CORONERS COURT OF SOUTH AUSTRALIA

INQUEST INTO THE DEATH OF MICHELLE STEPHANIE FOSTER

[2025] SACC 8

Inquest Findings of her Honour Deputy State Coroner Kereru

30 April 2025

CORONIAL INQUEST

Examination of the cause and circumstances of the death of Michelle Foster, a wife and mother of two children who died at the hands of a mentally unwell man, Jayden Lowah, shortly after a chance encounter at the Noarlunga Centre. The Inquest examined the events that led to Mr Lowah being in the community in a critically unwell state.

Held:

1. Michelle Stephanie Foster, aged 36 years of Ethelton, died at Noarlunga Centre on 25 October 2018 due to head injuries.

2. Circumstances of death as set out in these findings.

Recommendations made.

Counsel Assisting: MR P LONGSON THEN MS E ROPER

Interested Party: DEPARTMENT FOR CORRECTIONAL SERVICES, COMMISSIONER OF POLICE, NALHN, SALHN, BHFLHN
Counsel: MR T SIMPSON - Solicitor: CROWN SOLICITOR'S OFFICE

Interested Party: DR A GIANNAKOUREAS
Counsel: MR J HOMBURG - Solicitor: GILCHRIST CONNELL

Witness: MS S ZULIAN, DR L WILLIAMS, DR I JENNINGS, DR T SINGH, DR A TAYLOR, MS J MOORE, MR J BLANDFORD & MS D GRAY
Counsel: MR T SIMPSON - Solicitor: CROWN SOLICITOR'S OFFICE

Hearing Date/s: 19/09/2022-21/09/2022, 27/09/2022, 22/11/2022-24/11/2022, 30/11/2022, 14/12/2022, 20/03/2023, 28/07/2023, 31/07/2023, 18/08/2023, 13/09/2023-14/09/2023, 28/09/2023, 20/11/2023, 08/12/2023 & 16/02/2024

Inquest No: 30/2022 **File No/s: 2042/2018**

INQUEST INTO THE DEATH OF
MICHELLE STEPHANIE FOSTER
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Introduction

1 Michelle Stephanie Foster was born on 13 June 1982. She died on 25 October 2018 at the Colonnades Shopping Centre. Ms Foster was aged 36 years.

2 At the time of her death Ms Foster was in a defacto relationship with Ashley Thomas and they had two children together, aged 8 and 13.

3 On 24 October 2018 Ms Foster left the family home in Ethelton to visit her father, who lived in Huntfield Heights, following an argument with Mr Thomas. She took a train into the Adelaide CBD and then a train to Noarlunga, as she had done a number of times before when visiting her father. The closed-circuit television footage (CCTV) from the Noarlunga train station established that Ms Foster disembarked the train at 10:13pm. Upon alighting she walked in the direction of the Colonnades Shopping Centre. Ms Foster was reportedly drinking from a green wine bottle and also had a can of soft drink.[1]

4 Shortly thereafter, Ms Foster became acquainted with Mr Jayden Lowah outside the Bank SA building. A conversation took place between the two. This was not captured on CCTV as it was outside the view of the cameras.

5 At 11:57pm Mr Lowah was captured on the CCTV footage walking away from the Bank SA building with what appeared to be blood on his hands.

6 A passer-by, Mr Christopher Graham, found Ms Foster lying face down on the ground at approximately 12:04am on 25 October 2018. He could hear her breathing and called emergency services. Mr Graham was provided with instructions to turn Ms Foster onto her back. When he did, he observed severe injuries to her head and face. While attempting to apply pressure to Ms Foster's bleeding face and head wounds, he noticed that she had stopped breathing. Mr Graham performed cardiopulmonary resuscitation (CPR) and the police and ambulance officers arrived at 12:19am and 12:20am respectively.

7 Tragically, resuscitation efforts were unsuccessful and Ms Foster was pronounced life extinct at 12:25am on 25 October 2018.

8 Mr Lowah, who had remained in the vicinity of Ms Foster after the attack, approached a police officer who had just arrived on scene, pointed to Ms Foster's body and stated, '*I did that*'.[2] Mr Lowah was taken into custody and charged with Ms Foster's murder.

9 Mr Lowah later told police that Ms Foster had approached him while he was sitting down smoking a cigarette. They spoke for a while until Ms Foster walked away leaving her handbag behind. Mr Lowah stated that he waited for her to return for her handbag, having decided that he would kill her, as she had apparently touched him inappropriately (which was consistent with an aspect of his known delusional belief system). When Ms Foster returned as he expected, Mr Lowah grabbed her by the hair, kicked her legs out from

[1] Exhibit C31, Annexure A (ROI), pages 41-42
[2] Exhibit C20, page 3

under her and slammed her head, face down, onto the ground repeatedly, until he became fatigued. At one point he walked away after hearing a car. He returned shortly after and noticed Ms Foster was having difficulty breathing. Mr Lowah told police that he did not want to help Ms Foster and wanted her to die, so he left her and started walking around again. It was shortly after this that police arrived on scene and Mr Lowah announced what he had done.[3]

10 On 23 June 2020, his trial on the charge of murder was heard by Justice S Doyle (Doyle J) who found the objective elements of the offence of murder were established (*actus reus*),[4] however he found Mr Lowah was mentally incompetent to commit the offence of murdering Ms Foster. By operation of the *Criminal Law Consolidation Act 1935* (CLCA), that meant Mr Lowah was unable to have formed the necessary intent (*mens rea*)[5] to kill Ms Foster, which is required to prove the charge of murder. Therefore, by virtue of his mental illness, he was found not guilty of the offence. The consequence of the finding was that Mr Lowah was declared liable to supervision under Part 8A of the CLCA.

