to speak to the family members having regard to the pressure of the work that she was undertaking at the time. She trusted her team to be capable of having the necessary conversations with the family and that if her intervention was required they would bring this to her attention.[92]

7.40. When cross-examined by Mr Plummer, Dr Dham acknowledged that if a patient had presented at the ED at a metropolitan hospital with suicidal ideation and a previous history of having been admitted by way of an ITO, then they would have at least been seen by a psychiatric registrar.[93] She also acknowledged that at Berri there was simply too much work for one psychiatrist, recalling of course that she was the only psychiatrist there and was relieving Dr Attanayake. She agreed with Mr Plummer that if she had not been so busy performing her functions that day, then she would have had the capacity to see a patient such as Theo. To this she said:

> 'Definitely, definitely. And I think that's something that is a struggle in that place.' [94]

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[88] Transcript, page 600
[89] Transcript, page 600
[90] Transcript, page 602
[91] Transcript, page 604
[92] Transcript, pages 604-605
[93] Transcript, page 611
[94] Transcript, page 611

7.41. Dr Dham was asked again about Theo's presentation when seen by the GP in the ED. She was asked this:

> 'Q. You were asked some questions, both by his Honour and Mr Apps, in relation to if you had known certain pieces of information, would that've been important to you. But if you had known that when Theo presented at the emergency department, he 'Complained of racing thoughts of suicide, that he couldn't control them, thinks irrational thoughts of self-harm' - so, if you were aware that he had said that to the ED doctor, would you have seen him.
>
> A. Yes, yes, I would have definitely tried to make time to see him, because that sounds very concerning.' [95]

When asked as to whether such a presentation might have fallen within the criteria under the MHA, she said:

> 'That would, yes, that would definitely make me - if I had known that information, I would be more proactive.' [96]

As to the recorded statement that Theo thought that somebody was putting thoughts into his mind, she agreed that this suggested symptomatology of psychosis. She said '*Correct, definitely*'.[97] However, she acknowledged that she had understood from her conversation with Mr Guscott that there were no symptoms of psychosis. But if she had been made aware of that information, this would have impacted on her decision to actually see the patient herself. She agreed that the suggestion that Theo believed that someone was putting thoughts in his mind meant that he needed to be reviewed by a psychiatrist. Indeed, Dr Dham said:

> 'Correct, and it would definitely raise the threshold for the use of the Mental Health Act, definitely.' [98]

7.42. Finally, Dr Dham stated that she had not detected anything to suggest that Mr Guscott's review had been conducted while he had been under pressure for time.[99]

7.43. There is no question but that Dr Dham should herself have seen Theo that day. It represents a serious missed opportunity for Theo to have been properly assessed and treated involuntarily as an inpatient.

[95] Transcript, page 613
[96] Transcript, page 614
[97] Transcript, page 614
[98] Transcript, page 615
[99] Transcript, page 617

7.44. In her affidavit Mrs Papageorgiou asserts that when she spoke to Mr Guscott on 14 January 2016 before he saw Theo alone she had told him that Theo had been expressing suicidal thoughts and relayed to him a number of statements that Theo had made in that regard. She gave evidence on oath to the same effect. I have no doubt that her assertions are correct. It is highly likely that she did say to Mr Guscott that Theo was experiencing suicidal thoughts. That it was understood at the RGH that day that Theo was '*suicidal*' is borne out by the documentation that was raised on his arrival at the hospital. That was the very reason for his presentation that day. Dr Mahajan also recorded this during his own consultation. How that message did not get through to Mr Guscott, and in turn to Dr Dham through him, is astonishing.

7.45. Mrs Papageorgiou also asserted both in her affidavit and in her oral evidence that there was no discussion about Theo being hospitalised or not. There was no mention made of the availability of a bed. She said in her evidence, '*Theo was in such a way that we thought that he would get admitted because of the way he was presenting*'. She states that they were not offered a bed that day and was devastated when she later learned that a bed had been available.[100] Mrs Papageorgiou also asserts that she was not told that Theo had declined admission when spoken to privately by Mr Guscott. She said that if that had been said to her they would have spoken further to Theo about that. Cross-examined by Ms Cliff on behalf of Mr Guscott as to why she herself had not raised the question of admission with Mr Guscott, Mrs Papageorgiou reiterated that she had expected Theo to be admitted, meaning I think without the need for discussion or debate about it. She asserted, '*So, we trusted that the professionals with their experience and insight would have kept Theo in hospital*'. The assertion that Mr Guscott never mentioned the availability of a hospital bed is supported by Mr Papageorgiou in his oral evidence.

7.46. It is difficult to know what really occurred in relation to the issue of Theo's possible admission on this occasion. There cannot be any doubt that there was at least some internal discussion among the clinicians to the effect that Theo would be unlikely to agree to admission without his mother being present and that if he were to be admitted his mother's presence would not be permitted. That this translated into an unstated assumption that Theo's admission as a voluntary patient was out of the question, an assumption based principally on previous experience during Theo's admission in the

[100] Transcript, pages 993 and 998

November, is a possibility. It is also possible that Theo himself resisted the idea when reviewed privately by Mr Guscott, as Mr Guscott has asserted. But I do not believe that Theo's parents flatly refused to allow Theo to be admitted on 14 January 2016. This suggestion seems so unlikely to me that it requires rejection. All of this uncertainty could have been avoided if Dr Dham had herself brought the gravitas of her position as a psychiatrist to any discussion about admission with Theo and his parents. A fully and properly informed Dr Dham would in my view have probably recommended admission, if not detention under the MHA, and as will be seen, the independent expert Dr Naso also opines that detention was a measure that was probably open at that time. I think it highly unlikely that if Dr Dham had seen Theo, and had spoken to his parents about him, she would have countenanced him simply walking away. And Mr Apps for the Papageorgiou family makes a valid point when he argues that if Theo's parents had rejected the offer of admission for their son and if Mr Guscott had considered that hospitalisation was desirable, he could have advocated for that with Dr Dalamagas; he knew that Theo would be seen by his general practitioner later that day.

7.47. Theo did get to see Dr Dalamagas on the afternoon of 14 January 2016. This was the last occasion on which he saw Theo. The record of that consultation[101] appears to have been opened on the recording system at 4:04pm. The recorded reason for contact is simply '*depression*'. Dr Dalamagas gave oral evidence about this appointment.

7.48. It will be remembered that Mrs Papageorgiou had called Dr Dalamagas earlier that day prior to their presentation at the hospital. In his oral evidence Dr Dalamagas told the Court that in that earlier conversation with Mrs Papageorgiou she was worried that Theo was getting worse and was not responding. Dr Dalamagas confirmed that he advised that Theo should be taken to the hospital. Dr Dalamagas then contacted Dr Mahajan. He asked Dr Mahajan to call the mental health team and to get either the mental health nurse or the psychiatrist to review Theo. Later, Mr Guscott phoned Dr Dalamagas. Mr Guscott told him that he had advised admission for Theo but that he had not been admitted. Dr Dalamagas also told the Court that he had spoken to Dr Mahajan.

7.49. At the conclusion of Dr Dalamagas' consultation that afternoon he understood that the care management plan for Theo would involve Theo being reviewed again by the

[101] Exhibit C12, page 41

psychiatrist and have regular follow-up interaction with the mental health nurse and with himself. As indicated, however, this was the last occasion on which Dr Dalamagas saw Theo. It should be recorded that on 21 January 2016 which was three days prior to Theo's death, Theo's father endeavoured to contact Dr Dalamagas about Theo but for reasons that are not clear Dr Dalamagas did not get the message. Dr Dalamagas only became aware of the attempt to contact him after Theo's death.

7.50. At the 14 January 2016 afternoon appointment, at the request of Mr Papageorgiou, Dr Dalamagas created a referral letter to Mr Christopher Hamilton, a psychologist in North Adelaide. In that letter Dr Dalamagas suggested that Theo was presenting with '*? Bipolar disorder*'. He also asserted in the letter that Theo had been hospitalised for delusions. Dr Dalamagas attached various documentation regarding Theo. I will deal with Mr Hamilton's appointment in another section.

7.51. In cross-examination by Mr Apps on behalf of the Papageorgiou family, Dr Dalamagas confirmed that Mrs Papageorgiou had phoned him earlier on 14 January 2016. As a result, he had taken the view that the situation regarding Theo was serious, or at least was more serious than his situation had been to that point. For that reason he had asked them to attend at the ED.[102] So in conjunction with the referral to Mr Hamilton, Dr Dalamagas prepared a mental health plan. Dr Dalamagas also said that by this stage Theo's parents appeared to be frustrated and were trying to find ways to help Theo.

7.52. In further cross-examination by Mr Apps, Dr Dalamagas asserted that in this consultation he asked Theo about suicidal ideation. His response was as always. Theo's responses were negative about actually having a plan. However, Mrs Papageorgiou told him that Theo had said that he wanted to join his deceased grandparents. Dr Dalamagas recalled that Theo was quiet when this discussion occurred and he did not deny that he had said that[103]. It also seems obvious that Theo did not deny this was his current wish.

7.53. In cross-examination by Mr Plummer, counsel assisting, Dr Dalamagas said that his expectation had been that Theo would have been seen by the psychiatrist Dr Dham.[104] He was not so seen.

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[102] Transcript, page 135
[103] Transcript, page 154
[104] Transcript, page 189

7.54. To my mind it is clear that on 14 January 2016 Theo was depressed and was entertaining suicidal ideation that he could not control. Yet he received no meaningful assistance.

8. Theo's presentation at the RGH on Sunday 17 January 2016

8.1. I again refer to the affidavit of Mrs Papageorgiou in respect of Theo's presentation on this occasion. In her affidavit Mrs Papageorgiou states that on 17 January 2016, Theo woke in the early hours of the morning. She and her husband heard him. On investigation Theo was found holding his head against a wall. It looked like he was in severe pain. He said that he did not like the thoughts he was having. He said that he was confused and that he did not know what to do. Theo was distraught, frightened and highly anxious. He also said that he wanted to go into a deep sleep. As a result, Mrs Papageorgiou understandably felt that he needed urgent help. That morning Theo was arranged to call Mr Christopher Hamilton, a psychologist in Adelaide. As I understood the evidence, there was already in existence an appointment for Theo to see Mr Hamilton. Theo would see Mr Hamilton in Adelaide in the next few days. I will deal with Mr Hamilton's evidence separately. Mrs Papageorgiou's observation was that during this phone conversation on 17 January 2016, Theo was not making any sense and seemed unable to comprehend what Mr Hamilton was saying to him. Mrs Papageorgiou says that she spoke to Mr Hamilton herself and he told her to take Theo to the ED. She also rang Beyond Blue and the Remote and Rural Health lines who also provided advice that Theo should be taken to hospital. So Mr and Mrs Papageorgiou took him to the RGH where they had been three days earlier. They even packed a bag for Theo in anticipation of his admission there. I accept all of Mrs Papageogiou's evidence as described in this paragraph.

8.2. At the RGH they were seen in the ED by the duty doctor, Dr Sivarajah, who was a general practitioner. Mrs Papageorgiou asserts that she explained to Dr Sivarajah that Theo had presented three days prior to this at the ED and that she felt that his symptoms had increased in severity. She asked that Theo's medications be reviewed given that she thought that they were causing those symptoms. She recalls asking whether Theo needed to be admitted to the hospital. She states that she was bitterly disappointed by the way Theo was dealt with given that it was clear he was presenting with some very severe symptoms. She had expected him to be admitted. I have accepted that evidence.

8.3. I turn now to Theo's presentation to Dr Sivarajah.

8.4. Once again the admission documentation regarding Theo is telling. The reason for attendance was recorded in terms of Theo having racing thoughts with a shorthand symbol to suggest that the thoughts were escalating or had escalated. It was also recorded that it was said that Theo '*...just can't deal with life at the moment*'.[105] The documentation also records the fact that Mrs Papageorgiou that day had been in contact with the psychologist with whom they had an appointment on 20 January 2016. It also records the advice that they bring him to hospital.

8.5. The progress notes of Dr Sivarajah record that he saw Theo at approximately 4:16pm that day. It was a Sunday. It was recorded that '*he had the thought that he shouldn't be here*'.[106] Dr Sivarajah also recorded that Theo was unable to switch off his thoughts and that he was apologising to his family for his previous faults. It was recorded that '*He thinks he is hearing voices*'. It is noteworthy that this aspect of the notes is recorded in the present tense. Dr Sivarajah recorded, '*No suicidal thoughts/thouhghts (sic) to harm himself*'. It was also recorded that he '*Declined*' suicidal and harming thoughts to others. There is no record as to the nature of the voices that Theo was hearing and in particular whether the voices were speaking generally, speaking to him or whether they involved any ideation of harm.

8.6. Dr Sivarajah provided a statement to the inquest[107] and gave oral evidence. Dr Sivarajah obtained his medical degrees in Sri Lanka in 2003. He worked as a doctor in Sri Lanka until 2008. He emigrated to Australia in May 2009. In 2011 he commenced work at the Renmark Medical Clinic. He also performed his duties as a medical practitioner at the Renmark Paringa Hospital and at the RGH. He obtained his Fellowship from the Royal Australian College of General Practitioners in 2015.

8.7. Dr Sivarajah's statement contains an expansion of his progress notes. His statement and his oral evidence are that he reviewed the hospital records in respect of Theo's attendance three days earlier on 14 January 2016. He also saw the nursing staff record in relation to Theo's triage earlier that day.

8.8. Dr Sivarajah states that when he recorded that Theo said that '*he shouldn't be here*' it was meant to convey that Theo was expressing a view that he did not need to be seen. The reference to Theo thinking that he is hearing voices was meant to represent a past

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[105] Exhibit C17, page 101
[106] Exhibit C17, page 103
[107] Exhibit C35

history of hearing voices in the context of the psychotic patient. Dr Sivarajah asserts that his usual practice would have been to explore this aspect in the course of his mental state examination. He states that his notes are consistent with a conclusion that Theo was not hearing voices or hallucinating at the time of his examination. Indeed, the way Dr Sivarajah interprets his own notes as reflected in his witness statement, would almost suggest that Theo's presentation before him had no point at all, which is completely incongruent with the description of Theo as described by his mother and the reason for their attendance at the hospital that day.

8.9. Dr Sivarajah's statement goes on to say that he did not consider that there was any immediate risk of self-harm or harm to the community involving Theo. His assessment of Theo was that he did not require detention or admission to hospital. There was no evidence of severe psychosis and he was comfortable in discharging him into the care of his family, knowing that further review by other practitioners was scheduled. He said his usual practice is to check with the parents of the patient to establish that they are happy to take their child home. If there was any reluctance or concern expressed by the parents he would have noted it and there would have been a discussion about it with the parents.

8.10. In his oral evidence Dr Sivarajah confirmed his view that Theo had not been a detainable person. He observed that Theo was due to see a mental health nurse in the next day or so and was going to see a psychologist all of which of course was true. There was also the protective factor of his parents' support.[108]

8.11. Mr Apps naturally cross-examined Dr Sivarajah about the information that Theo's parents could have provided or did provide. The questions that Mr Apps posed in this regard elicited answers from Dr Sivarajah that he could not recall that Theo's parents had said that they were so worried about Theo that they were not sleeping; he could not recall whether they had told him that Theo had been holding his head and leaning against the wall; he did not recall whether they had told him that Theo did not like the thoughts that he was having; and he said he could not recall whether he had been told that Theo wanted to go into a deep sleep. Mrs Papageorgiou's evidence is that she explained to Dr Sivarajah the details of what Theo had earlier been saying to his parents. Dr Sivarajah did agree that Mrs Papageorgiou had said that they had brought Theo to

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[108] Transcript, page 625

the ED because the psychologist had told them to do so.[109] Dr Sivarajah said that he could not recall what Theo's parents had told him because he did not write anything down. He said, '*My main assessment depends on that* (sic) *Theo talked to me*'.[110] With respect, that is not correct. In order to make a proper assessment of Theo there was a need for Dr Sivarajah to obtain as much information as possible from the parents and to document it.

8.12. Dr Sivarajah also said that he did not recall whether Theo's mother told him that Theo had spoken about joining his deceased grandparents. He acknowledged that if he had been told that it would have caused him some concern. He said that this was so because they can assess psychotic symptoms. As well, this might be suggestive of suicidal thoughts.[111] It will be remembered that Dr Sivarajah recorded in his notes that Theo had no suicidal thoughts or thoughts to harm himself or others.

8.13. In his evidence Dr Sivarajah said Theo did not fulfill the criteria for admission to hospital. He placed Theo in the '*low–risk category*'.[112]

8.14. However, Dr Sivarajah acknowledged that three days earlier Dr Mahajan had recorded that Theo had ideas to harm himself and could not control his thoughts.[113] Dr Sivarajah had read that in Dr Mahajan's record. However, given that Theo did not mention anything about that to him on 17 January 2016, his impression was that Theo had improved since 14 January 2016.