11 On 7 August 2020, Doyle J made an order committing Mr Lowah to a mental health facility (James Nash House) for a limiting term of life.

12 Based on the findings of Doyle J, it is open on the evidence to find that Mr Lowah caused the death of Ms Foster on 25 October 2018, after a chance meeting at the Colonnades Shopping Centre a few hours prior.

Reason for Inquest

13 Following the completion of the criminal proceedings as detailed above, a decision was made by the State Coroner that it was necessary to conduct an Inquest to examine the cause and circumstances of the death of Michelle Stephanie Foster. Ms Foster did not know Mr Lowah. Simply by fateful chance she was in a place and at a time where Mr Lowah happened to be. Had she not met Mr Lowah on this day, she would not have died by his hand. It was therefore necessary to examine how and why Mr Lowah was at large in the community in a psychotic state and able to kill an innocent young woman 41 days after his release from prison. Disturbingly, this was also after having presented at the Noarlunga Hospital Emergency Department one day following his release from prison (and approximately six weeks before he killed Ms Foster), informing clinicians that he had formed homicidal intent. He was released back into the community without a fixed address just hours later.

14 As will be detailed below, there was not one act or omission on the part of any particular person or entity relating to the management of Mr Lowah's mental health that directly contributed to the death of Ms Foster. It was, however, open on the evidence to find that, following the cessation of depot medication in April 2017, there were a number of missed opportunities to have intervened and modified his illness trajectory. These missed opportunities saw Mr Lowah's illness deteriorate to such a point that even when depot medication was reinstated in November 2017, it did not have sufficient therapeutic effect

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[3] Exhibit C31, Annexure A (ROI), pages 41-42
[4] The physical act of committing a crime
[5] The intention or knowledge of wrongdoing that constitutes part of a crime

to prevent the actively psychotic state he was assessed to be in at the time he killed Ms Foster.

15 A letter written on 2 February 2015[6] by Dr Marshall Watson, consultant child and adolescent psychiatrist, to Dr Ken Hooper, consultant psychiatrist, for the purposes of handing over care, expressed the view that Mr Lowah had a provisional diagnosis of schizophrenia with differentials including schizoaffective disorder and delusional disorder. This letter was written at a time when Mr Lowah was 16 years old and having been released on Licence into the community after expressing homicidal ideation. This was directed towards his father due to a complex delusional system of perceived sexual abuse by him. In the letter, under the subheading of '*Ongoing Treatment*', Dr Watson said this:

> 'It is important to recognise that Jayden has been compliant with treatment to date. It is my opinion that Jayden does require ongoing treatment. Although he has been cooperative with treatment to date, Jayden will require very close monitoring of his mental health issues upon release. ***I am concerned that he will minimise his psychotic symptoms and this risks complacency with then a relaxing of treatment options, which could then again increase his risk.*** I believe the best approach at this time is to be alert, not alarmed.' [7]

16 This letter had a prophetical quality as, two years later, Mr Lowah was trialled for a period without depot medication after just one assessment by Dr Angelos Giannakoureas from the Northern Mobile Assertive Care (MAC) team. The cessation of the depot injections at this time was in response to a questioning of the diagnosis of schizophrenia with his behaviour thought to be more attributable to personality factors and illicit drug use. This decision was later described by consultant psychiatrist, Dr Paul Furst, as the '*destabilising event*' in Mr Lowah's mental health. Associate Professor (A/P) Danny Sullivan, expert psychiatrist, agreed with this opinion. While they shared the view that the decision to stop the depot was not unreasonable at the time, it was the subsequent management of Mr Lowah, or lack thereof, that saw his illness deteriorate, along with the withdrawal of the supportive structures that were in place for Mr Lowah in the community which had protective qualities. The consequence of this destabilisation was to place Mr Lowah at a baseline of mental illness that interventions were not able to address prior to Ms Foster's death.

17 As will be seen below, I have accepted the opinions of Dr Furst and A/P Sullivan that the decision to cease Mr Lowah's antipsychotic medication, aripiprazole (administered in a depot form)[8] on 11 April 2017, destabilised Mr Lowah's already fragile mental health. I have also found that the causal effect of this cessation was a disengagement with mental health services, the loss of his housing arrangement with ensuing homelessness, a deterioration in his mental state, and violent offending for which Mr Lowah was imprisoned. He was not investigated for a mental impairment defence and served his sentence as a prisoner. Mr Lowah was then released into the community without parole (as he had served his entire sentence) and within six weeks had killed Ms Foster. The

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[6] This letter was an almost verbatim repeat of a report that Dr Watson provided to the Magistrates Court dated 28 January 2015 in support of a mental incompetence defence for Mr Lowah for the offences which precipitated Mr Lowah's six-week in-patient stay at the Boylan Ward (WCH) after being apprehended on his way to kill his father

[7] Exhibit C55, page 319, emphasis added

[8] A slow-release form of medication that is administered intravenously

relaxing (in effect ceasing) of the treatment for Mr Lowah's schizophrenia, as predicted by Dr Watson, saw the risk that Mr Lowah posed to others increase.[9]

18 The appropriateness or otherwise of Dr Giannakoureas' (and his team's) management of Mr Lowah in this period will be examined later in this Finding.

19 Mr Lowah's lengthy involvement with the mental health system in South Australia revealed that he was difficult to manage both in the community and whilst institutionalised. Mr Lowah displayed violent and aggressive behaviours even when he was receiving depot medication. The extensive mental health case notes revealed that anyone who spent any length of time with Mr Lowah had concerns for the level of risk he posed to others. However, I remind myself that underlying this behaviour was an insidious disease, schizophrenia. Mr Lowah suffered a very early onset of this illness which meant, among other things, a poor prognosis.[10] Mr Lowah's description of his '*belief system*' that he experienced during psychotic episodes, as documented by Dr Furst in the months following Ms Foster's death, revealed the frightening nature of Mr Lowah's disease. This was reported as:

> 'a complex persecutory system of delusions about this world being a simulation populated with agents of artificial intelligence controlled by entities from another reality who maintain this reality and influence his life through "mind control" in order to influence his future … these entities had been torturing him mentally not only by controlling his mind and speaking to him constantly, but by causing spores to exude through his face which he experienced as like a "torture".[11]

20 Between July and November 2017, when Mr Lowah was not receiving depot injections, he came to the attention of three senior consultant psychiatrists[12] for assessment of his mental state, who did not detect clear evidence of active psychosis. As will be detailed below, it was the expert evidence of Dr Paul Furst that Mr Lowah was continuously psychotic from July 2017, and potentially as early as May 2017, when the effects of the last depot injection, administered a month earlier, wore off. It is not suggested that the assessments were globally erroneous, rather that it was difficult to assess Mr Lowah who possessed a level of insight into his illness and was able to (at times) actively mask his symptoms to avoid treatment, particularly in settings where there were short or cursory interactions in time-pressured environments. This was on a background of the recent questioning of the diagnosis of schizophrenia and drug use, and behavioural factors in the differential mix.

21 Compounding that, as was ultimately discovered after Ms Foster's death, Mr Lowah suffered from treatment resistant schizophrenia for which only one type of medication was effective: clozapine. This medication was only available in an oral form and could not then, and still cannot now, be administered as a slow-release depot injection. As will be outlined below, this method of administration of clozapine would have been troublesome for someone in the community with Mr Lowah's circumstances, living a transient lifestyle who was often non-compliant with medication. In fact, clozapine is not commenced in the community, but in an in-patient environment to watch closely for side-

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[9] Exhibit C55, page 323
[10] Transcript, page 939
[11] Exhibit C56, pages 42 and 39
[12] Dr Michael Nance, Dr Paul Furst, Dr Craig Raeside

effects. After Ms Foster's death, when in the custody of forensic mental health services, Mr Lowah was trialled on clozapine. Mr Lowah did suffer heart related side effects which saw the medication ceased and then reinstated slowly. This demonstrated that Mr Lowah suffered from a very serious and complex illness which was difficult to treat and at times difficult to diagnose.

22 These are all factors that I have considered when reaching certain findings.

Cause of death

23 Following Ms Foster's death, a post mortem examination was conducted on 26 October 2018 by Dr Neil Langlois, who is a forensic pathologist at Forensic Science South Australia (FSSA). Dr Langlois prepared a post mortem report dated 15 March 2019, which was received into evidence at Inquest.[13]

24 Dr Langlois cited the cause of Ms Foster's death as '*head injury*', with the significant findings being laceration with skin loss to the frontal region, lacerations with bruising to the left scalp, bruising to the right side of her face, acute damage to her upper incisor teeth, acute subdural haemorrhage, brain swelling, microhaemorrhages in the brain and early APP positive axons in the brain (consistent with a short period of survival). Ms Foster also had a significantly high blood alcohol level of 0.36%, which Dr Langlois opined would have been expected to produce effects ranging from marked impairment of judgment and coordination to unconsciousness. In his interview with police, Mr Lowah commented that Ms Foster appeared to be intoxicated or was pretending to be more intoxicated than she was.[14] The post mortem toxicology report provided strong support for a finding of the former. This also went some way to explain a level of disinhibition in Ms Foster's behaviour when approaching and speaking to someone unknown to her on the evening of her death.