8.15. In his oral evidence Dr Sivarajah reiterated that the hearing of voices was by way of history only.[114] Dr Sivarajah rejected the notion that Theo might not have been hearing voices at the time of his examination because he was distracted by the process of that examination. That said, he acknowledged that people who say that they have been hearing voices do not necessarily hear voices all of the time.[115] Dr Sivarajah acknowledged, therefore, that even if Theo had not been hearing voices during the actual consultation, he may have been hearing voices earlier in the day. When asked whether he had asked Theo what the voices were saying to him Dr Sivarajah said '*I*

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[109] Transcript, page 628
[110] Transcript, page 627
[111] Transcript, page 629
[112] Transcript, page 633
[113] Transcript, page 633
[114] Transcript, page 634
[115] Transcript, pages 634-635

should, but I didn't write it down in my notes…'.[116] Dr Sivarajah added that he could not recall. He was asked by me;

> 'Q. Wouldn't the voices and what they were saying be important enough for you to write that down in the notes.
>
> A. Yeah, that's right, Honour.
>
> Q. How do you know the voices weren't telling him to kill himself.
>
> A. Yeah, that's right.' [117]

8.16. Asked by Mr Apps as to whether it had occurred to him that Theo might benefit from obtaining a second opinion from a psychiatrist, Dr Sivarajah said that in his clinical judgment Theo was not going to be harming himself. As well, three days earlier the psychiatrist and mental health unit had decided not to admit Theo to hospital.[118]

8.17. In paragraph 25 of Dr Sivarajah's statement he asserts that his usual practice was to check with the parents that they are happy to take their child home. When asked as to whether he had checked with Theo's parents to see whether they were happy to take him home, Dr Sivarajah was somewhat evasive. At first he responded by saying that if the parents were reluctant he would definitely make a note of that. When further asked whether he had asked the parents about this issue he said, '*Yeah I should, but I didn't mention it there*'.[119] When asked for a third time he said that he could not recall anything at this stage but reiterated it was his usual practice. It would seem odd that if Theo's parents had been asked in accordance with Dr Sivarajah's usual practice whether they were happy to take their son home that they would have answered affirmatively without expressing any further concern. This is so having regard to Mrs Papageorgiou's evidence about Theo's condition that morning and the reason they brought him yet again to the ED, evidence which I accept. That they would have responded in such a manner is highly improbable. So much so that I reject any suggestion that they would have responded in such a way. It is improbable that they were even asked about whether they were happy to take Theo home.

8.18. In cross-examination Mr Plummer asked Dr Sivarajah why he did not contact the CMHT and ask them to review the patient. His answer was that they were going to

[116] Transcript, page 635
[117] Transcript, page 635
[118] Transcript, page 636
[119] Transcript, page 638

review him in one day's time and that he was confident that Theo was not in danger.[120] Pressed by Mr Plummer, Dr Sivarajah agreed that in the future he would do something by way of contacting the CMHT.[121] It must be understood, however, that it being a Sunday the members of the CMHT would not necessarily have been available. Dr Sivarajah agreed that with the benefit of hindsight he should have contacted the ETLS telephone service.

8.19. As to the compilation of a risk assessment form, a document that Dr Mahajan three days earlier had compiled, Dr Sivarajah acknowledged that he did not complete such a form but insisted that he had asked all the appropriate questions, such as questions related to suicidal ideation. When asked about other proforma documentation prepared by nursing staff that had included reference to Theo's assertion that he just could not deal with life at the moment, and whether that comment had concerned him as far as Theo's suicidality potential was concerned, Dr Sivarajah said it would place him in the low category.[122]

8.20. Dr Sivarajah agreed with Mr Plummer that when Theo stated that he should not be here, he could have meant that he was entertaining thoughts consistent with suicide; that is to say that he should not be here on earth.[123] Dr Sivarajah agreed that when coupled with his statement to the nursing staff that he could not deal with life at the moment, this appeared inconsistent with the statement that he had no suicidal thoughts or thoughts to harm himself.[124]

8.21. As to the note that Dr Sivarajah made as part of his management plan that he gave Theo a motivational talk, Dr Sivarajah explained that this was designed to increase Theo's positivity of his life. The only other part of his management plan was to advise Theo to take half a dose of lorazepam if he felt sleepy during the day.

8.22. Asked about whether he had considered offering Theo voluntary admission to the hospital, Dr Sivarajah said that he did not offer Theo admission. He could not recall anything that he had asked about that. He did not offer admission because of Theo's and his family's willingness to seek help and because Theo was happy to follow the plan as it existed. He agreed that Mrs Papageorgiou had explained to him that Theo

[120] Transcript, page 648
[121] Transcript, page 650
[122] Transcript, page 654
[123] Transcript, page 654
[124] Transcript, page 655

had presented three days earlier and that she felt his symptoms had increased in severity.[125] However, he could not recall if she had asked whether Theo needed to be admitted to hospital. He did not know whether, or notice whether, the Papageorgiou's had brought an overnight bag for Theo.

8.23. Further examination of Dr Sivarajah elicited that he did not recall whether he had asked Theo when he had last experienced suicidal thoughts but agreed that it would have been pertinent and relevant to have established how recently he had experienced such thoughts.[126] It was possible that he had been experiencing those thoughts the day before he came to hospital. When asked whether he had established whether or not Theo had experienced suicidal thoughts earlier in the day, he said he could not recall but that is what he would normally ask. He said he could not recall what Theo had said if anything as far as his most recent episode of suicidal ideation was concerned.[127] Dr Sivarajah said that he had no recollection of whether Theo had entertained a plan to commit suicide, although he said he thought he should ask such a question but that they do not write all the answers down. Dr Sivarajah could not recall whether he had asked Theo if he had contemplated any method of suicide, whether he had any reasons to live or what he had said, if anything, about his life plans.

8.24. Dr Sivarajah rejected the suggestion that his assessment of Theo had been inadequate.[128] To my mind it was inadequate, and his documentation of his assessment was inadequate.

9. <u>The events of 19 January, 20 January and 21 January 2016</u>

9.1. On 19 January 2016, the CMHT registered nurse, Ms Hogan, met with Theo at his mother's place of work in Renmark. At this meeting there was discussion about Theo's recent presentation to the ED. During her assessment Ms Hogan noted that Theo presented as more depressed, which was the opposite of what his presentation had been when he had first entered the mental health unit. It was decided that Theo would be called weekly and a home visit would be conducted fortnightly.

[125] Transcript, page 658
[126] Transcript, page 661
[127] Transcript, page 661
[128] Transcript, page 663

9.2. Then there was the appointment with Mr Hamilton on 20 January 2016 that I will deal with in the next section.

9.3. On 21 January 2016 Mrs Papageorgiou observed that Theo had awoken with pain, anxiety, frustration and suicidal thoughts. It was on this occasion that they attempted to contact Dr Dalamagas unsuccessfully. There is a record of a telephone call to the ETLS made by Mrs Papageorgiou on this day stating that Theo was having panic attacks with suicidal ideations on a daily basis. It was recorded that Theo just wanted to sleep and not wake up. It was asserted by members of the CMHT that they were not aware of this prior to Theo's death. In any event, a clinical meeting of the CMHT was held on 21 January 2016. This was the day before Dr Dham was due to conclude her locum placement. Dr Dham attended this meeting. At the meeting Ms Hogan spoke about Theo's recent attendance on 17 January 2016. In her statement Dr Dham asserts that this was described to her in terms similar to those in respect of the earlier presentation on 14 January 2016. Dr Dham was told that on this most recent presentation there had been no psychotic symptoms reported and was also told that Theo had denied intent or plans of self-harm. However, Dr Dham expressed concern that Theo had presented to the ED on more than one occasion in the previous few days. She asserts that she suggested that they should either admit Theo as a voluntary patient or under the MHA if he met the criteria. She was told that he did not meet the criteria. Nevertheless, Dr Dham asserts that she felt that a review by a psychiatrist was warranted in order to obtain a clearer picture of Theo's symptoms and with consideration being given to alternative treatment or even detention under the MHA. Dr Dham had some urgent outpatients booked for review on that day apart from her inpatient reviews. She also needed to complete paperwork for inpatients prior to her departure on 22 January 2016. It was decided that an appointment would be arranged with Dr Gupta. To this end Dr Dham spoke with Dr Gupta on the phone and asked him if he could accommodate a review of Mr Papageorgiou the following week when he was next in Berri. She told Dr Gupta that it appeared that the most recent episode was different and could have involved bipolar depression, with further consideration being given to a mood stabiliser. Dr Gupta agreed to review Theo. The other alternative would have been to arrange a tele-review with a psychiatrist in Adelaide which could usually be organised within 24 – 48 hours if urgent. The feeling of the team, however, was that the risks were not immediate and that Theo did not meet the criteria under the MHA. In the meantime Dr Dham suggested that they closely monitor Theo's

symptoms and to encourage admission or watch for the need to use the MHA. Dr Dham completed her tenure at Berri on Friday 22 January 2016 and returned to Canada.

9.4. It will be noted that Dr Naso, the independent psychiatrist, was of the view that Theo should have been detained on 17 January 2016. It will also be noted that all of these considerations and prognostications that occurred between Theo's presentation on 17 January 2016 and the meeting of 21 January 2016 were all conducted in the absence of Theo himself.

10. The consultation with Mr Christopher Hamilton, psychologist, on 20 January 2016

10.1. Mr Hamilton has practised as a psychologist since 1973. He practises from rooms in North Adelaide. Mr Hamilton provided to the inquest a witness statement and other relevant documentation. He also gave oral evidence.

10.2. Mr Hamilton confirmed that Theo was referred to him by Dr Dalamagas and that he saw Theo on Wednesday 20 January 2016 in his rooms at North Adelaide.[129]

10.3. It will be remembered that Mrs Papageorgiou's evidence was that prior to attending at the RGH ED on Sunday 17 January 2016 a telephone conversation had been conducted with Mr Hamilton. The referral from Dr Dalamagas had been communicated by fax to Mr Hamilton three days earlier on Thursday 14 January 2016. In the telephone conversation of 17 January 2016 Theo himself had spoken to Mr Hamilton and according to Mrs Papageorgiou he had not made any sense. Mrs Papageorgiou spoke to Mr Hamilton herself and was told to take Theo to the ED which she did. In his witness statement Mr Hamilton makes no mention of this telephone conversation. In his oral evidence he maintained that he had no recollection of any such conversation. I have found that the conversation took place. Its significance will be discussed in a moment.

10.4. Mr Hamilton told the Court that the 20 January 2016 consultation took approximately 45 minutes. Mr Hamilton was examined on the content of some handwritten notes that he had made at the time. The notes included reference to Theo's acknowledgement that he had taken ice in the past, to his assertions that his mind had become somewhat unstable, that he was worried about his future and that from time to time had thought

[129] Exhibit C36

that he did '*not necessarily want to be here*'. Interestingly, this is an expression strikingly similar to the expression he had used during his consultation with Dr Sivarajah at Berri three days earlier on 17 January 2016. Theo told Mr Hamilton that he had wondered whether he had damaged part of his brain with drug taking; he was finding it increasingly difficult to apply common-sense to anything. Theo said that he was hoping to get better but that he could not see this happening. He said '*sometimes it felt like it was winter everyday*'.

10.5. In his evidence Mr Hamilton acknowledged that he had been aware that Theo had been the subject of an ITO at the Berri hospital but said that he was unsure as to whether he had been aware of the presentation to the Berri ED three days prior on 17 January 2016.

10.6. As to suicidal ideation, Mr Hamilton said this was not apparent on the day of his consultation. He said that at no stage did Theo indicate a specific suicidal ideation, although he was certainly upset and worried about his past and his present and was anxious about his future. Mr Hamilton said '*he gave me no specific indications on that day by any of the content of what he said that he had suicidal thoughts at that stage*'. When asked by Mr Plummer of counsel assisting as to whether he had specifically asked Theo about thoughts of suicide, Mr Hamilton said that he probably would have done so but could not recall whether he had asked him that. He said that he commonly would ask that question of patients as it is part of '*my standard protocol*'.[130]

10.7. It is common ground in the evidence as between Mr Hamilton and Theo's parents that Theo's parents did not spend much time in the consultation room. However, according to Mr Hamilton's witness statement which was taken on 1 June 2020, at the conclusion of the consult he communicated with Mr and Mrs Papageorgiou regarding his concerns about the mental health of Theo '*…and strongly recommended that they take him to emergency*'.[131] In his oral evidence Mr Hamilton explained that he had noticed reference in documentation provided by Dr Dalamagas to suicidal ideation and fleeting thoughts of the same but that there had been no current plan or intent and that there was no risk to others. However, out of an abundance of caution he said that he recommended to Theo's parents that they take him to hospital after the appointment. He said that he did this because they could check for any potential or current drug use. They could also review his medications as Mr Hamilton as a psychologist was not

[130] Transcript, page 675
[131] Exhibit C36, paragraph 7

qualified to do this. In addition, Mr Hamilton said that he thought that prior to Theo returning to see him a few days later, a presentation to hospital would provide '*continuity of support*' and psychiatric access to support.[132] In fact Mr Hamilton said that he '*strongly encouraged*' Theo's parents to take him to hospital in order to obtain ongoing support.[133]

10.8. In examination by Mr Plummer, Mr Hamilton said that he did not necessarily infer that Theo might be having suicidal thoughts from utterances such as that he did not want to be here and that he could not see himself getting better despite his hopes in that regard. He was not alarmed by any of this to the point that he thought that Theo might be having suicidal thoughts. If he had thought that Theo was having such thoughts and that they were immediately and manifestly obvious, he would have made sure that his parents took him immediately to Emergency. This of course is what he actually had said in his witness statement, namely that they take him to Emergency due to his concerns regarding Theo's mental health.

10.9. On a number of occasions in his evidence, Mr Hamilton suggested that his recommendation that Theo be taken to hospital was made on the basis that he would be provided with continuity of care and support, and also just to be on the safe side.[134]

10.10. Mr Hamilton acknowledged that he did not contact any hospital in respect of any recommendation that he made.[135] He rejected the suggestion put to him by Mr Plummer that his recommendation was based on an assessment that Theo was suffering from suicidal ideation. He could not recall saying to Mr and Mrs Papageorgiou, as asserted by Mrs Papageorgiou in her affidavit, that he had said to Theo that Theo had dug himself into a hole.

10.11. Mrs Papageorgiou also asserts that she did not recall Mr Hamilton saying anything to the effect that they should take Theo to hospital. She asserted that if that had been said she and her husband would have done that. I asked Mr Hamilton whether it was possible that Mr Hamilton's mindset was that he had strongly recommended that they

[132] Transcript, page 677
[133] Transcript, page 677
[134] Transcript, page 680
[135] Transcript, page 682

take Theo to an ED in Adelaide because of the urgency of his situation. To this he said he did not recall that.[136]

10.12. In cross-examination by Mr Apps of counsel for Mr and Mrs Papageorgiou, Mr Hamilton acknowledged that it was possible that Mrs Papageorgiou had phoned him on 17 November 2015 saying that she believed her son was suicidal and asked what she should do.[137] In further cross-examination Mr Hamilton referred to fleeting thoughts of suicidal ideation as had been described by Dr Dalamagas. He did not recall being advised of the 14 January 2016 presentation at Berri Hospital either, which was the day that Theo had seen Dr Dalamagas and which was the date on the referral documentation sent by Dr Dalamagas.

10.13. When asked by Mr Apps as to why Mr Hamilton had not seen Theo's parents separately from Theo and had asked them for their perspective, he said that there was no particular reason. Theo had been brought to see him, he obtained some background and he wanted an objective indication of Theo's psychological status.[138]

10.14. Mr Hamilton was questioned by me in relation to his recommendation that Theo be taken to hospital. Mr Hamilton said in response to these questions that there was no particular urgency about this and he contemplated that the hospital ED could either be in metropolitan Adelaide or in the Riverland. He had not been specifically concerned about Theo's potential for self-harm but reiterated that he wanted there to be continuity of service and assistance and that was why he had recommended that Theo's parents take him to some form of further hospitalisation prior to the next appointment with him. Pressed as to whether he had or had not recommended Theo being taken to an ED because of the concern that he had entertained about potential level for self-harm, Mr Hamilton said that he had no evidence that that was the case. When pressed again about that issue Mr Hamilton was adamant that he did not recommend Theo being taken to an ED because of a concern for self-harm. These assertions flew in the face of the contents of a letter that in March 2020 he had written to Detective Brevet Sergeant Bussenschutt, the investigating SAPOL officer in respect of Theo's death.

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[136] Transcript, page 684
[137] Transcript, page 686
[138] Transcript, page 693

Mr Hamilton's letter was in response to certain written questions that the detective had posed to him about his examination of Theo. Question 4 was as follows:

> 'Were immediate risk factors apparent and, if so, who did he contact in relation to their management?'

The answer as contained in Mr Hamilton's letter in reply was as follows:

> 'As a treating practitioner I was concerned about his potential level for self-harm and advised his parents to take him to an emergency department immediately after they collected him following his appointment with me.' [139]

10.15. This recommendation or exhortation to Theo's parents was denied by Mrs Papageorgiou. However, what Mr Hamilton stated in this answer is highly reminiscent of the telephone conversation that Mrs Papageorgiou said she had with him on 17 January 2015 as a result of which she did take Theo to an ED, namely at the Berri Hospital.

10.16. In the event I was unable to reach any safe conclusion as to what Mr Hamilton had made of Theo's risk of self-harm during his consultation of 20 January 2016. On careful reflection it is possible that in providing Mr Bussenschutt with the above answer he has transposed his thought processes from the phone conversation that he conducted with Mrs Papageorgiou on 17 January 2016 and it was on that occasion that he had been concerned enough about Theo to recommend to his parents that they take him immediately to ED, which they did.

10.17. It is difficult to see what therapeutic benefit, if any, was afforded to Theo in his consultation with Mr Hamilton. I have no doubt that Mrs Papageorgiou is correct in her affidavit when she asserts that after Mr Hamilton's consultation Theo was clearly sad and seemed to have lost all hope. '*He appeared to be completely hopeless and demoralised*'.[140]

11. <u>The evidence of Dr Maria Naso – independent psychiatrist</u>

11.1. Dr Maria Naso is an independent psychiatrist working within the public sector. She provided a written overview and opinion regarding Theo's care and treatment. Dr Naso also gave oral evidence in the inquest. Dr Naso is an experienced psychiatrist who has

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[139] Exhibit C20, letter dated 30 March 2020

[140] Exhibit C6, paragraphs 117-118

given evidence in this Court on a number of occasions. She is a legally qualified medical practitioner and a specialist psychiatrist. She has been a Fellow of the Royal Australian and New Zealand College of Psychiatrists since 2002. She has been employed as a senior staff psychiatrist at the Modbury Hospital where she provides a service to the ED of that hospital and is responsible for the Consultation Liaison Service. Dr Naso has provided psychiatric opinions for AHPRA and for the State Coroner. Dr Naso also conducts a private practice in association with Unicare where she assesses and manages students referred to her from the Adelaide University. She is a member of the South Australian Parole Board and is a committee member of the Borderline Personality Disorder Foundation.

11.2. Dr Naso gave evidence in relation to a number of broad areas relating to Theo's care including as follows;-

- Theo's diagnosis and care in the period from late 2014 to early 2015;
- The accuracy of Theo's diagnosis during and following his detention in November 2015;
- Theo's detention, treatment and care at the RGH in Berri in November 2015;
- The appropriateness of the revocation of Theo's ITO and his discharge from hospital on 1 December 2015;
- The quality of Theo's care in the community following his discharge from hospital;
- Whether Theo's care on his presentation to the RGH on 14 January 2016 was appropriate, and in particular whether he should have been admitted as an inpatient on that occasion;
- Whether Theo's care on his presentation to the RGH on 17 January 2016 was appropriate, and in particular whether he should have been admitted as an inpatient on that occasion;
- Whether the care provided by the CMHT on 19 January 2016 was appropriate;
- Whether Theo's medication regime as it existed from time to time was appropriate;
- Whether Theo's death could have been prevented.

11.3. Dr Naso's opinions are expressed both in her original report[141] and in her oral evidence.

11.4. In her report Dr Naso observed that in November 2014 when Theo was seen by his usual GP Dr McLeod, he had presented with hypomanic symptoms including restlessness, pressured speech, elevated mood and with possible psychotic features including beliefs about premonitions. There was also an issue surrounding Theo's stated use of methamphetamines which Dr McLeod, in his referral to psychiatrist Dr Warhurst, postulated had triggered Theo's seeming bipolar disorder with hypomania.

11.5. Dr Naso also noted Dr Dalamagas' initial involvement in March 2015. As well, she noted that Dr Dalamagas had observed that in November 2015 Theo was paranoid of people and situations and that he had earlier referred Theo to Dr Gupta who saw and detained Theo but not until that November.

11.6. Dr Naso expressed the opinion that Theo's presentation particularly as revealed to Dr McLeod in November 2014 had given rise to a suspected episode of psychosis. The information surrounding the events in November 2014 and which would have been available a year later when Theo was evaluated at that time, were of some significance. Dr Naso was of the view that when Theo came to be assessed in November 2015 his assessment was based on what she termed '*cross-sectional information*'.[142] This meant that at that time it appeared as if Theo was presenting with psychotic symptoms for the first time which is a quite different scenario from having a past history of psychosis with the potential for a manic overlay. Dr Naso said that the treatment pathway is different where the diagnosis is not a first episode psychosis as was made by Dr Attanayake. Rather than being a first episode psychosis, Theo's diagnosis in November 2015 was potentially that of a person who had experienced a relapse of an already existing psychotic illness.[143] For my part it is not difficult to see why this distinction would be of some importance, particularly in relation to an assessment of the risk of relapse or deterioration. Dr Naso suggested that regard should have been had to Theo's earlier presentations in late 2014. Those earlier presentations had significance in terms of Theo's care. Dr Naso believed that when Theo was assessed and detained in November of 2015 he was not exhibiting a first episode psychosis. This

[141] Exhibit C47
[142] Transcript, page 903
[143] Transcript, page 903

of course is contrary to the diagnosis or impression arrived at by Dr Attanayake. Dr Naso stated as follows:

> 'Firstly, the fact that it was no longer a first episode psychosis. Secondly, the significance of that is that it's a different trajectory. The management plan for someone who presents with first episode psychosis, versus someone who we believe has a bipolar disorder, is going to be different. And that includes aspects of management plan in terms of the medications, and early warning signs, relapse. You have to be able to tell families what to look for, with the potential for relapse. And if you're not aware that there's a potential for a manic involvement, then families aren't going to necessarily be alerted that that's a red flag to early relapse.' [144]

As well, Dr Naso suggested in her report that if Dr Attanayake had explored the events of 2014 he would not have diagnosed Theo with a first episode psychosis and would have been aware that Dr McLeod had been considering a diagnosis of bipolar disorder. She suggested that Dr Attanayake had missed important past information that would have alerted him to the likelihood that when Theo was commenced on Effexor it triggered another manic episode with psychosis. On his admission to the RGH, Theo should have been treated with a mood stabiliser in addition to an anti-psychotic. This was due to the fact that he was presenting with symptoms both of psychosis and hypomania which can commonly give rise to the development of a depressive disorder following a remission of hypomania. In her evidence Dr Naso said if a patient has a bipolar mood disorder one would never prescribe an anti-depressant without mood stabilisation cover; she said '*It's way too risky, because it can trigger significant mania, plus psychosis*'.[145] Thus, Dr Attanayake would have needed to know all of Theo's history to have been able to properly diagnose his condition and to decide which medications to place him on when he ultimately presented to hospital.

11.7. Indeed, Dr Naso stated in her evidence that having regard to all of his longitudinal history, Theo's course of illness was quite predictable. She said that he had presented with what was initially considered to be a drug induced psychosis. However, clearly his presentation had not been that because after three months Theo's symptoms were still in existence. Dr Naso also postulated that the drug Effexor probably brought on manic or mixed affective symptoms which had manifested itself in Theo's speeding

[144] Transcript, page 913
[145] Transcript, page 914

episode. She stated that following a manic illness with psychosis people '*…can have an incredibly severe depressive illness after that first manic illness*'. She said:

> 'Once that resolves then what you are left with is a patient who is intelligent with insight, looking back and feeling a sense of shame and failure which makes the depressive symptoms even worse and that's what I saw happen with Theo, but I would have predicted that given the manic illness.' [146]

11.8. It will be remembered that Dr Attanayake acknowledged in his own oral evidence that when assessing Theo it would have been important to know of his symptoms of mania in the year prior to Dr Attanayake first seeing him in November 2015.[147]

11.9. One matter that Dr Naso did emphasise was that an important issue surrounding management of a patient such as Theo, is the determination of risk. One cannot determine risk unless one has collateral information and the patient's longitudinal history '*…because that is what will give us the best prediction of the illness trajectory*'.[148]

11.10. I accept Dr Naso's evidence regarding Theo's diagnosis. To my mind when Dr Attanayake assessed him in November 2015, his diagnosis that Theo was experiencing a first episode psychosis was an incorrect diagnosis. It failed to properly take into account Theo's longitudinal history. The missed diagnosis had significant consequences. It was ultimately Dr Naso's opinion that by the middle of January 2016, at a time approximately a week before Theo took his own life, he was presenting with symptoms that were consistent with depressive symptoms as well as with persecutory beliefs. There was also evidence of some hypomania and some grandiosity. It was at that point that Theo was transitioning along to a '*full on depression*'.[149]

11.11. In short, Dr Naso was of the opinion that Theo's presentation from November 2015 onwards and his diagnosis was not a fully informed one having regard to his earlier presentations in late 2014 and early 2015. This in turn had adverse consequences in terms of his medication. And it was predictable that Theo might experience an episode of depression.

[146] Transcript, page 917
[147] See paragraph 5.25 herein
[148] Transcript, page 960
[149] Transcript, page 921-922

11.12. Regarding Theo's detention under the MHA, in her report Dr Naso stated that in November 2015 Theo had appropriately been placed on the ITO as he fulfilled all criteria under the MHA. She noted Dr Gupta's observation that Theo might need treatment in a closed psychiatric unit in Adelaide given his threatening behaviour when placed on the ITO.

11.13. Dr Naso opines that on the day that Dr Attanayake reviewed the imposition of the ITO, which was 25 November 2015, he had documented a thorough review of Theo in the casenotes. However, as seen, she observes that based on Theo's previous presentations, in her opinion the diagnosis of a first presentation psychosis was incorrect.

11.14. Both in her report and in her evidence, Dr Naso states her opinion that during Theo's hospital admission, it was apparent that staff were unable to form a therapeutic relationship with him. She acknowledged that Theo's parents were without a doubt supportive and caring and had been heavily involved in Theo's care. Such support she said was '*…incredibly invaluable*'.[150] Dr Naso was naturally asked about her view of the presence of Theo's mother on the ward and whether that would have had any therapeutic effect. Dr Naso suggested that from what she could gather from reading the progress notes and from examining documentation compiled by the nursing staff during Theo's admission it appeared that the nursing staff were having difficulty directly engaging with Theo beyond the superficial provision of medication and asking him how he was. She said it was important for hospital staff to have built a rapport with him. She believed that there had been instances where the opportunity for engagement had been potentially lost.[151] Dr Naso added that it appeared that the nursing staff had been spending a reasonable amount of time supporting the family without necessarily being able to '*…get to the bottom of what was going on with Theo*'.[152] Dr Naso suggested that the ability to develop rapport with a patient who has a psychotic illness with persecutory beliefs is absolutely vital. It would have been particularly important in Theo's case where he had a tendency not to trust people apart from his immediate family.

11.15. As to why Dr Naso believed that the assessments of Theo while under detention were superficial, she said that Theo had presented with florid psychotic symptoms requiring

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[150] Transcript, page 904
[151] Transcript, page 904
[152] Transcript, page 904

heavy use of anti-psychotic and sedating medication. '*Then by some miracle on day six everything's okay*'.[153] However, the documentation suggested that Theo was presenting as guarded. He refused to fill out one of the discharge care plans as if to suggest that there was some ongoing paranoia operating. He said that he had '*lots of plans*' [154] which if anything was potentially a red flag. In respect of this aspect of his presentation Dr Naso said:

> 'Now I'm not saying that that all necessarily means that, yes look, he was definitely unwell, but it definitely is something which an experienced psychiatrist would be thinking, you know, what's going on here, after six days we had a man who we were potentially going to send to a closed bed on day one and now, on day six, everything somehow is not detectible (sic). So that's why I say that because of the lack of rapport and therapeutic engagement the assessments when (sic – should be '*were*') superficial.' [155]

So, Dr Naso suggested that at the time of discharge, Theo was still psychotic with mood symptoms but was presenting well. It appeared to her that the clinicians were reluctant to engage with Theo as it may have agitated him.[156]

11.16. In cross-examination by Mr Apps of counsel for Theo's family, Dr Naso agreed that the presence of members of Theo's family while he was detained in the mental health unit of the RGH may have impeded a reliable assessment of Theo's condition.[157] This in turn may have meant that any decision to discharge Theo ultimately may have been faulty.

11.17. Dr Naso in her report opines that given that the staff were unable to engage therapeutically with Theo, and where the patient was as guarded as he had been, it would have been difficult to elicit evidence of psychotic thinking. She said that Dr Attanayake needed to consider extending the detention for a maximum of a further 42 days under what would have been a level 2 ITO with the likely outcome that Theo would have become angry with the potential need for closed bed intervention. While she agreed in her report that from what Dr Attanayake had documented, Theo had in fact been presenting as '*well*' and on that basis would not have fulfilled the criteria for a level 2 ITO, from her experience it was highly likely that on discharge Theo in reality was still psychotic with mood symptoms. This was evidenced by Theo refusing to comply with the nursing discharge plan and saying that he had '*lots of plans*'. This

[153] Transcript, page 905
[154] Transcript, page 905
[155] Transcript, page 905
[156] Transcript, page 906
[157] Transcript, page 957

pointed to the possibility of ongoing hypomanic symptomatology which was not explored. Dr Naso expresses the view that staff had been unable to form a therapeutic relationship with Theo and that this had inhibited the exploration of relevant issues with him.

11.18. I questioned Dr Naso about Theo's prescient assertions on 29 November 2015 that he was going home tomorrow after he had seen the doctor and whether there had been any significance in them. Dr Naso suggested that his boastfulness tended to reflect that there had never been a level of challenge with Theo during his admission. Theo was a large man and had the ability to become highly agitated. Telling the nursing staff that he would be going home tomorrow could have resulted in the nursing staff continuing with the way they had apparently been treating him throughout his admission which was not to challenge him. Dr Naso agreed with the proposition that if Theo was voicing an expectation that he would be discharged, it was always going to be difficult not to meet that expectation. If on the following day his expectations had not been met, distress, trauma and agitation giving rise to a very unpleasant situation may have been anticipated. I asked Dr Naso whether Theo possibly had an intention to manipulate the doctor the following day so as to bring about an outcome where he would be discharged, and/or whether his assertion suggested that he might conduct himself in a way that would bring his expectation to fruition. To this Dr Naso observed that Theo was an intelligent man who would have known what had landed him in hospital, namely voicing numerous delusional beliefs and being agitated and upset. Dr Naso believed that because Theo did not want to be in hospital he was able to cover his symptoms such that if he were to be asked directly whether he had any fears he would not give an affirmative answer because that would potentially see him being detained for a longer period of time and in particular on a level 2 ITO that would involve his transfer to Adelaide. Dr Naso agreed with the suggestion that it would have been helpful for Dr Attanayake when seeing Theo to have been told of Theo's assertions about his predictions of going home of the day before. Dr Naso also said that given that the nurses are with the patient 24 hours a day, as distinct from a psychiatrist seeing the patient in 20 or 30 minute interviews, this means that one has to rely on nursing observations. Where it was apparent that Theo was very keen to go home, there was a need to look beyond statements that Theo was making to the psychiatrist and to perhaps challenge him in some ways, not necessarily to the point of aggression or agitation. In this regard it has been the experience of this Court that patients who are intent on being

discharged can tailor their behaviour and language to suit that desired outcome. I speak here of the **Noakes** inquest to which I shall refer in another context later in these findings.

11.19. Dr Naso expanded on her opinions regarding the circumstances surrounding Theo's discharge. She expressed the opinion that Theo was still psychotic at the point of discharge despite the outward impression that he was presenting well.[158] Theo's refusing to fill out his care form and his presentation regarding many plans would have been a red flag for Dr Attanayake to investigate further.[159] The document was a significant one and represented another opportunity to gain more information and to develop rapport and engagement. Dr Naso postulated why Theo would not want to sign the documentation. One would want to engage with him on that topic to determine whether he was experiencing delusional thinking; normally people do not have any issue with completing such documentation.

11.20. To summarise, the thrust of Dr Naso's evidence was that the decision to discharge Theo was not a properly informed one. There was a flawed diagnosis based upon inadequate longitudinal information. A therapeutic relationship with clinical staff had not been established. An improvement only over the space of a few days had been somewhat miraculous and therefore unlikely. He still exhibited possible paranoid thinking on the day of his discharge as evidenced by refusing to acknowledge routine documentation that was designed for his benefit. So, while Theo may have presented well on the day that the ITO was revoked, and on the following day when he was discharged home, his presentation may not have been a true reflection of his state of wellbeing.

11.21. To my mind the obtaining of all collateral information involving Theo's presentations from November 2014 onwards should have been regarded as a crucial requirement in respect of his assessment in November 2015 and should have been taken into consideration in Theo's diagnosis as well as in the decision to discharge him from hospital. I so find.

11.22. Dr Naso makes a general observation about the standard of care provided by Dr Attanayake. Dr Attanayake was working in the capacity of a consultant psychiatrist in the Riverland. He was the sole resident psychiatrist in that region. The other

[158] Transcript, page 906
[159] Transcript, page 924

psychiatrists such as Dr Gupta and Dr Dham were either visiting psychiatrists or relieving psychiatrists. Dr Attanayake had not yet completed his work-based assessments. He was expecting to complete those assessments by the end of 2017 at which stage he would qualify as a Fellow of the Royal Australian and New Zealand College of Psychiatrists. Dr Attanayake was essentially under the supervision of more senior psychiatrists in Adelaide such as Dr McKenny and Dr Mosler. In his capacity as a practitioner in the Riverland at the time with which this inquest is concerned, Dr Attanayake would have enjoyed limited registration with AHPRA on the basis of his regular supervision. In Dr Naso's opinion the utilisation of a practitioner who has not completed their fellowship training can only occur if there is close supervision from a senior psychiatrist. This situation in her opinion highlights how under-resourced country mental services are. Her opinion is that Dr Attanayake required closer supervision than was provided.

11.23. Dr Naso also commented on the care that was provided to Theo within the Riverland community following his discharge from hospital at the end of November 2015. One of the first matters of note is the fact that the discharge summary that was compiled by Dr Attanayake did not make its way to Dr Dalamagas until 17 December 2015. It will be appreciated that Theo's care within the community was of a multifaceted nature involving care to be provided by his GP as well as by the CMHT that comprised Dr Attanayake and nursing staff as well as by Dr Dham in the latter part of that period prior to Theo's death. This meant that the discharge summary containing as it did the management plan for Theo was not immediately available to his GP and to the CMHT. Accordingly, there was no way for Dr Dalamagas to know what Theo had been like on the day of his discharge, how he had progressed while in the hospital and what the issues surrounding his medications were, and in particular whether Theo was willing to take medication or not. This served to place Dr Dalamagas in a difficult position if and when it came to prescribing medication given that there would be an inability on Dr Dalamagas' part to determine whether Theo had been improving or was becoming worse or whether it was simply the status quo prevailing. As far as the CMHT were concerned, this team needed to know things such as the dynamic between Theo and his parents as well as the nature of the rapport that had been developed as far as the engaging of Theo was concerned. The team would have needed to know if Theo was potentially still paranoid. The content of a discharge summary constitutes a vital piece of communication that can impact on the patient's management.