25 Ms Foster's brain was retained for neuropathological examination. This examination was undertaken by Neuropathologist, Professor Peter Blumbergs of FSSA. Professor Blumbergs prepared a macroscopic[15] and microscopic[16] report, both of which were tendered to the Court. Professor Blumbergs' findings included a subdural haemorrhage[17] and patchy subarachnoid haemorrhage.[18] There was a tiny contusion[19] of the left temporal pole of the brain including the brain stem. Microhaemorrhages were present within the brain including the brain stem. Dr Langlois, in his post mortem report stated that these findings were in keeping with head injury resulting in damage (tearing) of blood vessels and damage to the brain. Another important finding (as touched on above) was early

[13] Exhibit C1
[14] Exhibit C3, Record of Interview at Christies Police Station
[15] Exhibit C3a
[16] Exhibit C3b
[17] Blood between the inner lining of the skull and the brain
[18] Blood on the surface of the brain
[19] A bruise

APP[20] positive axons found in the corpus callosum[21] and the brainstem.[22] Dr Langlois opined:

> 'Impacts to the head can shake the brain. This is more likely when the mechanism of injury is for the head being rapidly accelerated and decelerated, such that would occur with inflicted impacts onto a hard surface. This can result in deformity of the brain matter within the skull causing damage to axons, which are the long processes of nerve cells.' [23]

26 The pathologist's finding was in keeping with the acceleration and deceleration action that Mr Lowah described he used when hitting Ms Foster's head against the concrete steps. This was in addition to the odonatological finding of damaged teeth and the appearance of injuries to Ms Foster's head and face, as well as the microscopic findings of injury to her scalp, mouth and tongue. This was all supportive of a finding of blunt head injury being inflicted shortly before death.

27 I accept Dr Langlois' cause of death and find that Ms Foster died from '*head injury*'.

Evidence at Inquest

28 The documentary evidence at Inquest comprised 91 exhibits.

29 In addition to the documentary evidence, oral evidence was heard from:

- Ms Stephanie Zulian, Social Worker, Yatala Labour Prison
- Mr Luke Williams, Psychologist, Yatala Labour Prison
- Dr Ian Jennings, retired Psychiatrist formerly of SA Prison Health Service
- Mr Shaun Lowah, father of Jayden Lowah
- Ms Jennifer Moore, Mental Health Nurse, Barossa Hills Fleurieu LHN
- Detective Superintendent James Blandford, SAPOL Public Protection Branch
- Detective Chief Inspector Denise Gray, SAPOL Serious & Organised Crime
- Dr Andrew Taylor, Psychiatrist, Southern Drug and Alcohol Services
- Dr Tushar Singh, Psychiatrist, Mental Health Service, Southern Area LHN
- Associate Professor Danny Sullivan, Expert - Consultant Forensic Psychiatrist
- Dr Paul Furst, Expert - Forensic Psychiatrist
- Dr Angelos Giannakoureas, Senior Consultant Psychiatrist
- Dr Michael Nance, Psychiatrist, Flinders Medical Centre
- Dr Zhao Wang, Medical Practitioner, formerly of Flinders Medical Centre

30 Ms Tamar Allner, case co-ordinator at the Adaire Clinic, Noarlunga Hospital, was summonsed to give oral evidence at the Inquest. Upon application by her solicitor,

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[20] Amyloid precursor protein
[21] The structure that joins the two sides of the brain
[22] The part of the brain that connects with the spinal cord to the body and contains vital centres that regulate breathing and circulation
[23] Exhibit C1a, page 3

Mr Jamie William Dayman, Ms Allner was excused from her summons due to ill health.[24] Mr Dayman's affidavit comprehensively set out the reasons why Ms Allner should be excused from both oral evidence and the requirement to provide an affidavit. I accepted Mr Dayman's submissions.

31 As Ms Allner's dealings with Mr Lowah were pivotal to some of Dr Furst's opinions, certain conclusions in relation to Ms Allner's involvement with Mr Lowah while he was a client of the MAC team (based on forensic analysis of the notes and other oral evidence), were reasonably open on the evidence. Ms Allner was provided with an opportunity to respond to draft findings that concerned her involvement with the clinical care of Mr Lowah by way of letter dated 16 January 2025.

32 On 27 February 2025, Ms Allner filed a detailed affidavit with the Court. This was prepared with the assistance of documents that had been tendered during the Inquest.[25] Ms Allner's affidavit was sent to the other interested parties and a Directions Hearing was held on 14 March 2025. Ms Allner's affidavit was received into evidence with the agreement of all interested parties.[26]

33 Ultimately no further evidence was called and, with the caveat that Ms Allner's version of events was not challenged in cross-examination, the Findings below have taken her evidence into account while balanced against that of other oral and documentary evidence.

Ms Michelle Stephanie Foster

34 In examining the issues considered relevant to the cause and circumstances of Ms Foster's death, it was important to focus on the illness and treatment of Mr Lowah, who had been diagnosed with schizophrenia from the unusually early age of 15. Consequently, there was a focus away from Ms Foster, her life and who she was to her family. Ms Foster's mother was invited to prepare a detailed statement about her daughter; a much-loved member of her family and a mother of two young children. Annexed to Andrea Foster's affidavit were touching letters from Ms Foster's daughter and brother. Ms Foster's partner also provided an affidavit to the Court and spoke lovingly of her.