11.24. Dr Naso expressed various opinions regarding Theo's treatment within the community following his discharge from hospital on 1 December 2015. Dr Naso made some general observations about the standard of that care. She agreed with Mr Apps of counsel for Theo's family that there had been too much of a cross-sectional approach to his care and not enough reference to the whole of his history. The therapists appeared to be working independently from each other without continuity and without a longitudinal assessment.[160] In a similar vein, Dr McKenny in his review would conclude that there had been an inappropriate tendency for clinicians involved in this case to derive assurance from the fact that Theo had future appointments to be seen by somebody else, instead of dealing with the matter in the here and now.

11.25. Dr Naso also commented upon the care specifically provided by the CMHT. She observed that it was difficult to identify the primary person coordinating Theo's care. The cross-sectional assessments lacking in longitudinal depth appeared to be attributable to a lack of communication. She suggested that there was no one who took primary responsibility for Theo's care. In particular, the care coordinator did not know if she was the primary or secondary person responsible for care. Dr Attanayake had stated that he would not follow up Theo and that Theo's care would continue with Dr Gupta who was not going to be available until the end of January 2016. Mr Guscott had assessed Theo on 14 January 2016 and was relying on the locum psychiatrist, Dr Dham, and the GP Dr Dalamagas. Dr Dalamagas did not have the necessary experience and relied on others. It will also be observed that Dr Dham did not actually see Theo on 14 January 2016. As well, Dr Naso observed that there were inexperienced ED doctors who did not adequately assess Theo or communicate with the CMHT adequately. Dr Naso suggested in her report that all the while Theo was deteriorating. She also observed that from her reading of the matter, the CMHT service was understaffed and required more specialist psychiatric input than it possessed.

11.26. Dr Naso was especially critical of the way in which Theo was managed during his successive presentations to the RGH ED on 14 January 2016 and 17 January 2016.

11.27. As far as the RGH presentation on 14 January 2016 was concerned, Dr Naso observed that Theo had presented with racing thoughts, an inability to sleep, a low mood that was flat and tearful, low energy, self-harming thoughts, difficulty thinking and feeling tired

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[160] Transcript, page 959

of having to cope. This was in spite of the fact that he had been compliant with olanzapine and lorazepam medication. In her opinion, as expressed in her report, Dr Naso stated that Theo was presenting with symptoms of a bipolar mood disorder with mixed affective features. To the extent that Mr Guscott had wanted Theo to be admitted to hospital, this had been sensible. However, Theo was discharged and while the lorazepam may have helped him sleep, it would have made him feel even more lethargic, more unable to function and make him ultimately more depressed. Dr Naso queried why detention under an ITO was not considered on this occasion. She raised this as an issue both in her report and in her oral evidence. She stated that around 14 January 2016 Theo was clearly significantly depressed and psychotic. In her oral evidence she stated as follows:

> 'I say that because with bipolar disorder you have hypomania, mania on one end, you have depression on the other end. All of those states in between can present with psychotic symptoms. The mixed affective stuff in the middle was that he, from my reading, he was presenting with symptoms which were consistent with depressive symptoms as well as persecutory beliefs which were kind of mood incongruent and that why it appears that it was mix affective. I think there was also evidence of some hypomanic, maybe some grandiosity that was still there. What I was trying to get across was that he was transitioning along to a full on depression.' [161]

Dr Naso expressed the view that on this occasion Theo needed lithium for mood stabilisation.[162] She observed that Dr Dham, the relieving psychiatrist, had recognised a need for mood stabilisation at the time.

11.28. In querying why on 14 January 2016 Theo was not considered for detention under an ITO, Dr Naso observed that it was unlikely that Theo would have considered being admitted as a voluntary patient having regard to the anger he had displayed at his first admission. Dr Naso suggested that it would have been somewhat inappropriate for Theo's parents to have been expected to make the decision for him in relation to voluntary admission to hospital. However, Dr Naso suggested that it was likely that on 14 January 2016 Theo fulfilled the necessary criteria under the MHA for detention in spite of him denying on this occasion that he had any intention to end his life. His complaint of racing thoughts which were out of control and describing his brain as damaged and that he had difficulty thinking, demonstrated a likelihood of psychotic thinking. She says in her report, '*Theo needed to be seen by a psychiatry*

[161] Transcript, page 921-922
[162] Transcript, page 922

registrar/psychiatrist at this point, with consideration given to placing him on an ITO'. In the same context Dr Naso queried why it was that on this occasion Theo was not assessed by Dr Dham the psychiatrist. Dr Naso made the observation that if Theo had been at a metropolitan ED on a Thursday during working hours, he would have been assessed by a psychiatric registrar and his case would have been discussed with a responsible psychiatrist. Dr Naso stated:

> 'Instead, because he was presenting to an ED in the Riverland, he received what I consider to be substandard treatment. It was not good enough to suggest that Theo could wait until the 27/28 January to see Dr Gupta'.[163]

I agree with that assessment and so find. Theo should have been seen by the psychiatrist on this occasion and serious consideration should have been given to detention under the MHA by way of a level 1 ITO.

11.29. I turn now to Dr Naso's opinions regarding Theo's care when he presented at the RGH ED on Sunday 17 January 2016. On this occasion he was assessed by a local GP, Dr Sivarajah. In her report Dr Naso refers to the apparent contradiction involving Theo thinking that he was hearing voices but not experiencing hallucination. She also noted Dr Sivarajah's documented plan that Theo could be reviewed by his usual GP. Dr Naso was of the opinion that at this presentation Theo was psychotic, depressed and suicidal. She opines that he was clearly fulfilling the criteria for detention under the MHA and should have been placed on a level 1 ITO. Instead, his lorazepam was halved and was provided what very much sounded like a motivational talk consisting of encouragement that Theo, as it were, '*hang in there*'. In her report Dr Naso regards that as a '*completely useless*' strategy. It is hard to disagree. Dr Naso opines that it was clear from the ED documentation that the doctors in the ED who assessed Theo that day had inadequate psychiatric experience. There was no basic mental state examination completed and the documentation was contradictory to the way Theo was presenting. There was no evidence of any suicide risk assessment and his management plan was rudimentary. I accept that evidence and so find.

11.30. In her oral evidence, Dr Naso restated her view that:

> 'At that point, without a doubt, he fulfilled criteria for an ITO. So he should have been placed under an ITO. His symptoms were really severe and quite frightening really, I think, that it would have been too risky to consider him voluntary.' [164]

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[163] Exhibit C47, page 12
[164] Transcript, page 928

In her evidence Dr Naso thereafter convincingly brought Theo within the then existing criteria for detention even including lack of capacity, which as will be seen was not a requirement for detention as the MHA existed at that time. In particular as far as protection from harm was concerned, Dr Naso referred to suicidal thinking but also to risk of harm to Theo's reputation and to his finances but that the greater risk was the risk of harm to himself and the unpredictability of his presentation.[165]

11.31. Mr Crocker of counsel for Dr Sivarajah cross-examined Dr Naso and challenged her assertions that on 17 January 2016 Theo was detainable and that he should have been detained under an ITO. Mr Crocker asked her to identify within the clinical notes taken that day her asserted evidence of intense suicidal thinking. Dr Naso acknowledged that there was a denial of suicidal ideation. However, it could be concluded from collateral information that would have been in the possession of Theo's parents, and which could have been provided by them if it had been explored, that Theo experienced suicidal ideation. As well, it was recorded that he had said that he should not '*be here*' and had been unable to switch off his thoughts. Dr Naso said that she had initially read that as evidencing suicidality.

11.32. Dr Naso rejected the suggestion put to her by Mr Crocker that Dr Sivarajah's only fault was not to have sought further expert mental health guidance. To this Dr Naso said that there was more criticism adhering to Dr Sivarajah's care than what Mr Crocker was suggesting. She said that an ED doctor should have had the collateral information that would have been available from the family. It was not as if the family were not present. There should also have been available to Dr Sivarajah the details of Theo's presentation three days earlier on Thursday 14 January 2016. It was pointed out to Dr Naso that Dr Sivarajah had in fact read the notes of 14 January 2016 and was put to her in cross-examination that it would still have been unrealistic for him to have made the decision to detain Theo on an ITO without first obtaining available mental health expertise. To this Dr Naso responded by saying that every medical practitioner is trained in the imposition of ITOs. Medical practitioners have power to impose a level 1 ITO in the first instance. Dr Naso rejected the proposition that it would have been imprudent for Dr Sivarajah to have imposed an ITO without seeking mental health

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[165] Transcript, page 929 - 930

expertise. To this suggestion Dr Naso added that Theo had also been really unwell on 14 January 2016 three days earlier. Given that, she said:

> 'I'm talking about the - so he's presented with very supportive parents, who have been given a kind of management plan. Theo has gotten worse, otherwise the parents are not going to bother bringing him in on the 17th. The fact that he got brought in on the 17th, should alert any emergency department doctor 'Look, the family are really concerned, it's obviously gotten worse. I don't have access to anyone here, so what is the safest thing for me to do? Given that he's gotten worse and the family are highly distressed'. I put it that that to me indicates - it doesn't matter that we've seen them the day before. I can see someone 24 hours before and if they're presenting again the following day, that to me, indicates that they're still unwell and I need to relook at things. So just because they've seen the psychiatrist or a mental health worker, however experienced they are, does not mean that the mental state has not deteriorated. Because mental state fluctuates.' [166]

In her evidence Dr Naso emphasised that the fact that Theo had re-presented three days after his initial presentation on 14 January 2016 was a '…*huge red flag*'.[167] Dr Naso reiterated her opinion that Theo should have been admitted to hospital on 14 January 2016 in any event.[168] But the fact that he had re-presented meant that whatever management was commenced on 14 January 2016 had not been enough to hold Theo to a point where he and his family felt comfortable enough not to re-present three days later. She agreed that Theo's trajectory was that he was becoming worse. And having regard to his longitudinal trajectory overall, the picture was that Theo was deteriorating.[169] I agree with Dr Naso's commentary regarding the presentation of 17 January 2016. Theo was clearly deteriorating. The fact that he had re-presented within three days of his previous presentation was not adequately taken into account. Gaining knowledge of his condition from Theo's parents should have been regarded as a fundamental aspect of his assessment. The assessment of Theo on this occasion was superficial and inadequate. He should have been detained and placed on a level 1 ITO that day. This would have meant that he would have been the subject of psychiatric review within the following 24 hours.

11.33. Dr Naso also passed comment on certain aspects of the care provided by the CMHT. It is not necessary to comment on every aspect of Dr Naso's appraisal in that regard. However, there is one specific event upon which she has passed particular comment. The nurse, Ms Hogan, and a colleague saw Theo at the Renmark Community Centre on

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[166] Transcript, page 951
[167] Transcript, page 952
[168] Transcript, page 959
[169] Transcript, page 953

19 January 2016. On this occasion Theo was documented as having described regrets and of feeling overwhelmed. Ms Hogan documented that she would organise a review with Dr Gupta as Theo had presented as '*more depressed*' and as being the opposite of what he had been when he had entered the Berri hospital in November. Mrs Papageorgiou told Ms Hogan that Dr Dalamagas had also felt that Theo was presenting as more depressed. The plan that was documented was to conduct weekly phone calls and fortnightly home visits with Theo. The attendance on 19 January 2016 was only five days before Theo's death and only two days after his recent presentation to the RGH ED on 17 January 2016. Ms Hogan had been aware that Theo had in fact presented to that hospital on that occasion. Dr Naso's opinion is that the follow-up plan involving weekly phone calls and fortnightly home visits was inadequate, although she acknowledged that Ms Hogan then did present Theo at a clinical review meeting. However, the plan to wait another six days for a review by a psychiatrist indicates that the CMHT missed the fact that Theo was presenting with serious acute symptoms which required emergency assessment and admission. Dr Naso was referring here to the fact that on 21 January 2016 at the clinical meeting, it was documented that Theo could be assessed by Dr Gupta on 27 January 2016. Of course by that time Theo had taken his own life.

11.34. Elsewhere in these findings I have referred to the fact that on 20 January 2016 Theo was seen by the psychologist Dr Chris Hamilton. Dr Naso commented upon Dr Hamilton's assertions regarding the need for a referral to an ED for the provision of continuity of care. Dr Naso's concern with this approach was that if one had an immediate concern in respect of the mental health of a patient, then they would not be sent to an ED for continuity of care. She said that EDs are for emergencies. She said:

> 'So to me it seemed quite foreign, the concept of sending someone to an emergency department when the emergency department doctors don't know Theo, the Royal Adelaide doctors weren't going to know Theo. So to send him to one of those departments would, to me, mean that you were concerned, that it's not just about ongoing long-term management.' [170]

Also, she added that if Dr Hamilton had been so concerned about Theo, to the extent that he wanted to send him to an ED, he would have expected a letter or a phone call to that department.[171] To my mind Dr Hamilton's assertions that Theo needed to be sent

[170] Transcript, page 925
[171] Transcript, page 926

to an ED for continuity of care purposes bordered on the absurd. If on the day of his personal consultation with Theo Dr Hamilton had harboured a perception that Theo needed acute and immediate ED care it could only have been because he thought that Theo was profoundly and acutely unwell. But as indicated earlier in these findings, I am unsure what Mr Hamilton made of Theo at that consultation.

11.35. Dr Naso commented on Theo's medication regimes. In her oral evidence, Dr Naso expressed the view that Effexor had been the wrong medication for Theo to have been prescribed. Although it is an excellent medication for depression and anxiety, given Theo's longitudinal history of mania it was the wrong antidepressant. One would not provide that medication without mood stabilisation.[172] Dr Naso regarded the abrupt cessation on olanzapine as having had the potential to give rise to a discontinuation syndrome. The commencement of aripiprazole had its own side effect profile and this, like the olanzapine, was going to take another one to two weeks to reach a steady state. Then there was the cessation of aripiprazole and the recommencement of olanzapine so that the whole process was started all over again. Asked by Mr Plummer of counsel assisting as to what the potential impact of that may have been Dr Naso said:

> 'So I don't - so it is clouded is what I'm saying. I don't know what was discontinuation syndrome, I don't know what was side-effects from the anti-psychotics and I don't know what was illness progression. What I do know, however, is that by the time he presented on, I think around 14 January, he was clearly, significantly depressed and psychotic, that I do know.' [173]

Dr Naso was asked in the light of the tendency for olanzapine to cause weight gain and given that Theo was a man who was already heavy and endeavouring to lose weight, whether Theo would have been better placed on aripiprazole in the first place. She said that in an ED setting olanzapine is excellent but that it can be not tolerable. She said it is very difficult to maintain taking olanzapine in the long term. She agreed that in the first instance in order to settle Theo down, olanzapine was appropriate. However, she said:

> 'In terms of continuing that long term, definitely not because it was predictable that Theo would not want to continue taking it. Why would he, if it's making him sedated, he is putting on a huge amount of weight which is only feeding back into his feelings of inadequacy and failure because then he is not able to maintain a full day at work. It gives you pre-diabetes as well. So with the weight, he was at risk of a metabolic syndrome. So there is no reason why you can't start Abilify (ed. the commercial name for aripiprazole)

[172] Transcript, page 914
[173] Transcript, page 918

> and in fact if you are going by the working diagnosis which Dr Sarath was going by, which is first episode psychosis, I think you will find in the literature the first line treatment is risperidone, it's not olanzapine.' [174]

As to the reintroduction of olanzapine following the change to aripiprazole Dr Naso said that she struggled with the thinking behind that. Medication adherence in Theo's case was vital to him becoming well. He had not coped with olanzapine. The aripiprazole had not worked either for whatever reason. Dr Naso said, '…*I struggle to comprehend why you would then put him on a medication that he didn't want to be on in the first place*'.[175] The suggested alternative would have been risperidone or other medications.

11.36. In respect of Theo's presentation on 14 January 2016, where in her opinion Theo was exhibiting mania, or bipolar disorder, one would not treat the individual with just an antipsychotic. It would not be enough to stabilise the swinging of mood. Dr Naso was of the view that the standard treatment would have been lithium; this was the medication that Dr Dham had recognised might be required. It was evident that olanzapine was not stabilising Theo's mood.[176]

11.37. Finally, Dr Naso's opinion regarding the preventability of Theo's death comes to be discussed. In her written report Dr Naso has devoted an entire section to this question.

11.38. Dr Naso suggests that Theo's diagnosis was never adequately clarified and that Theo's follow-up was inadequate with superficial assessments. As indicated earlier, her opinion was that the timeline of his deterioration was not seen longitudinally, with each presentation appearing unconnected to the previous one. For my part, that much is obvious. In addition, there was no clarity as to who the primary coordinator in the CMHT was. This had resulted in a distressed family going directly to the Berri hospital seeking assistance on the two occasions within three days in January 2016. Dr Naso opines that assessing suicidal patients in the ED requires clinicians who have adequate skills and access to peer support. She believes that the ED assessments were very poor and that there was no excuse for not communicating the outcomes to the CMHT. Dr Naso points out that Theo's death has highlighted the gross inadequacies in country mental health services. The obvious levels of understaffing placed the clinicians in this

[174] Transcript, page 919
[175] Transcript, page 920
[176] Transcript, page 922

case in a difficult situation. She regards it as inappropriate that there is no avenue for staff education and training.

11.39. As far as Theo's November 2015 admission to hospital under detention was concerned, in her report Dr Naso expressed the following opinions:

> 'What should have occurred was that following the ITO by Dr Gupta, Theo should have been admitted and observed. A family meeting should have occurred, explaining the reasons why Theo's mother could not stay overnight, for the purpose of staff developing a therapeutic relationship and assessing Theo's mental state.
>
> The likely outcome would have been that Theo would have become aggressive and transferred to Adelaide. He would have stayed in a closed unit until he was calm, and in the meantime, staff would have gained collateral from Dr Mcleod, Dr Dalamagas, psychologists and Theo's parents.
>
> Without his mother's presence, it would have been harder for Theo to minimise his symptoms and he would have been placed on an antipsychotic (not Olanzapine due to the reasons I have already given) and either Sodium Valproate or Lithium Carbonate. Given the unmasking of his symptoms, he would likely have been placed on a level 2 ITO and had a lengthier admission. This would have ruled out the possibility of a Drug Induced Psychosis and allowed time for referral to the CMHT and to a psychiatrist. Whilst in hospital, he would have developed depressive symptoms and his suicidal ideation could have been explored.' [177]

Dr Naso states that in her experience patients with a relapse with a bipolar mood disorder tend to stay in hospital for a number of weeks and not just six days. If Theo had been released by virtue of the perception that he was not fulfilling the criteria under the MHA, he should have been allocated a primary CMHT worker who would have seen him initially at least weekly; and psychiatrists would have seen him more than just the once. The CMHT worker would liaise in those circumstances with the GP, a psychologist and Theo's parents. According to Dr Naso Theo was most likely fulfilling the criteria under the MHA on 14 January 2016, but by the time of his presentation on 17 January 2016 he most definitely was.

11.40. In short, Dr Naso expresses the opinion that Theo's death was preventable.

12. <u>The evidence of Dr Brian McKenny</u>

12.1. Dr McKenny is a consultant psychiatrist. He has been a Fellow of the Royal Australian and New Zealand College of Psychiatrists since 1998. At the time with which this inquest is concerned he was the Clinical Director of Mental Health, Country Health SA

[177] Exhibit C47, page 26

Local Health Network. At the time of the inquest he was the Clinical Director of the Rural & Remote Mental Health Services of South Australia. In his position as the former Clinical Director of Mental Health, CHSALHN, he had responsibilities for clinical governance of mental health services in Country South Australia. He was the line manager for Dr Attanayake in Berri. Dr McKenny provided a statement and annexures to the inquest.[178] Dr McKenny also gave oral evidence in the inquest. Dr McKenny was an impressive and candid witness.

12.2. It should first be observed that Dr McKenny and Dr Mosler, who was also referred to by Dr Attanayake in his evidence, did not have a specific supervisory role in relation to Dr Attanayake's involvement in Theo's case other than by way of the provision of some advice. Dr McKenny states that he did not consult with Dr Attanayake in relation to the latter's decision to discharge Theo from the level 1 ITO. He did not believe that Dr Mosler had been consulted about that specific matter.

12.3. In his oral evidence, Dr McKenny agreed with the proposition that in light of the fact that the RGH at Berri could only administer a level 1 ITO there had been potential for a doctor at Berri to err in releasing a patient after six or seven days and that the potential would be relatively significant. He said that this was one of the reasons he had the structure for the imposition of ITOs changed at the Berri Hospital. The Berri Hospital was now able to administer level 2 ITOs, albeit without the ability to place the patient within a closed ward. He said that the fact that the hospital did not have the ability to administer a level 2 ITO had become an impediment. In the case of Theo, Dr McKenny suggested that a trajectory of improvement had been seen by Dr Attanayake and that this was probably the driving force for Theo going home. Dr McKenny expressed a view that there may have been too much criticism in relation to Theo's discharge given the impression that he had been improving and also given that a trajectory of improvement continues when a patient is taken home with a supportive family and an agreement to take medication. The difficulty in Theo's case in Dr McKenny's view was that he started to deteriorate. That said, Dr McKenny did not suggest that he would go as far as to say that Theo's inpatient care was exemplary as Dr Groves the Chief Psychiatrist opines in a review document that I will discuss in the next section of these findings.

[178] Exhibits C37, C37a – C37d

12.4. Dr McKenny was not particularly critical of the fact that the psychiatrist did not review all of the relevant information at the time of actual discharge on 1 December 2015. In any case it appeared to the nursing staff that Theo was smiling, was '*okay*' and was keen to go home. That may have been sufficient for Dr Attanayake in any event. However, Dr McKenny stated:

> 'But I guess it's whether that he understood that there was still some grandiosity and he wasn't really compliant with some of the expectations, that would be evidence that some of that - there may be supporting evidence that the discharge was premature in that regard, that he was still unwell and he wasn't really resolving his symptoms after six days.' [179]

Dr McKenny went on to say that having a discharge at six days is probably a slightly more risky strategy based on just a verbal hand over.

12.5. One matter that Dr McKenny did place emphasis upon in his evidence was that Theo had done well over the weekend with short periods of leave, which meant that there had probably been an opportunity to then '*…really try to get to the bottom of what was going on in terms of diagnosis and collateral history*'.[180] Dr McKenny's criticism of Theo's management while under detention was that early in that week and before the ITO expired there had probably been an opportunity for the hospital team and for Dr Attanayake to have spent time getting to grips with what had been going on with Theo, but instead he was allowed even further leave with the family and then overnight leave. In his evidence Dr McKenny stated that although Theo's parents had been extremely supportive of the care that had been administered to their son in the inpatient unit, he acknowledged Dr Naso's criticism that there had been a lost opportunity to understand Theo and his level of delusions early in that week. He said:

> 'So, I think that was the key time that the family, in hindsight, obviously, could have withdrawn somewhat from being there all the time, and then a diagnosis be reached, because the next time that opportunity arose was on 16 December when Dr Attanayake reviewed as a planned discharge after two weeks, and that was another opportunity then to come to grips with what the underlying diagnosis was.' [181]

12.6. In cross-examination by Mr Plummer of counsel assisting, Dr McKenny said that Theo's family were very helpful in terms of containing his anxiety and his distress, but it was an open question as to whether the nursing staff had established a rapport with Theo. One way of establishing that rapport would have been to ask the family if they

[179] Transcript, page 768-769
[180] Transcript, page 714
[181] Transcript, page 715

could cease staying with him overnight or as often. After the weekend there had been an opportunity to say to the family that perhaps they should go home so that the hospital clinicians could try to understand Theo a little bit more before coming back to the decision about discharge. That said, Dr McKenny added in Dr Attanayake's defence that it appeared to Dr Attanayake that everything seemed to be on the improve.[182]

12.7. Dr McKenny agreed with Dr Naso's view that the assessments in the hospital had been superficial[183] and that if the staff had been provided with an adequate opportunity to get to know Theo better they would have detected that he was more unwell than was thought. Dr McKenny suggested that the view that Theo could be released from detention may have been countered and have been better tested by curtailing the family's presence, which may then have elicited a view that Theo probably needed to stay a little longer in hospital. In this regard it is worth noting that Dr McKenny agreed that there appears to be no evidence that continued voluntary admission to hospital had been properly considered.[184]

12.8. Like Dr Naso, Dr McKenny also questioned Theo's diagnosis. In addition, he stated that although the diagnosis at the conclusion of Theo's detention was recorded as '*first episode psychosis for further review*', this begged the question as to when that review was going to be undertaken. He agreed with Dr Naso that '*…in hindsight*'[185] there had been a change from a manic presentation into a severe depressive situation. Theo's presentation having switched to a psychotic depression or to a severe depression should have been viewed by an experienced clinician as a significant danger sign. His stated desire to join his deceased grandparents, kissing his family's hands and repeated apologising should have required immediate action which would have consisted of persuading Theo to be admitted to hospital for a proper review. Dr McKenny believed that at that stage one would be extremely alarmed. He opined that most senior clinicians would be extremely alarmed.[186] Dr McKenny added:

> 'Now, that's not necessarily bipolar disorder and there would be some people who were reviewing the case would not automatically assume that it's entirely bipolar disorder but that's irrelevant, the fact is that he's becoming severely depressed whether it's just from his

[182] Transcript, page 771
[183] Transcript, page 771
[184] Transcript, page 775
[185] Transcript, page 741
[186] Transcript, page 741

> psychosis or his bipolar, he's severely depressed, the tenure (sic) of the conversation has changed, the anxiety, the anguish is clear, something needed to be done.' [187]

12.9. As to the suggestion that there had been a failure to obtain proper collateral information and that Theo's assessments had been largely and unduly cross-sectional, Dr McKenny acknowledged that it was abundantly clear that the family had much information about what had been happening with Theo. One only had to examine Mrs Papageorgiou's notes to realise that what had been taking place was being extremely well documented. He said that most experienced clinicians would have sought information from the family; he agreed with the proposition put to him by Mr Apps of counsel for the family that in a sense the patient is perhaps the last person to be relied upon; one would want to cross check what they were telling you. Asked pointedly by Mr Apps as to whether it was a serious flaw in this case that the family's concerns were not heeded, Dr McKenny stated that although there had been contact with the family at the beginning of Theo's inpatient admission and upon discharge, and that the family had been listened to at that time,

> '…there were failures in terms of not getting that extra information about the history from Dr McLeod, for example or other background history. It's not usual, of course to ask the mother's - what's your mother's GP thinking about someone, but if there's a past treatment of someone by another GP then that's important information. I mean most experienced clinicians in mental health would be seeking that sort of information to get a proper formulation we call it, a formulation of what's going on, on the case.' [188]

12.10. Dr McKenny himself had seen Theo on 26 November 2015 by way of a video conference. When asked whether he had noticed any signs of mania, Dr McKenny said that his presentation was more paranoid and had some grandiose ideas. There was not an associated elevation in his mood that was typical of mania, but on review it was clear that there was an irritable quality to his mood, and a changing of his mood. Dr McKenny acknowledged that:

> '…with the benefit of hindsight and further collateral information I would think that the driving force at that stage probably was an atypical manic presentation.' [189]

12.11. Dr McKenny also commented upon aspects of Theo's care in the community once discharged from MHA detention. Included among Dr McKenny's comments were that the level of sophistication of knowledge of general practitioners is poor. He said that

[187] Transcript, page 741-742
[188] Transcript, page 740
[189] Transcript, page 713

one of his main takeaways of this sad case was how everyone involved in Theo's care seemed reassured that Theo had an appointment with someone else. The reader of these findings would have detected several examples of this. Dr McKenny called this '*treatment by appointment*'.[190] He said:

> '…he's got an appointment with somebody else, and he's got an appointment with somebody else, and everyone seems reassured.'

The fact that Theo had a close family had led to possible assumptions that everything would be alright. Dr McKenny also said:

> 'Rather than really someone grasping the nettle and say well he has an illness that is going down very seriously. Having said that, I wish to add that cross-sectional judgments by GPs in an ED, it's an invidious situation that they - and you only often see a cross-section, and if Theo's saying everything's okay or whatever reassurance they may seek, that that is kind of the window that they have, and it does require a capacity to sort of try to see things over a longer term perspective and get more information about what's going on. So it's a difficult position to be in and nobody wants to be the last person to see someone in this situation.' [191]

12.12. Dr McKenny also agreed that clarity had needed to be established as to who the primary clinician in the CMHT was, although he believed that it was clear that the primary clinician ought to have been considered as being Ms Hogan.[192]

12.13. Dr McKenny made certain other observations that included the undesirability of antiquated communication systems such as by way of the faxing of documents including discharge summaries. In addition, he stated that 20% of community positions in the mental health sphere are vacant at any one time.[193]

12.14. As to whether in his view Theo's death could have been prevented, Dr McKenny said that this was obviously a determination for this Court to make but he agreed with Mr Plummer's proposition that Theo's death was preventable. He said that Theo's illness was an acute illness that was eminently treatable. He acknowledged that there certainly had been failings within the South Australian Mental Health Service to properly identify and treat Theo's illness.[194]

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[190] Transcript, page 738
[191] Transcript, pages 738-739
[192] Transcript, page 753
[193] Transcript, page 753
[194] Transcript, page 774

13. The report of the Chief Psychiatrist

13.1. Tendered to the Court was the report regarding Theo's care that was prepared by the then Chief Psychiatrist, Dr Aaron Groves, after his review and investigation. The report was apparently released in May 2017.[195]

13.2. The Chief Psychiatrist made a number of findings in relation to Theo's care that with one material exception, generally accord with views of Dr Naso. The exception to which I refer concerns Dr Groves' view of the quality of Theo's care while under detention in the RGH mental health unit. Dr Groves asserts that Theo made a '*rapid and dramatic response with marked reduction and probable resolution of his psychotic symptoms*'. In this context Dr Groves observed that a central factor in Theo's response was the engagement of his mother within the unit. Dr Groves suggested that the approach to engagement with Theo's mother '*is highly commended as best practice*'.[196] In his findings[197] Dr Groves suggests that the quality of Theo's inpatient care was of a high order. To my mind the evidence is overwhelming that Theo did not make any rapid and dramatic response during his inpatient admission. His psychotic symptoms were not resolved. He was guarded, grandiose and possibly paranoid on his discharge. I do not need to repeat the evidence about that. Views also differed in the evidence about the desirability of Theo's mother's almost constant presence on the ward. The preponderance of evidence would suggest that this in fact acted as an inhibiting factor in the development of the therapeutic relationship between Theo and clinical staff. Again, I do not need to repeat the evidence about that.

13.3. I agree with Dr Groves' other observations that include;

- Theo required a full psychiatric assessment after his discharge given his decline in his mental health. This should have required a full and comprehensive specialist assessment. Theo did not receive that.[198]
- The severity of Theo's depression was underestimated.[199]
- Poor communication existed between the various parts of the health service. There was no shared clinical file between the ED of the RGH, the CMHT, the

[195] Exhibit C10d, "Chief Psychiatrist Investigation into certain matters in relation to Theo Papageorgiou conducted by the Office of the Chief Psychiatrist"
[196] Exhibit C10d, page 3
[197] Exhibit C10d, page 9
[198] Exhibit C10d, page 9
[199] Exhibit C10d, page 10

Berri Integrated Mental Health Unit and the Emergency Triage Liaison Service (ETLS). The sharing of information between these SA Health entities and other providers including the GP and private psychologist represented '*unacceptable gaps in the clinical system*'.[200]

- The GPs who make assessments in the RGH ED do not understand the nature of the local mental health service. Clinical notes of assessment that were undertaken in the ED were not readily available to other parts of the service. ETLS does not have routine access to vital parts of the clinical record when providing further advice to health professionals, especially out of hours.[201]
- There was no clinical review of Theo once evidence of clinical deterioration emerged. Dr Groves concluded that the process of clinical review by the mental health service had significant deficiencies. There was no evidence of a methodical comprehensive case review after Theo's discharge. There did not appear to be a level of specialist oversight of the clinical care that such a pattern of deterioration would dictate needed to occur. That so many parts of the health service were involved and did not recognise the need for a comprehensive review contributed to the underestimation of Theo's clinical risk.[202]
- There was a lack of access to clinical supervision for staff of the mental health service. An adequate model and provision of clinical supervision is required to ensure members of a multi-disciplinary team provide a high standard of care and identify reasons for a person's deteriorating clinical state.
- There was limited ability for a consultant psychiatrist to undertake home visits or make assessments in the person's usual residence. Dr Groves opines that the practice of requiring a newly referred person to the CMHT to sign a consent form was not good practice and introduces an unnecessary barrier to establishing either proper rapport or a therapeutic relationship. It led to alienation developing between Theo and the CMHT which in turn led to a reduced likelihood that he would share his feelings with the CMHT. That observation, in my view, highly relevant in the assessment of Theo's care.[203]

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[200] Exhibit C10d, page 10.1
[201] Exhibit C10d, page 10.2
[202] Exhibit C10d, page 10.3
[203] Exhibit C10d, page 11

- There were missed appointments with the CMHT which represents a risk to the provision of high-quality care. Dr Groves states '*lack of assertive follow up in the early stages of establishing a clinical relationship can lead to poor outcomes, which should be mitigated more actively than it was in this case*'.[204]

I agree with all of those observations. The evidence supports them.

13.4. The Chief Psychiatrist's report sets out seven recommendations for change which were ventilated during the course of this inquest. The recommendations and a description of the actions taken in response to those recommendations are annexed to these findings.

14. Further observations regarding the Mental Health Act 2009

14.1. It is necessary to say something further about the structure of section 21 of the MHA which is the provision under which Theo was subject to the level 1 ITO.

14.2. I set out section 21 of the MHA as it existed in 2015 and 2016.

> '**21—Level 1 inpatient treatment orders**
>
> (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.
>
> (3) A level 1 inpatient treatment order must be made in writing in the form approved by the Minister.
>
> (4) A level 1 inpatient treatment order, unless earlier revoked, expires at a time fixed in the order which must be 2 pm on a business day not later than 7 days after the day on which it is made.

[204] Exhibit C10d, page 11

(5) On the making of a level 1 inpatient treatment order, the following provisions apply:

(a) the patient must be examined by a psychiatrist or authorised medical practitioner, who must, if the order was made by a psychiatrist or authorised medical practitioner, be a different psychiatrist or authorised medical practitioner;

(b) the examination must occur within 24 hours of the making of the order;

(c) if it is not practicable for the examination to occur within that period, it must occur as soon as practicable thereafter;

(d) after completion of the examination, the psychiatrist or authorised medical practitioner may confirm the level 1 inpatient treatment 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.