35 Ms Foster was the daughter of Andrea and Steven Foster. Ms Foster's parents separated when Ms Foster was young, and she was raised by her mother. Ms Foster was described by her mother as a beautiful baby who was content to amuse herself for hours and slept well. As she grew older, she developed into a '*caring happy go lucky person*'.[27] Ms Foster was someone '*who always wanted to do things for others*'.[28] She was very protective of her younger brother (Peter Spiniello) who was born when she was 14 years old. In Mr Spiniello's letter to the Court he remembered his sister as someone who '*nurtured an environment of openness and community*'. He reflected on the mother that Ms Foster was, describing her two daughters as being shaped by her grace, resilience and

[24] Affidavit of Jamie William Dayman dated 2/11/2023
[25] Exhibit C63; Inquest Transcript
[26] Exhibit C71
[27] Exhibit C7, page 11
[28] Exhibit C7, page 5

enduring affection.[29] Mr Spiniello stated, '*in the wake of Michelle's passing, her laughter may have dimmed, but the harmonies she sings still resonate within my heart*'.[30]

36 Ms Foster attended Mitcham Girls High School in her early teens and left in Year 10 to commence employment at a patisserie in Arndale, where she was eventually promoted to the role of Manager. Andrea Foster described this employment as giving her daughter a sense of identity.[31] Ms Foster met her partner, Mr Ashley Thomas, when she was 19 years of age and they had two daughters together. They lived in the north-western suburb of Ethelton. Mr Thomas described his partner as a very friendly person who loved her children and who would talk to anyone regardless of who they were or their background.[32] Mr Thomas remembered Ms Foster's kind and giving nature, specifically when she visited her father and made roast pork for him and the other residents at the caravan park. On another occasion, Ms Foster made soup for a family who were experiencing difficulty.[33]

37 Around May 2018 Ms Foster rekindled her relationship with her father and would spend time with him at his home, often overnight. Mr Thomas described that Ms Foster would catch a train into Adelaide city and then another train to Noarlunga and then walk to her father's caravan in Huntfield Heights. Ms Foster's father's house was approximately 30 minutes walking distance from the Noarlunga train station.[34] Mr Thomas noted that Ms Foster's visits to her father often coincided with her consuming alcohol. Ms Foster's mother thought her daughter had difficulty with binge drinking and perceived this to be in part due to her tumultuous relationship with Mr Thomas.[35] Notwithstanding Ms Foster's mother's concerns for her relationship with Mr Thomas, it was plain that Ms Foster was dearly loved by her family and was a caring and devoted mother to her two young children. Mr Thomas stated the following:

> 'As a result of what was done to Michelle, I have lost the partner I love and mother of my children. [The two girls] have lost their mother and have to grow up without her. Even now, it has not sunk in, and we expect her to be coming home, like after a few days at her Dad's, but she isn't. Every part of us hurts'.[36]

38 Ms Foster was enroute to her father's house when she had the tragic misfortune of meeting Mr Lowah on 24 October 2018.

39 In a poignant tribute to her mother, Amelia Thomas, described the difficult stages of grief she experienced during her childhood, having never stopped missing her mother's warm hugs. Now that she is a young adult, Amelia has stopped asking why her mother left but imagines that she is by her side. Whenever a butterfly passes by, she says hello to her mother and hopes that she is proud of her. In her note, Amelia promised that she will do whatever she can to show others what an amazing person her mother was.[37]

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[29] Exhibit C14a, Annexure AF3
[30] Exhibit C14a, Annexure AF3
[31] Exhibit C14a, paragraph 8
[32] Exhibit C7, page 12
[33] Exhibit C7, pages 11-12
[34] Exhibit C17, page 5
[35] Exhibit C14, page 2
[36] Exhibit C7, paragraph 32
[37] Exhibit C14a, Annexure A of AF1

40 Ms Foster's mother, who attended for each day of the Inquest along with her Aunt Leslie, made a powerful observation which has remained with me, particularly when considering the findings below. While Andrea Foster had good reason for feeling hatred towards Mr Lowah, she saw her daughter's death in a different light after hearing the evidence at Inquest. Andrea Foster said the following:

> '[Michelle] was robbed of life and that cannot be replaced. In respect to Jayden Lowah; fundamentally as a system, we failed Jayden and the community. He was released when it was not safe to do so and he was not in a position where he could be safely reintegrated into the community. I believe that if it wasn't Michelle, it would have been someone else that Jayden Lowah would have killed.' [38]

41 As I have said, while the focus of the Inquest was necessarily elsewhere, I have not overlooked the significance of the loss of Ms Foster's life. I am grateful to her family for providing such touching tributes and photographs.

Expert evidence

42 The Court heard from two expert witnesses, A/P Danny Sullivan and Dr Paul Furst.

43 A/P Sullivan is an expert forensic consultant psychiatrist who received his medical degree from the University of Melbourne in 1994. He holds three master's degrees in Medical Law, Bioethics and Management. He is a Fellow of the Royal Australian and New Zealand Psychiatrists and a Fellow of the College of Psychiatrists (UK) and Associate Fellow in the Royal Australasian College of Medical Administrators. He is an accredited member of the Faculty of Adult and Forensic Psychiatry of the RANZCP. A/P Sullivan is currently the Executive Director of Clinical Services at the Victorian Institute of Forensic Mental Health, a role he has held since 2004. He has been involved in Serious Incident Reviews relating to homicides. He has clinical experience in forensic community, prison and hospital settings, including the assessment and management of mentally disordered offenders.