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

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

Note—

A psychiatrist or authorised medical practitioner who revokes a level 1 inpatient treatment order may, in substitution, make a level 1 community treatment order under Part 4 Division 1.

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

14.3. It can immediately be observed from these provisions that they not only relate to the need to protect a person with a mental illness from harm, but also relate to the need to protect other persons from the harm that might be presented by a person with a mental illness. Those other persons would obviously include the general public. That the protection of persons other than the person with a mental illness is an important consideration in relation to the administration of the MHA is reflected in the Objects provision in the Act, section 6. One of those objects is that persons with severe mental illness should retain their freedom, rights, dignity and self-respect as far as is consistent with their protection and '*the protection of the public*'.[205]

14.4. Also of note is the fact that the harm from which the person with a mental illness might need protection can consist of harm involved in the continuation or deterioration of the person's condition. Thus seen, the harm to the person with a mental illness that the

[205] Section 6(a)(ii) MHA

MHA contemplates is not necessarily confined to self-harm of a physical nature. The need for protection of a person from an exacerbation of the person's mental illness of itself could trigger an ITO if all other elements are satisfied.

14.5. At the time with which this inquest is concerned there were three broad elements that needed to be satisfied in the mind of the medical practitioner or other authorised mental health professional before a level 1 ITO could be put in place. Those three elements are reflected above in section 21(1)(a), (b) and (c).

14.6. Section 21(2) in effect expands the element encapsulated in section 21(1)(c). Section 21(2) stipulates that in considering whether there is no less restrictive means than an ITO of ensuring appropriate treatment of the person's mental illness, consideration must be given to the prospects of the person receiving all treatment of the illness necessary for the protection of the person and of others on a voluntary basis or in compliance with a CTO. In other words, if voluntary treatment or treatment pursuant to a CTO would *ensure* that the individual would receive appropriate treatment, then an ITO with its concomitant detention in an approved treatment centre would not be imposed. I observe that Parliament chose to use the word '*ensuring*' and not merely '*facilitating*' as a descriptor of the manner in which appropriate treatment could be provided to the person with a mental illness. In my view, use of the word '*ensuring*' in section 21(1)(c) and section 21(2) implies a high degree of likelihood that voluntary participation or compliance with a CTO will deliver the appropriate treatment for the person's mental illness.

14.7. As well as the three criteria for detention contained within section 21(1), regard also needed to be had to the guiding principles set out in section 7 of the MHA. Relevantly as far as the issues in this inquest are concerned, one stated principle is to the effect that services should be provided on a voluntary basis as far as possible and in the least restrictive way and in the least restrictive environment that is consistent with the efficacy of those services and public safety. The issue of public safety as an important consideration is again emphasised. Another principle is that the services should be provided at places as near as practicable to where a patient or his or her family or other carers or supporters reside.

14.8. It is apparent that if the three elements for detention under the MHA were all fulfilled there was still a discretion to be exercised as to whether in all of the circumstances an

ITO should be imposed. This discretion stems from the use of the permissive expression '*may make an order*' in section 21(1) of the Act.

14.9. The MHA as it existed at the time with which this inquest is concerned, did not contain any element, principle or other stipulation to the effect that before a person could be detained under section 21 of the Act consideration needed to be given as to whether or not the person had impaired decision-making capacity either in general or had impaired decision-making capacity relating to appropriate treatment of the person's mental illness in particular. This circumstance would hardly be surprising. One would think that a person who has a mental illness that requires treatment for that person's own protection from harm or for the protection of others from harm might frequently have impaired decision-making capacity relating to, and have uncertain insight into, the appropriate treatment for their mental illness. The existence of decision-making capacity was not a legal impediment that prevented the imposition of an ITO in an otherwise appropriate case. In my view, the three elements set out in section 21(1) of the MHA stood as a code as to the matters that had to be considered and established before the discretion to impose an ITO was enlivened. Once those elements were established, to my mind they negated the right of the person to refuse consent to medical treatment.[206] The MHA, as it then was, established a regime for the administration of treatment of persons with a mental illness without their consent in circumstances where the person was a danger to themselves or to others. And this was so regardless of whether or not the person had the requisite capacity to provide or refuse that consent. Consent and decision-making capacity were not considerations that a medical practitioner contemplating imposing a level 1 ITO needed to have regard to as a matter of law. An unimpaired decision-making capacity on the part of the individual concerned could not of itself, as a matter of law, stand in the way of the exercise of the discretion to impose mandatory treatment and detention for that purpose if necessary. As will be seen below, this has changed.

14.10. The concept of decision-making capacity was a matter that engaged this Court's attention in the inquest into the death of **Geoffrey Scott Noakes,** the findings of which were delivered on 13 July 2016.[207] In that inquest a psychiatrist who had revoked a level 1 ITO that had been imposed by the deceased's own GP testified that Mr Noakes

[206] See **Rogers v Whittaker** (1992) 175 CLR 479 at 498
[207] Inquest number 25/2015

had a capacity to make decisions for himself. This capacity appeared to have been a key factor in the psychiatrist's decision to revoke the ITO. In respect of this issue this Court stated the following in its findings:

> 'If (the psychiatrist) 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.'

This Court found in the **Noakes** inquest that on the day of Mr Noakes' discharge from the hospital at which he had been detained pursuant to a level 1 ITO, he was still at extreme risk of suicide and that his ITO should not have had been revoked. On the day of that revocation, and after he had been discharged from hospital, Mr Noakes took his own life.

14.11. In the course of this current inquest more than one medical practitioner who was involved referred to the issue of Theo's decision-making capacity in the context of whether or not the ITO of which Theo had been the subject should be revoked, renewed or indeed imposed in the first instance. The evidence of at least one of these medical practitioners suggested that Theo's decision-making capacity played a part in the decisions made as far as detention or continuing detention under the MHA was concerned. To my mind this approach was again questionable as it had been in the case of **Noakes**.

14.12. Since the events with which this inquest is concerned, the MHA has been amended so as to include an additional element relating to the person's decision-making capacity. In effect, the MHA now makes decision-making capacity the legal impediment to which I have earlier referred. This alteration occurred in the following circumstances.

14.13. When the MHA came into operation on 1 July 2010, section 111 of the Act obliged the relevant minister, within four years after the commencement of the Act, to cause a report to be prepared on the operation of the Act and to cause a copy of the report to be laid before each House of the South Australian Parliament. A review pursuant to section 111 was conducted. The review culminated in the provision and tabling of a report that was forwarded by the Chief Psychiatrist to the Minister for Mental Health

and Substance Abuse by letter dated 23 May 2014. The report, entitled 'A Report by the Chief Psychiatrist of South Australia May 2014' (the Section 111 report), was laid on the table of the House of Assembly on 1 July 2014. The Section 111 report is freely available on the internet.

14.14. It is clear that the Section 111 report and the findings and recommendations contained within it formed the basis of the amendment to the MHA to which I have referred. Thus a fourth criterion relating to decision-making capacity was enacted and is accommodated in section 21(1)(ba) of the MHA. This amendment came into operation on 5 June 2017. There were other amendments that came into operation on the same date including an amendment to section 21(1)(b) specifying that *harm* could be physical or mental. Thus from 5 June 2017 section 21(1) of the MHA became as follows (the amendments are in bold):

> '**21—Level 1 inpatient treatment orders**
>
> (1) A medical practitioner or authorised **mental** 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 **mental** 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 (**whether physical or mental**, **and** including harm involved in the continuation or deterioration of the person's condition) or for the protection of others from harm; and
>
> **(ba) the person has impaired decision-making capacity relating to appropriate treatment of the person's mental illness**; 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.
>
> (3) A level 1 inpatient treatment order must be made in writing in the form approved by the Chief Psychiatrist.
>
> (4) A level 1 inpatient treatment order, unless earlier revoked, expires at a time fixed in the order which must be 2 pm on a business day not later than 7 days after the day on which it is made.
>
> (5) On the making of a level 1 inpatient treatment order, the following provisions apply:
>
> (a) the patient must be examined by a psychiatrist or authorised medical practitioner, who must, if the order was made by a psychiatrist or

authorised medical practitioner, be a different psychiatrist or authorised medical practitioner;

(b) the examination must occur within 24 hours of the making of the order;

(c) if it is not practicable for the examination to occur within that period, it must occur as soon as practicable thereafter;

(d) after completion of the examination, the psychiatrist or authorised medical practitioner may confirm the level 1 inpatient treatment 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.

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

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

Note—

A psychiatrist or authorised medical practitioner who revokes a level 1 inpatient treatment order may, in substitution, make a level 1 community treatment order under Part 4 Division 1.

(8) Confirmation or revocation of a level 1 inpatient treatment order must be effected by notice in the form approved by the Chief Psychiatrist.'

14.15. As to what is meant by *decision-making capacity* a new section 5A of the MHA was enacted at the same time as the new section 21(1)(ba). It is as follows:

'5A-----Decision-making capacity

(1) A person is, in the absence of evidence of evidence or a law of the State to the contrary, to be presumed to have full decision-making capacity in respect of decisions about his or her health care, residential and accommodation arrangements and personal affairs.

(2) For the purposes of this Act, a person will be taken to have impaired decision-making capacity in respect of a particular decision if-

(a) The person is not capable of-

(i) understanding any information that may be relevant to the decision (including information relating to the consequences of making a particular decision); or

(ii) retaining such information; or

(iii) using such information in the course of making the decision; or

(iv) communicating his or her decision in any manner; or

(b) in the case of a person who has given an advance care directive – the person has satisfied any requirement in the advance care directive that sets out when the person is to be considered to have impaired decision-making capacity (however described) in respect of a decision of the relevant kind.

(3) For the purposes of this Act-

(a) a person will not be taken to be incapable of understanding information merely because the person is not able to understand matters of a technical nature or trivial nature; and

(b) a person will not be taken to be incapable of retaining information merely because the person can only retain the information for a limited time; and

(c) a person may fluctuate between having impaired decision-making capacity and full decision-making capacity; and

(d) a person's decision-making capacity will not be taken to be impaired merely because a decision made by the person results, or may result, in an adverse outcome for the person.'

14.16. Decision-making capacity relating to '*appropriate treatment of the person's mental illness*' would no doubt encompass one's capacity to give consent to appropriate treatment or to refuse such consent.

14.17. The above amendments were not in operation either at the time of the **Noakes** inquest or at the time of the events as they related to Theo Papageorgiou. However, it is clear that by the time this Court conducted the inquest into the death of Mr Noakes in 2015 and 2016, the Section 111 report had been tabled in Parliament and that the enactment of the amendments to which I have referred in Section 21(1), including the addition of the element of impaired decision-making capacity, were within contemplation. These circumstances were not drawn to the Court's attention during the **Noakes** inquest. Had those circumstances been drawn to the Court's attention in **Noakes**, I would unhesitatingly have recommended that the amendment relating to impaired decision-making capacity that is now encapsulated in section 21(1)(ba) not be enacted. This is so given that it was apparent from Mr Noakes' reviewing psychiatrist's evidence, and as the Court had found, that the taking into account of Mr Noakes' capacity to make decisions for himself had acted to Mr Noakes' detriment.

14.18. I have alluded above to the fact that the amendments were also not in operation at the time of the events surrounding Theo Papageorgiou in late 2015 and early 2016. Yet, as seen elsewhere in these findings, Dr Attanayake, the psychiatrist who revoked Theo's level 1 ITO, said in evidence that in revoking the order he had taken into consideration that Theo had '*reasonable capacity, considering the four criteria in the Mental Health Act*'.[208] Dr Attanayake explained that Theo had the capacity to make decisions relating to the following up of treatment in the community.[209] Dr Attanayake explained that in

[208] Transcript, page 249
[209] Transcript, page 372

his eyes the concept of capacity had been relevant because '*all four criteria should be fulfilled for me to continue an ITO*'.[210] However, as seen, at that time the fourth criterion relating to capacity had not yet been added. Dr Attanayake was questioned by me as follows:

> 'Q. You mentioned this question of capacity to make decisions relating to his treatment. Were you aware that that was not a relevant consideration under the Mental Health Act, at the time that you discharged him, that that requirement only came into effect in 2017, under the law.
>
> A. It could have been, but still the principles were the same, we're looking at where the patient is, the mental illness available treatment ... strategy and the risk.
>
> Q. See, a person might have capacity to make decisions, but that doesn't mean that that person will make the correct decision, does it.
>
> A. If you're specifically considering the capacity to that specific area or task, you're talking about where the patient is able to communicate, understand my information, communication, communicating back, and have a discussion, that's how we go about that one.'[211]

Elsewhere in these findings I have dealt with the evidence of Dr Dham, the psychiatrist who on 14 January 2016 was on duty at the RGH but who did not assess or see Theo after he was assessed by Mr Guscott of the Mental Health Team. It will be remembered that Dr Dham stated that she had recommended that it would have been preferable for Theo to have been admitted to hospital because it is sometimes difficult to obtain a full assessment, but that if it had come to forcing Theo to be admitted he had the capacity to make his own decision. I am uncertain whether since Theo's death Dr Attanayake and Dr Dham or either of them have seized upon the amendment to the MHA as an ex post facto makeweight to explain, at least in part, why Theo would not have fulfilled the legal criteria for detention. However, if Theo's capacity to make decisions relating to the appropriate treatment for his mental illness had at the time been taken into consideration as a matter of itself precluding detention, this would have been a mistake in law.

14.19. As will be seen, the independent psychiatric expert who overviewed this case, Dr Maria Naso, took a different and more pragmatic view about capacity, a view that in my opinion is to be preferred.

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[210] Transcript, page 373
[211] Transcript, page 375

14.20. It is worthwhile examining the findings and recommendations within the Section 111 report tabled in Parliament which led to the amendments to section 21(1). The relevant findings are as follows:

> '**Capacity and Refusal**
> The Act is illness based legislation and does not provide for questions of capacity. However, in consideration of the Advance Care Directives Act 2013 and the inclusion of a capacity section in the Act as proposed in section 2 of this report, it would be appropriate to include capacity as a threshold criterion for involuntary treatment. This would mean that the health practitioner or Guardianship Board, when making an order, must consider the person's capacity to make decisions regarding treatment for their mental illness as part of their overall assessment. It is recommended that capacity be added as a criterion for involuntary treatment, for example:
>
> *(e) the person lacks capacity to make decisions regarding treatment for their mental illness, in accordance with section [proposed 7B, see section 2 of this report].*
>
> Some jurisdictions link a refusal criterion to the capacity criterion, so that a treatment order can only be made if a person has a mental illness and is at risk of harm and "does not have capacity to make decisions about treatment for the mental illness or has unreasonably refused treatment". The addition of refusal to the capacity criterion through the use of "or" does not add clarity to the involuntary threshold nor does it further protect the rights of individuals, as health practitioners can ignore the question of capacity and use the unreasonable refusal provision instead. The linking of the refusal criterion to the capacity criterion reduces the importance of the person's capacity when an involuntary treatment order is being considered. This criterion does not assist health practitioners to make decisions nor does it shed light on a person's state of mind, as most people will refuse involuntary treatment most of the time. It is recommended that a refusal criterion should not be added, either as a stand-alone criterion or linked to the capacity criterion.' [212]

14.21. The consequent recommendation, which was recommendation 68 within the report, was as follows:

> '68. The threshold criteria for involuntary treatment should include a capacity criterion.' [213]

14.22. The above passage from the review's findings is unpersuasive. For instance, the passage, and the Section 111 report as a whole, does not explain why the capacity criterion was now necessary when it had not been considered necessary when the new MHA 2009 was enacted in the first place. It will also be noted from that passage that the review drew parallels with the concept of decision-making capacity as contemplated in the Advance Care Directives Act 2013. The Section 111 report also deals with this issue in an earlier section of the report.[214] The extensive reference in the report to the

[212] The Section 111 report at page 50. There is an earlier discussion in section 2.1 of the Section 111 report at pages 7-8
[213] The Section 111 report at page 51
[214] See section 2.2 of the Section 111 report at page 9

Advance Care Directives Act is in spite of the fact that this Act has only a tangential connection with acute situations involving the prevention of physical or mental harm to individuals or to the public in general, but is principally concerned with enabling competent adults to allow decisions to be made about their future health care, residential and accommodation arrangements and personal affairs to be made by another person on their behalf if and when the individual's decision-making capacity becomes impaired. This is to be contrasted with the MHA which not only exists to enable persons with a mental illness to receive appropriate treatment, but also serves to protect those persons, and the general public, from harm. Whereas the essential element in the activation of an advance care directive is the existence of impaired decision-making capacity and that all else flows from that, the essential element in the imposition of an ITO under the MHA is a mental illness that may require acute treatment for the protection from harm. In reality there was no proper parallel to be drawn from the Advance Care Directives Act.

14.23. It will also be observed that except for section 5A(1), section 5A of the MHA, which in effect describes the parameters of *decision-making capacity* for the purposes of the MHA, has been lifted virtually verbatim from the corresponding provision within the Advance Care Directives Act. Section 5A(1) describes a presumption of decision-making capacity in relation to decisions about a person's '*health care, residential and accommodation arrangements and personal affairs*'. It is unclear as to whether this provision is intended to have general application or whether it is simply intended to apply to the MHA. It is also not clear as to why the decision-making capacity described in that provision is not expressly related to the relevant matters that the MHA addresses, namely decisions relating to appropriate treatment of a person's mental illness. The wording of section 5A(1) is all the more perplexing when it is recognised that the MHA has only the most incidental connection with such matters as a person's residential and accommodation arrangements and personal affairs and with advance care directives. The decision making-capacity as contemplated within the MHA is that relating to decisions made in respect of a person's treatment for a mental illness. When examining section 5A of the MHA it is difficult to think of a worse example of ill-considered parliamentary drafting or of a legislative provision less suited to its purpose.

14.24. As indicated elsewhere in these findings, the Court in the present inquest called Dr Maria Naso who is an independent psychiatrist working within the public sector and who provided a written overview and opinion regarding Theo's care and treatment. Dr Naso also gave oral evidence in the inquest.

14.25. Given that at least two psychiatrists in the inquest who had been involved in Theo's care had referred to Theo's capacity to make decisions in relation to his treatment, I regarded it as appropriate to ask Dr Naso about that issue during the course of her oral evidence. I questioned Dr Naso as to her view about the inclusion of the new section 21(1)(ba) and the introduction of a new element as a pre-requisite for detention under the MHA, namely impaired decision-making capacity relating to treatment. I asked her as follows:

> 'Q. I've had some difficulty with that, in that if all of the other criteria are fulfilled - namely, he's got a mental illness, he requires treatment for his protection from harm, and there's no less restrictive means of ensuring that - then, if he had an intact capacity to make his own decisions regarding treatment, how does that then trump all of the other elements that are satisfied. I've never understood that.
>
> A. Yes, well, I've never understood it either, because I can tell you that if somebody is psychotic and they're suicidal or homicidal, even though they've got - and they've got a mental illness, definite mental illness - then, whether they have capacity or not is not going to be the determining feature. I've struggled with that myself, and so have my colleagues.
>
> Q. Yes. But yet it's another element that has been introduced by parliament that seems to be an element that trumps all the other elements, -
>
> A. Yes.
>
> Q. - if they're satisfied.
>
> A. Yes. I think that's really interesting. I'm not quite sure what has been driving that, because the concept of capacity and consent is something which we as psychiatrists have been considering anyway; because that is part of the whole concept of mental illness. And if you have a significant mental illness, just by its nature, it's going to impact on your capacity …' [215]

14.26. I agree with and accept everything that Dr Naso has stated in this passage of her oral evidence. The clear point that Dr Naso is making is that if a person has a mental illness that involves a need for the person to undergo treatment for the person's own protection from harm or for the protection of others from harm, then there will be an almost inevitable impact upon the person's decision-making capacity relating to the

[215] Transcript, page 930

appropriate treatment for the person's mental illness. Therefore, the question that would need to be posed is why is there a need for specific consideration to be given to that capacity? What the relevant provision in the MHA now seems to be suggesting is that where a person has a mental illness and that because of the mental illness the person requires treatment for that person's own protection from harm or for the protection of others from harm, and there is no less restrictive means other than an ITO of ensuring appropriate treatment of the person's illness, all of that counts for nought if the person despite that mental illness and despite its potentially harmful consequences has unimpaired decision-making capacity relating to their appropriate treatment. So if that person elected not to undergo treatment, there is nothing that can be done for that person and that is so however unreasonable the refusal to undergo treatment either in a detained environment or in any other environment might be, and regardless of the danger that the person might present to him or herself or to somebody else. Even a community treatment order would not be lawful given that the imposition of such an order requires satisfaction of the same criteria including impaired decision-making capacity.[216] In his evidence Dr Attanayake suggested that Theo would not have qualified for a CTO given his capacity.[217] The section 21(1)(ba) amendment appears to work on the questionable assumption that a person who is so mentally ill that he or she requires treatment for their own protection or for the protection of others might nevertheless quite rationally decide not to have that treatment thereby avoiding detention and treatment, and possibly as a result, putting themselves and/or the general public at risk of harm. For instance, a person with a mental illness might be so intent on suicide that they would be determined to avoid treatment at all costs. In such a circumstance, it would be utterly inappropriate and unhelpful for a medical practitioner to pause and ask whether or not the unwillingness to undergo treatment was the product of impaired decision-making capacity. Dr Naso with her customary pragmatism illustrated the difficulty thus:[218]

> 'So, I can have somebody who's floridly psychotic, but if they say to me, and they're agitated, 'I'll come into hospital', I'm still going to put them on an ITO, because the risk of harm trumps, will always trump the least restrictive (*means of ensuring appropriate treatment*).' (bracketed and italicised part added for proper context)

[216] Section 10(1)(c) of the Mental Health Act
[217] Transcript, page 365-366
[218] Transcript, page 929

However, now that the MHA has been amended in the manner described above, focussing as it now does on capacity, I am not certain that such a sensible approach would be lawful.

14.27. It is of some significance that the Victorian Mental Health Act 2014 is structured such that except in cases involving electroconvulsive treatment (ECT) or neurosurgery, an authorised psychiatrist may make a compulsory treatment decision if satisfied that no less restrictive treatment option is available, even if the person has capacity to give informed consent and refuses to give it. So much is clear from section 71(3) of the Mental Health Act 2014 (Vic) and from the discussion of Bell J regarding that provision in **PBU and NJE v Mental Health Tribunal and Others** [2018] VSC 564 at [78]-[80]. As Bell J observed at [80], '*It follows that, where a person who has capacity to give informed consent refuses to give it, the person may be subjected to compulsory treatment or medical treatment if the conditions are satisfied, unless it is ECT (or neurosurgery),…*'. His Honour observed that capacity is a critical consideration confined to cases involving ECT and neurosurgery. Nowhere in this long and detailed judgment did His Honour make any adverse observation in respect of the fact that decision-making capacity does not have a role to play in the provision of compulsory treatment other than in respect of ECT or neurosurgery. Nor did His Honour suggest that human rights instruments such as the Victorian Charter of Human Rights or any other international treaty and agreement to which Australia is a signatory should dictate otherwise.

14.28. The New South Wales Mental Health Act 2007 contains no fixed element or requirement relating to decision-making capacity before involuntary detention and treatment may be imposed in respect of a person with a mental illness. Section 68 of that Act, which identifies the NSW Act's principles for care and treatment, states '*every effort that is reasonably practicable should be made to obtain the consent of people with a mental illness or mental disorder when developing treatment plans and recovery plans for their care, to monitor their capacity to consent and to support people who lack that capacity to understand treatment plans and recovery plans*'.[219] Thus read, the consent of persons with a mental illness or disorder is not a pre-requisite for treatment and that is so regardless of whether or not they have the capacity to consent to treatment.

[219] Section 68(h1) of the Mental Health Act (NSW) which section was added to the NSW Act, and came into effect, on 31 August 2015

Incapacity to consent is not an essential element for the imposition of involuntary treatment as it is in South Australia. What the NSW provision does is to express an aspiration or preference that persons with a mental illness or disorder who have the capacity to consent will be treated with their consent. As well, the existence of such capacity is a matter to be monitored in the hope that a person who has demonstrated a capacity to consent to treatment will in fact give his or her consent. However, it clearly contemplates that a person who has that capacity may nevertheless be subjected to involuntary treatment should they refuse that consent. In this respect, the NSW capacity provision differs from the South Australian capacity provision in that the latter provision in effect constitutes a statutory bar to the administration of involuntary treatment if the person has decision-making capacity relating to appropriate treatment of the person's mental illness. Had the NSW legislature intended capacity to consent when it introduced the principle in section 68(h1) in August of 2015, it would have done this in more robust terms and have made it an express essential ingredient for involuntary treatment.

14.29. I note that the Northern Territory Mental Health and Related Services Act 1998 for the purposes of involuntary admission and detention on grounds of mental illness contains a criterion that the person is not capable of giving informed consent to treatment or has unreasonably refused to consent to the treatment.[220] As already seen above, this is the type of provision that the section 111 review recommended should be avoided. This is to be contrasted with the current South Australian position where a person who is a danger to themselves or others but has an unimpaired capacity to give informed consent and refuses to give consent, may not be detained or treated involuntarily regardless of how irrational that refusal might be in all of the circumstances.

14.30. The South Australian Act now houses an essential element regarding the administration of compulsory treatment for mental illness across the board that the Victorian and the New South Wales equivalents eschew. It is to be observed that the Section 111 report asserted that other Australian jurisdictions '*champion*' the inclusion of capacity in their respective pieces of legislation.[221] That may be so in some cases, but not so in New South Wales as an essential element to involuntary treatment, and only in Victoria to a limited degree confined to ECT and neurosurgery. Bearing in mind that those two

[220] See sections 14(b)(iii) and 39 Mental Health and Related Services Act 1998 (NT).
[221] See section 2 of the Section 111 report at page 7

jurisdictions together account for greater than half of the Australian population, it could hardly be said that decision-making capacity as a necessary criterion for involuntary treatment short of ECT and neurosurgery was championed throughout this country.

14.31. The additional element relating to decision-making capacity now applies across the board in South Australia in relation to ITOs of all levels and even to CTOs of both levels. And that is so regardless of whether the order is imposed by a general practitioner working under the pressures of a rural Emergency Department or is imposed within the relative comfort of SACAT in both its original and review jurisdictions. No account is taken of the differing circumstances in which the imposition of an ITO or a CTO needs to be considered. Indeed, perhaps the most important decision that can be made, being the initial deprivation of the person's liberty when a level 1 ITO is imposed in the first instance, is frequently made by the person least equipped to make it. The issue of capacity is an element that is apparently troubling sections of the psychiatric community and is liable to defeat the making of an ITO in cases where an ITO is not only appropriate but plainly essential for the person's own protection from harm or for the protection of the general community from harm. It is an element that effectively reduces a consideration of what is in the best interests of the patient with a mental illness to a matter of irrelevance.[222] And, as earlier alluded to, it must be emphasised that the MHA not only deals with the treatment and detention of persons who are at risk of self-harm, but also deals with the treatment and detention of persons who are at risk of inflicting harm on the community. The MHA has an objective not only to protect individuals who have a mental illness from harm, but also an objective to protect the general community from harm from those individuals. A provision that enables a person with a mental illness to avoid treatment, either as a detained inpatient or in the community, and to do so in circumstances where they present as a danger to the public, simply because that person is perceived to have the capacity to make a decision to avoid treatment would clearly be incompatible with and defeat that objective. And it is not difficult to think of such circumstances that would not be readily amenable to police intervention.

[222] See **TSC v Department for Health and Wellbeing** [2021] SASCA 93 at [40] per the Court.

14.32. I intend making a recommendation in these findings that the requirements within the MHA 2009 relating to a requirement for impaired decision-making capacity be deleted except as they relate to ECT and neurosurgery.

15. Conclusions

15.1. The Court reached the following conclusions regarding the cause and circumstances of the death of Theo Nickolas Papageorgiou.

15.2. Theo Nickolas Papageorgiou died on 24 January 2016. The cause of Theo's death was compression of the neck due to hanging. At the time of his death Theo was suffering from a severe depression. I find that Theo acted alone in respect of the act of hanging. No other person was involved in the incident. I further find that the act was accompanied by an intention on the part of Theo to end his life.

15.3. Theo had been suffering from a mental illness that was recognised in November 2014. For the next twelve months he was treated by general medical practitioners, namely Dr McLeod in the first instance and then Dr Dalamagas, both of whom practise in the Riverland region. During this period Theo was referred to psychiatrists but for reasons that are not clear Theo did not take up those referrals. Ultimately, however, on 24 November 2015 he was seen by the psychiatrist Dr Neeraj Gupta who correctly identified a need for Theo to undergo inpatient treatment and care. Dr Gupta also correctly imposed a level 1 ITO in respect of Theo. In the normal course of events that Order, once confirmed and if then not subsequently revoked, would have expired on 1 December 2015.

15.4. The Integrated Mental Health Inpatient Unit within the Riverland General Hospital in Berri did not have the capability of administering a level 2 ITO. This would have meant that if any further involuntary inpatient admission was considered necessary, Theo would have needed to be transferred to a facility in the metropolitan area for further involuntary inpatient treatment and care.

15.5. In my view the limited ability of the RGH at Berri to accommodate inpatients detained under a level 2 ITO created an atmosphere of deterrence against imposing this measure on a patient already detained at the RGH at Berri under a level 1 ITO. To my mind such a circumstance should never be repeated at any other country medical facility.

15.6. Theo's level 1 ITO was confirmed by Dr Sarath Attanayake on 25 November 2015. Dr Attanayake made a diagnosis of a first episode psychosis. I find that this was an erroneous diagnosis. If proper regard had been had to Theo's longitudinal history over the previous twelve months, it would have been seen that Theo's presentation in November 2015 was probably a relapse of a psychosis that he had exhibited in November 2014 and following. The diagnosis that this was a first episode psychosis, and not a relapsed or an ongoing psychosis, had the potential to engender adverse consequences in respect of Theo's care and treatment. If it had been recognised that Theo's latest episode of November 2015 should be viewed against the entire background and history, a differing trajectory of treatment would have been imposed. Such a regime of treatment would have involved a need to guard against the possibility of relapse, would have involved consideration being given to a possible diagnosis of bipolar disorder with the risk of Theo developing depressive illness and also would have involved consideration being given to a different medication regime.

15.7. Theo was an involuntary inpatient from 24 November 2015 to the day of his discharge, which was 1 December 2015. The level 1 ITO which had been correctly confirmed by Dr Attanayake on 25 November 2015 was revoked by Dr Attanayake one day early on 30 November 2015. During the course of Theo's detention and inpatient care Theo's mother Mrs Poppy Papageorgiou stayed with Theo for the most part. Theo also had periods of leave including overnight leave towards the end of his period of inpatient admission. To my mind Theo's assessment during his period of detention was inhibited by these circumstances and was superficial. A therapeutic relationship between Theo and clinical staff was at no time properly established. Although it may have been thought that Theo had improved in the few days over which he was an inpatient in the hospital, the improvement was illusory. The evidence suggests that Theo continued to exhibit psychotic symptomatology. At the point of his discharge, he exhibited behaviour that suggested the strong possibility of ongoing hypomanic symptomatology which was not properly evaluated or explored. It was likely that on discharge Theo in reality, was still psychotic with mood symptoms.

15.8. I find that inadequate consideration was given to whether Theo should have been subjected to a level 2 ITO and transferred to an approved treatment centre in Adelaide for that purpose.

15.9. Following Theo's discharge from hospital his care was managed by the Berri CMHT. Theo was only seen by a psychiatrically trained medical officer, Dr Attanayake, on the one occasion following his discharge.

15.10. Throughout the period from and including the beginning of Theo's detention under the ITO until his death, Theo's management lacked leadership and cohesion. This was manifested by a number of circumstances that included:

- Presentations to general practitioners at the RGH ED who were poorly equipped to deal with Theo's management;
- There was inadequate regard paid to Theo's longitudinal history. Most if not all of the assessments of Theo that took place during that period were of a cross-sectional nature that did not adequately take into account Theo's longitudinal history, and in particular have regard to the collateral information about Theo that could have been provided by Theo's parents;
- Too much reliance was placed on, and reassurance derived from, the fact that Theo had future appointments that were from time to time scheduled with various clinicians. Rather than dealing with the matter at hand, inappropriate reassurance was derived from the fact that Theo would be seeing some other clinician in the future;
- Aside from Dr Attanayake's review of Theo on 16 December 2015, there was inadequate input in Theo's care from psychiatrically trained medical practitioners. In particular, there is no doubt that upon Theo's presentation to the RGH ED on 14 January 2016 he should have been seen by Dr Pallavi Dham, psychiatrist;
- There was inadequate continuity of care. This manifested itself in Theo being seen by different psychiatrists in the first instance and by different clinicians. This owed itself to the transience of staff in the mental health services in the Riverland that included locum practitioners and to a lack of mental health care resources in that region. Counsel assisting Mr Plummer in his final address summed up the issue succinctly and accurately when he submitted, '*Yet the moment Theo left that hospital, he and his family were essentially cut adrift. They were left to desperately scramble from emergency department, to GP, to nurse, to psychologist. None of whom were properly talking to one another and with no one to provide oversight or continuity of care*'. I so find.

- There was poor communication between clinicians who tended to act in silos, with little or no cohesion between them;
- There was a failure to recognise that Theo was deteriorating and that he was experiencing severe depression.

15.11. I agree with the conclusion of the Chief Psychiatrist that Theo required a full psychiatric assessment after his discharge from the RGH and I so find. Such an assessment should have involved a full and comprehensive specialist assessment. Aside from Dr Attanayake's review of Theo on 16 December 2015, Theo did not receive any firsthand psychiatric input. He was not seen by Dr Dham who was the locum psychiatrist for most of January 2016. As well, the appointment that was made for Theo to see Dr Gupta on 27 January 2016 was too distant in the future and this is so not merely in hindsight. Once evidence of his clinical deterioration emerged, Theo required a complete clinical review. The fact that this failed to occur arises from an inadequate level of specialist oversight of the clinical care of Theo. Such a full and comprehensive psychiatric review should have addressed Theo's appropriate diagnosis, an evaluation of his entire mental health history, a review of his medication and the gathering of collateral information about Theo's condition that could have been provided by members of his family. Theo's appointment with the psychologist Mr Hamilton did not in any meaningful way advance the quality of Theo's care.

15.12. As a result of this lack of psychiatric input and review, the fact that Theo was mentally deteriorating and was developing a severe depression was not recognised. The failure to recognise signs of severe depression in Theo meant that there was an inadequate appreciation of the risk to Theo in terms of possible self-harm or suicide. Theo's severe depression I find could have been predicted had his longitudinal history been appropriately taken into account and if appropriate, collateral information had been regularly obtained from his parents. Too much reliance was placed by clinicians on statements made by Theo himself.