44 Dr Furst was conferred with his medical degree in 2002 and began his psychiatric training, obtaining his Fellowship of Psychiatry in March 2010. He completed an Advanced Training Certificate in Forensic Psychiatry in December 2011. Notably, Dr Furst was employed as a consultant psychiatrist with the Forensic Community Mental Health Service in 2010. In January 2011 he took on the role of in-patient psychiatrist at James Nash House. In August 2016, Dr Furst took up the position of Head of Unit of Forensic Community Mental Health Services. He has conducted outpatient clinics at Yatala Labour Prison (Yatala), the Adelaide Remand Centre and Mobilong Prison. Dr Furst holds the title of Clinical Lecturer in Psychiatry with the University of Adelaide and was awarded the Associate Fellowship of the Royal Australasian College of Medical Administrators. Dr Furst assessed Mr Lowah briefly in September 2017 when covering for Dr Craig Raeside at James Nash House. He then interviewed Mr Lowah in November 2018 and then on another three occasions for the purpose of assessing his mental competence to commit the alleged offence of murder and his mental fitness to plead and stand trial. This also occurred at James Nash House.

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[38] Addendum affidavit of Andrea Foster, paragraph 34

45 Dr Furst's role as an expert witness was unique in the sense that he had been briefly involved in Mr Lowah's mental health treatment (prior to Ms Foster's death) and undertook the investigation into Mr Lowah's mental incompetence, at the request of Mr Lowah's solicitor, following Ms Foster's death. This required a number of interview hours with Mr Lowah. Dr Furst prepared a very detailed report for the Supreme Court proceedings which then became an exhibit at the Inquest.[39] As Dr Furst had expressed certain opinions about Mr Lowah's mental health management in this report, he was asked to provide a further report for the Court in order to answer questions relevant to the cause and circumstances of Ms Foster's death and give oral evidence, both of which he did.

46 It was submitted by Mr John Homburg of counsel (for Dr Giannakoureas) that given Dr Furst formulated his opinions in a different clinical environment to that of Dr Giannakoureas, undertook extensive interviews with Mr Lowah for the purpose of a mental impairment assessment and had the benefit of all available historical information concerning his mental health, there was a risk that his opinions could become infected by outcome bias and retrospective reasoning. It was submitted that this was particularly the case with the opinions expressed relating to Dr Giannakoureas' involvement with Mr Lowah's care. I agree that this risk existed, particularly given Dr Furst's main contact with Mr Lowah was when he was so floridly unwell after the death of Ms Foster (November 2018) that he was unable to tolerate in-depth interviews. In his oral evidence, Dr Furst also acknowledged this risk.

47 A/P Sullivan provided a forensic psychiatric opinion as an entirely independent expert witness. He did not assess Mr Lowah at any time and was not involved in the mental competence investigation. After Dr Furst gave oral evidence, A/P Sullivan was requested to provide a further report and was recalled to give evidence. This was in part to comment on the opinions expressed by Dr Furst. Ultimately, I considered the opinions of both experts aligned on the main issues of criticism. I have accepted the evidence of both Dr Furst and A/P Sullivan.

Hindsight Bias

48 I warn myself concerning a vital consideration in the assessment of the evidence and any potential criticisms of witnesses in this Inquest, namely hindsight bias.

49 A description of 'hindsight bias' is given in the Australasian Coroners Manual, namely as:

> 'The tendency after the event to assume that events are more predictable or foreseeable than they really were. What is clear in hindsight is rarely as clear before the fact. If it were, there would be far fewer mistakes made. It is an obvious point, but one that nonetheless bears repeating, particularly when Coroners are considering assigning blame or making adverse comments that might damage a person's reputation…
>
> Hindsight, of course, is a very useful tool for learning lessons from an unfortunate event. It is not useful for understanding how the involved people comprehended the situation as it developed. The distinction needs to be understood and rigorously applied.'

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[39] Exhibit C56

50 As stated, I am very mindful of this warning when considering the evidence in this Inquest.

Definitions

51 It is important at this juncture to define the terms that will be used throughout this Finding. Firstly, a Community Treatment Order (CTO) is an Order made in the South Australian Civil and Administrative Tribunal (SACAT) to require a person with a mental illness to cooperate with treatment determined necessary by a psychiatrist or authorised medical practitioner, including taking any medication for that mental illness absent their consent.[40] If a person the subject of the Order refuses to abide by the conditions, they can be taken under the care and control of police, SAAS or an authorised mental health professional in order to receive that treatment.[41]

52 A Mental Impairment Supervision Licence (a Licence) imposes conditions set by the Court on offenders who commit an offence but are found to be not guilty by reason of mental impairment and are subsequently released into the community. A Licence is in force for a 'limiting term' which is fixed with regard to the likely sentence of an offender who was not mentally impaired. Supervisory responsibility for those released on Licence is divided between the Parole Board and the Minister for Health.[42]