15.13. Theo's presentation at the RGH ED on 14 January 2016 should have resulted in his hospitalisation either as a voluntary patient or as a detained patient under another level 1 ITO. To my mind Dr Dham was inadequately briefed about Theo's presentation in terms of his longitudinal history and collateral information that could have been provided by his parents. Inadequate information was provided to Dr Dham about

Theo's suicidal ideation and risk of self-harm. In any event Dr Dham should have evaluated Theo herself. This would have provided a greater opportunity for Dr Dham to have taken into account all relevant information relating to Theo. I do not believe that Theo's parents flatly refused to allow Theo to be admitted to hospital on this occasion. In any event strong advice should have been tendered to Theo and Theo's parents that Theo required admission to hospital on this occasion. If this advice had been resisted, serious consideration should have been given to the imposition of an ITO.

15.14. Theo should have been detained on a level 1 ITO upon his presentation to the RGH ED on 17 January 2016. Theo's assessment on this occasion was inadequate and was again not based on adequate relevant information about Theo. Theo's deterioration since his presentation three days earlier on 14 January 2016 was not adequately recognised.

15.15. The plan formulated on 21 January 2016 was inadequate in that it involved an arrangement that Dr Gupta on his return to the Riverland would see Theo on 27 January 2016 which, as already indicated, was too late and too distant.

15.16. Theo's medication from time to time was inadequately managed, probably due to an incorrect diagnosis. In particular, there was a failure to recognise that Theo was probably exhibiting bipolar disorder which meant that he required mood stabilisation. Although contemplated by Dr Dham, no attempt was made to reassess Theo and to prescribe the necessary treatment. In the event Theo developed a severe depression which not recognised.

15.17. In my view Theo's death was preventable. It is not possible to identify at what point or points during Theo's long episode of mental illness the outcome could have been altered. If adequate care and management had been bestowed upon Theo, his treatment would have been more effective.

16. Recommendations

16.1. 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.

16.2. Attached to these findings is an updated action plan[223] in response to the investigation report of the Chief Psychiatrist to which I have already referred. The report of the Chief Psychiatrist contained seven recommendations. Each of those recommendations are described in the annexed document.[224] The progress of the updated actions as at January of this year, and I assume as at the time of the inquest, are also described in the document. Dr McKenny gave oral evidence about the recommendations and the actions taken in response to those recommendations.

16.3. I will make some comments about the Chief Psychiatrist's recommendations and the responses.

16.4. Recommendation 1 addresses the issue as identified in this inquest that clinical records would not necessarily be shared among clinicians when dealing with a mental health patient. In particular, as highlighted in the inquest, there were occasions when clinicians did not have access to previous documentation; on 14 January 2016 the CMHT did not have access to notes made by the GP Dr Mahajan in the ED. Given that GPs have a key role to play in the delivery of care to mental health patients in rural settings, it is my view that consideration should be given to enabling GPs to immediately access previous clinical notes of patients that are housed in SA Health databases. Certainly, a situation in which a mental health team does not have easy and immediate access to progress notes compiled in an emergency department should not be repeated.

16.5. Regarding Recommendation two, which relates to the role of a consultant psychiatrist within CMHTs, and the recommendation that this role be reinforced, it is difficult to disagree with the wisdom of such a recommendation. In his oral evidence, Dr McKenny drew parallels with an issue identified in a previous coronial inquest in which there had been criticism of a lack of psychiatric oversight of the activities of community teams within the Child and Adolescent Mental Health Service (CAMHS). It appears that the inquest that Dr McKenny had in mind was that of **Jason William Hugo-Horseman** in which a need for more robust psychiatric intervention was identified within that organisation. No doubt Recommendation two owes itself to the lack of psychiatric overview of the activities of the Berri CMHT, and in particular the

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[223] Highlighting within the document was performed prior to tendering to the Court
[224] Exhibit C37e as tendered to the inquest

fact that Dr Dham did not have any meaningful input into Theo's management upon his presentation on 14 January 2016.

16.6. Recommendation six concerns suggested credentialing of external providers (local general practitioners) to clinical situations such as rural emergency departments to ensure that they are able to safely make assessments of people with mental health presentations. No doubt this recommendation was developed having regard to the events in the ED of the RGH of 14 and 17 January 2016 where Theo was seen by two local GPs. However, Dr McKenny in his evidence suggested that this recommendation is not without its difficulty. He explained that credentialing is an exercise in which the purpose is to establish the competency and capacity of GPs to provide a particular service. Dr McKenny explained that credentialing of GPs is not a simple and straight forward exercise. Secondly, questions arise as to the manner in which the validity of the person's competency can be evaluated. Rather, in Dr McKenny's opinion, with which I agree, the focus of this recommendation should be on the education and training of, and the provision of greater and more effective support to, GPs who work in rural hospitals and who are expected to provide care to mental health patients. Dr McKenny suggested a more practicable measure would be to develop the subject of mental health as a core component of continuing professional development of GPs. He believes that that is a more achievable objective than a formal credentialing process.

16.7. In the course of Dr McKenny's oral evidence he spoke of a measure that is not covered by the Chief Psychiatrist's recommendations. This involves the subject of what he termed '*journey boards*'. Dr McKenny explained that a journey board is a download of all information relating to a mental health patient that can be displayed on an electronic board. Without going into the precise detail, such a device, among other things, would set up warnings relating to follow-up of patient care so that matters such as appointments are not missed or overlooked. Dr McKenny stated:

> 'So all cases are visible and we can also identify a flag, clients of concern, in this case Theo might have been - would have been identified as a client of concern and there would have been more attention paid by the community team which it doesn't allow that level of someone else might do it later. So it's more visible and we think that that's made a substantial improvement in terms of clinical safety.' [225]

[225] Transcript, page 730-731

16.8. In his statement Dr McKenny highlighted the fact that community health services do not operate on weekends. As well, there is no after hours, face-to-face cover for mental health in country SA. After hours support to GPs in country emergency areas is provided by a telephone emergency line supported by on-call psychiatrists and with video conferencing. It is said, rightly in my view, that his situation reflects a lack of resources for mental health in rural areas.

16.9. In his oral evidence Dr McKenny was asked by his counsel Ms Cliff about the question of resources, and in particular how it could have transpired that due to her asserted caseload on 14 January 2016, Dr Dham did not review Theo. In addition, the CPC, Mr Guscott who was a locum, had also been extremely busy. To this Dr McKenny said that the question of resources still remained problematic at the time of the inquest. CMHTs were still operating with significant caseloads. He said that much of the recent financial injections of funds into mental health have gone into private psychologists and psychiatrists. The situation is compounded by the fact that there are few psychiatrists who actually reside outside of the Adelaide metropolitan area. Another difficulty which is associated with that set of circumstances is the fact that members of clinical staff in mental health teams can frequently be on leave. While Dr McKenny stated that he was generally content with the quality of the service that is provided, the resources are certainly stretched '*…pretty thin*'.[226] He said that obtaining locums as exemplified by Dr Dham filling in for Dr Attanayake presented its challenges. He pointed out that Dr Dham had flown herself back from Canada as a volunteer. Dr McKenny stated that at the time of the inquest the psychiatrist position at Berri was vacant, albeit that there was a locum there who was a retired senior psychiatrist from the Flinders Medical Centre. Dr McKenny said, '*I'm finding that is a particularly challenging part of my job*'.[227] Similarly, Dr McKenny recognised the difficulty articulated by Dr Attanayake who said in evidence that he needed but did not have a registrar working under him. Dr McKenny said that while there was funding for a resident medical officer, there was no funding for a psychiatric registrar. He said that they had not been able to fill this position in the last three years because there were no applicants. In short, as far as resources are concerned the situation does not appear to

[226] Transcript, page 733
[227] Transcript, page 733

be appreciably different from what it was in the Riverland in 2015 and 2016. It was clear to me that mental health services in 2015 and 2016 were under-resourced.

16.10. I direct the following recommendations to the Minister for Health, the Chief Psychiatrist and the Chief Executive of SA Health. It is recommended that:

1) SA Health continue to implement and action the recommendations of the Chief Psychiatrist as described within the Action Plan in Response to the Investigation Report of the Chief Psychiatrist, with the only modification being that emphasis should be placed on the need for continuing professional development of rural general practitioners in relation to mental health care as distinct from the credentialing of those practitioners;

2) A comprehensive review be conducted in relation to clinical resources in respect of mental health services in all rural regions in South Australia. The review should be conducted with a view to;

   (i) Community Mental Health Teams in regional areas being staffed by a resident team consultant psychiatrist and a resident psychiatric registrar. It is recognised that in order for this recommendation to be implemented there will be a need to incentivise these positions.

   (ii) ensuring that there is continuity of care in relation to the management of mental health patients in regional areas.

   (iii) hospitals in regional areas that administer mental health services being provided with the ability and resources to administer level 2 Inpatient Treatment Orders.

3) I recommend that psychiatrists and other practitioners and clinicians who practise in rural areas be advised of, or be reminded of, the following:

   - That purely cross-sectional analyses of patients presenting with mental illness or possible mental illness should be avoided.
   - That there is a need to examine the longitudinal history of the presenting patient.
   - That there is a need to gather collateral information from family members and associates of the presenting patient. The need for the gathering of collateral information has been a repeated theme in a number of coronial inquests. A similar need was identified in the inquest of **Noakes**. I also observe that as discussed in **Noakes** the SA Health Guidelines for Working with the Suicidal Person - Shared Learning in Clinical Practice identified that:

> 'Collateral information, particularly from the family or support person, should always be sought as part of the re-assessment of suicide risk. Reports from the Coroner's office are very clear that this is a source of information frequently ignored by clinicians.'

The same document also stated:

> 'A consultant psychiatrist's opinion should be sought early, wherever possible, in the assessment and management of a person with suicide risks. This may be available as part of the teams routine case review meeting.'

- That there is a need to evaluate and identify a deterioration in the mental health of a patient from one presentation to the next.
- That in particular cases there may be a need for general practitioners practising in rural hospitals to utilise the services of Emergency Triage Liaison Service.
- That there is a need for psychiatric evaluation of a patient who makes repeated presentations.

4) I recommend that except in relation to electro-convulsive therapy and neurosurgery, the relevant provisions of the Mental Health Act 2009 be amended by deleting as a requirement for the imposition of any level of Inpatient Treatment Order or Community Treatment Order that the person in question has impaired decision-making capacity relating to appropriate treatment of the person's mental illness.

Key Words: Suicide; Mental Health; Country Health; Inpatient Treatment Order

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

Seal the 4th day of November, 2021.

Deputy State Coroner

Action Plan in Response to Investigation Report: CP 004 – updated January 2021

No	Recommendation	Referred to	Lead	Updated Actions	Status
1	CHSALHN takes steps to ensure a single clinical record is available for each person who accesses services that includes details of inpatient care, ED assessments and treatment, advice and assessments through ETLS, and the CMHT file notes. Ultimately the system should ensure that information is available in a timely fashion.	CHSALHN **Now RRMHS**	Dr Brian McKenny Clinical Director	We recognise that the interface between systems remains a challenge. It was anticipated that EPAS was to be rolled out across the Rural Regions and advice was that this was the statewide strategy for single patient records. Unfortunately, there have been changes to this plan, with an independent review recommending in December 2018 that there be a fundamental reconstruction of roll out and governance of the electronic medical records program, which means that the rollout of EPAS in its current form to Rural Local Health Networks will not occur. A Business Case is under development considering how best to address the multiple system interface issues associated with medical records including Sunrise and CCCME. In the meantime, we put the following strategies in place, which have been retained: - Emergency Triage and Liaison Service (ETLS) is a 24-hour service that has as one of its functions the collation and provision of all available information. Any treating practitioner can contact ETLS at any time to request this information. The CMHT records its contacts with consumers in CCCME, and this database is accessible to all ETLS staff. - The Riverland Emergency Department is now staffed through SA Health, ensuring consistent access to SA Health medical records platforms.	Ongoing

No	Recommendation	Referred to	Lead	Updated Actions	Status
				- RiverDocs in the Riverland General Hospital Emergency Department were provided access to OACIS, which is an electronic record that is used to store and distribute hospital discharge summaries. - The former CHSA LHN developed a Patient Medical Discharge summary document and a Nursing/Allied Health discharge summary document to aid in appropriate discharge documentation.	

No	Recommendation	Referred to	Lead	Updated Actions	Status
2	CHSALHN, Mental Health should review existing models of Clinical Review. As part of this review the processes that ensure comprehensive review and the role of Consultant Psychiatrists within Community Mental Health Teams should be reinforced. This should include a consideration of the Australian Commission on Safety and Quality in HealthCare's July 2014 report on "Recognising and Responding to Deterioration in Mental State".	CHSALHN Mental Health **Now RRMHS**	Dr Brian McKenny Clinical Director	The Psychiatry Clinical Governance Framework was introduced in April 2017 to all then CHSALHN mental health regions. It provides a systemic and integrated approach to clinical responsibility and accountability including clinical review processes within the team. This document also outlines the clear clinical leadership roles and responsibilities within the Rural LHN Mental Health structure. Training modules added to our annual training calendar introduced since Mr Papageorgiou's death include: - Senior Psychiatrist provides training sessions for staff on Comprehensive Mental Health Assessment and Risk Assessment in Clinical Practice - Competency Based Training program covers the deteriorating patient. - Nurse Practitioner provided training sessions to identify signs of mental state deterioration (see Training Calendar examples provided). - National Standards regarding recognising and responding to mental state deterioration have been released. - The Rural Support Service is working with the SA Health Safety & Quality Unit to finalise a Recognising and Responding to Mental State Deterioration Medical Record form to guide practice. Rural LHNs have offered to be trial sites. - The staff orientation package includes training about deterioration of mental state. - Towards Zero Suicide program is to be rolled out across the Regional LHNs. This program is in its early stages of development, having recently been offered funding from the OCP.	Completed

No	Recommendation	Referred to	Lead	Updated Actions	Status
3	CHSALHN should ensure members of the Berri Inpatient Mental Health Unit and the Riverland CMHT have access to training, education and clinical supervision that supports high quality assessment and treatment for the most common presentations to specialist mental health services in particular psychosis. In addition, CHSALHN should ensure staff are trained in the Connecting with People approach to suicide mitigation.	CHSALHN Mental Health **Now RRMHS**	Ruth McPhail – Service Manager Acute Services/DON	Within the Psychiatric Clinical Governance Framework established in April 2017 there is a process for regular case presentations and discussion within the team. This is led by the Regional Psychiatrist. Connecting with People (CwP) training was identified as a 2017/18 training priority and the majority of Riverland staff received this training. An additional three CHSA LHN MH staff are now qualified to provide training to ensure capacity to educate all staff. All clinicians have access to regular clinical supervision within the RRMHS Supervision Framework. CwP training has been part of the training calendar since 2017.	Completed
4	CHSALHN should develop a policy for its CMHT about home visits and appropriate communication with families / consumers when an assessment does not proceed as planned due to unforeseen circumstances.	CHSALHN Mental Health **Now RRMHS**	Ruth McPhail – Service Manager Acute Services/DON	The Clinical Directors, in consultation with the Serious Incident Review Group, published a MH Executive Check listing learnings from reviews. This was sent to all Mental Health staff advising that when a clinician is unable to make a scheduled appointment, this must be communicated to the consumer/family. A feature called 'scheduler', which is in the CCCME electronic record, is being used across the Rural LHNs, including the Riverland, to track Community Mental Health Team (CMHT) home visits and this program enables anyone in the team to see what appointments were allocated to particular clinicians to manage these at times of unexpected staff absences or delays.	Completed
5	CHSALHN Mental Health develop more close working relationships with General Practitioners in their catchment areas so that those people who are jointly managed between CMHT and GPs have a clearer and agreed understanding of	CHSALHN Mental Health **Now RRMHS**	Dr Brian McKenny Clinical Director	The Community Model of Care outlines key points of communication and engagement with GPs as part of sound clinical practice. Education and Training Modules for GP's in Mental Health has been funded as part of the Rural Health	Completed with additional actions ongoing

No	Recommendation	Referred to	Lead	Updated Actions	Status
	their respectiveroles.			Workforce Strategy in conjunction with the Rural Support Service, GPex and Rural Divisions of General Practice. Progress to date includes: - created resources for GP education for suicidal ideation, working with many stakeholders to do so including the Suicide Prevention Program, Primary Health Networks and GPex. - These resources have been field tested in Pt Lincoln, Pt Augusta and Clare. - COVID-19 has placed some limitations on the broader delivery, however the program is now being rolled out across all rural LHNs at sites with visiting psychiatrists.	
6	CHSALHN should consider the credentialing of external providers (such as GP) to Emergency Departments to ensure they are able to safely make assessments of people with mental health presentations	CHSALHN **Now RRMHS**	Dr Brian McKenny Clinical Director	CHSA Executive members, Rural GP advisors and the Chair of the Credentialling Committee considered this this recommendation. The firmly held view was that Mental Health is core business for GPs and does not require specific credentialing. It was recommended that an increased focus of training and education as part of a CPD process was the best strategy.	Closed
7	Finally the CHSALHN should develop a system whereby the Clinical Leadership of the Riverland MHS is able to ensure all Clinical Staff are able to meet the Clinical Competencies expected of specialist mental health professionals.	CHSALHN Mental Health **Now RRMHS**	Dr Brian McKenny Clinical Director	The current Workforce Strategy Action Plan has established MH specific orientation and induction programs across the rural LHNs. The implementation of the new Community Mental Health Model of Care encompasses workforce development and support to ensure that the workforce has the appropriate skill, capacity, knowledge and values. A newly developed Competency Framework is also being implemented across the RRMHS.	Completed