53 An Inpatient Treatment Order (ITO) is an order made by a medical practitioner or authorised mental health professional that a person receive treatment as an in-patient in a treatment centre. Following an examination, it must be determined that the person has a mental illness and, because of the illness, the person requires treatment either for their protection from harm or for the protection of others from harm. In addition, they must have impaired decision-making capacity relating to appropriate treatment of the person's mental illness, and there is no less restrictive means than an ITO of ensuring appropriate treatment of that illness.[43]

54 A Domestic Violence Intervention Order (formerly known as a Restraining Order) is instituted to restrict the behaviour or actions of a particular person. It is to protect people from domestic or family abuse.[44]

The emergence of Jayden Lowah's mental illness and the focus of the Inquest

55 Jayden Lowah was born on 8 August 1998 to parents Sharon Buer and Shaun Lowah. Jayden was the middle child of three boys. Mr Lowah's parents separated in 2001, with the children remaining in the care of their mother. It was around this time that Ms Buer was hospitalised due to her mental health deteriorating, and the three boys spent eight weeks in foster care. Thereafter, Ms Buer was hospitalised a number of times for her mental health which caused extensively documented trauma to Mr Lowah. This appeared to have set the scene for Mr Lowah's scepticism of his own psychiatric illness and mental

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[40] Legal Services Commission of South Australia 2024, *Community Treatment Orders*, accessed 4 October 2024, https://www.lawhandbook.sa.gov.au/ch30s04s01.php

[41] Provided that the conditions set out in s56 of the Mental Health Act 2009 (SA) are satisfied.

[42] Department for Correctional Services 2024, *Licences*, Government of South Australia, accessed 4 October 2024, https://www.corrections.sa.gov.au/community-corrections/licences

[43] Sections 21-28 of the Mental Health Act 2009

[44] Government of South Australia 2024, Intervention Orders, accessed 4 October 2024, https://www.sa.gov.au/topics/housing/emergency-shelter-and-homelessness/legal-protection-from-domestic-violence/*intervention-orders*

illness in general. Dr Craig Raeside (consultant psychiatrist) in 2017 described Mr Lowah as rejecting the medical model of mental illness.[45]

56 Mr Lowah attended Seaford Rise Primary School and was noted to be of above average intelligence and accelerated in his learning. In 2008, at the age of 10, Mr Lowah was referred to the Child and Adolescent Mental Health Service (CAMHS) due to concerning behaviour at home.[46] This included aggressive and threatening behaviour towards his mother and younger brother.[47] Reports of this behaviour continued as Mr Lowah commenced high school, with Mr Lowah also coming to the attention of police after engaging in criminal activity.[48] It was reported that he had commenced using cannabis in 2012.[49] It was around this time that Mr Lowah reported his father hitting him repeatedly during a contact visit. For a period following this, Mr Lowah was noted to be very angry with his father and refused contact with him.

57 On 3 June 2014, when Mr Lowah was 15, he stole his mother's car with the stated intention of travelling to Goolwa, where his father lived, to kill him with a knife. Mr Lowah was apprehended by police before he arrived in Goolwa and detained under a Level 1 ITO pursuant to the *Mental Health Act 2009* by staff at the Victor Harbor Hospital.[50] Mr Lowah admitted to having used cannabis the day before. He informed a medical officer that he had recently stayed with his father which had stirred up bad memories (the details of which he refused to disclose at the time) and planned to stab him. When speaking to staff at the hospital he described feeling less outraged than earlier, but that he still wanted to cut off his father's leg and let him die.[51] Mr Lowah was then transferred to the Women's and Children's Hospital (WCH), where he was admitted to the paediatric psychiatric ward (Boylan Ward) for a period of six weeks, between 3 June and 28 July 2014. At the time of his admission he was noted to be floridly psychotic.

58 The principal diagnosis for this period of admission was '*first episode psychosis*',[52] for which Mr Lowah was commenced on a depot antipsychotic, risperidone, (due to concerns about non-compliance with medication) 25mg intramuscularly per fortnight. Underlying the psychosis was thought to be a diagnosis of schizophrenia. Upon discharge, Mr Lowah was placed under a CTO on 1 July 2014 and referred to ongoing follow up through CAMHS.[53]

59 At the time of his apprehension by police, Mr Lowah was charged with three criminal offences relating to his attempts to act on homicidal ideation towards his father.[54] As part of the investigation into Mr Lowah's mental competence to commit the offences against

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[45] Exhibit C59a, pages 157-161
[46] Exhibit C41, page 185
[47] Exhibit C41; Transcript page 936
[48] Exhibit C34b, Annexure B, pages 8-9 (2012)
[49] Exhibit C41, page 185
[50] Exhibit C35, page 8
[51] Exhibit C35, page 11
[52] Exhibit C41, page 185
[53] Exhibit C55, page 319
[54] Threaten to kill or endanger life (aggravated), Carry Offensive Weapon, and Unauthorised person to Drive Motor Vehicle on Road

his father, Dr Marshall Watson provided an opinion to the Magistrates Court in a report dated 28 January 2015. Dr Watson stated:

> '[a]lthough Mr Lowah had previously been diagnosed with a psychotic illness, it is my opinion as per the DSM-V criteria that on balance at this point in time, Jayden has a diagnosis of Schizophrenia (with symptoms including delusional ideation, irritability, guardedness and social isolation that have occurred in the absence of substance misuse).'[55]

60 This report was reproduced almost verbatim in the handover letter to Dr Hooper dated 2 February 2015, a portion of which has been extracted above in this Finding. Of note was the comment by Dr Watson that:

> 'without treatment, [Mr Lowah's] risk of relapse with a mental illness [was] high, as [was] his potential risk for violence towards those incorporated in his delusional belief system.' [56]

61 These charges were dealt with on 12 February 2015 by way of a Part 8A CLCA investigation, with Mr Lowah found to be mentally incompetent to commit the offences and released on Licence. A limiting term of 12 months was fixed.[57] Relevantly, there were several conditions attached to the Licence including:

- Mr Lowah was to be under the supervision of the WCHN-CAMHS, except in relation to the treatment and monitoring of his mental health, which was entrusted to the Clinical Director of WCHN-CAMHS and any other psychiatrist or psychologist nominated by the Clinical Director;
- Mr Lowah be required to reside where directed;
- Mr Lowah abstain from drugs and alcohol;
- Mr Lowah attend regular psychiatric or psychological reviews.[58]

62 The significance of the above conditions was twofold. Firstly, during this period of Licence it was observed by Mr Lowah's treating psychiatrist (Dr Watson) that apart from two brief periods, one of several days and one of several weeks, Mr Lowah had spent the entire period of his Youth Team Episode of care back in secure care in the Adelaide Youth Training Centre (AYTC) due to breaches of his Licence conditions.[59] While less than ideal for Mr Lowah, this demonstrated that there was an imposed structure in place for his frequent non-compliance. Secondly, and in contrast, when arrested for violent and unprovoked criminal offences in August 2017 (detailed later in the Finding), after the cessation of the depot medication, Mr Lowah pleaded guilty (without applying for a mental incompetence investigation) and was sentenced to an immediate term of imprisonment. He spent two periods in James Nash House during this period of imprisonment[60] with the second admission revealing his schizophrenia had relapsed secondary to the planned cessation of antipsychotics.[61] He was recommenced on the

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[55] Exhibit C39, page 129
[56] Exhibit C39, page 128
[57] Exhibit C55a, page 319
[58] Exhibit C39, page 103
[59] Exhibit C41, page 278
[60] August 2017; 15-28 November 2017
[61] Exhibit C59a, pages 157-159

antipsychotic aripiprazole once released from Yatala into the community on 14 September 2018 (after serving his entire sentence), but he was not subject to supervision. The only enforced structure for Mr Lowah in the community was to have his depot medication once a month as required by the CTO.

63 As will be detailed below, the Parole Board[62] and those caring for Mr Lowah in the High Dependency Unit (HDU) of Yatala in 2017-2018 held serious concerns about the risk Mr Lowah posed once released into the community in September 2018. The Parole Board denied Mr Lowah parole when he applied in June 2018, stating that the Board considered him '*such a significant risk to the community as to be unsuitable for release on parole*'.[63] When Mr Lowah's head sentence came to an end, extensive efforts were made by the HDU, in particular Ms Stephanie Zulian and Mr Luke Williams, to ameliorate this risk. However, these were unsuccessful for a number of reasons. As will be detailed below, the Parole Board had no power over Mr Lowah when released in September 2018, and the HDU and social workers were constrained by his lack of engagement and the lack of formal mental health orders, such as a Licence or ITO. Following his release, other than those administering his medication, there were no eyes on Mr Lowah, with tragic consequences for Ms Foster.

64 It was therefore a focus of the Inquest as to the basis for Dr Angelos Giannakoureas' decision to cease Mr Lowah's antipsychotic medication in April 2017, which on its face appeared incongruent with the previous diagnosis and treatment for schizophrenia and the warning of treatment complacency by Dr Watson.

Circumstances leading up to the death of Ms Foster

The cessation of depot medication

65 Returning to the period of time following the diagnosis of first episode psychosis, Mr Lowah was admitted to Boylan Ward on six further occasions between December 2014 and August 2016. These admissions were relatively brief and for different reasons, including a change in antipsychotic medication (due to a common side effect with risperidone),[64] breakthrough auditory hallucinations following drug use, and emotional dysregulation. This history was supportive of his early diagnosis of schizophrenia at the age of 15. A/P Sullivan in his evidence opined that a diagnosis of schizophrenia at this age was unusual, but not rare.[65] There was no suggestion during the Inquest that this diagnosis was made in error.

66 After the initial diagnosis and the institution of antipsychotic medication by way of depot injection, there were two occasions where Mr Lowah's depot was ceased. The first occasion occurred on 31 December 2015. While not directly relevant to Ms Foster's death, I touch on this occasion as it was a well-documented example of Mr Lowah's propensity to relapse without regular antipsychotics. The circumstances giving rise to this occasion were that, following a period of mental health stability, Mr Lowah requested that the depot be ceased. Coincidentally, the CTO that had been put into place the year before had lapsed. Mr Lowah's depot treatment regime had been the antipsychotic

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[62] Exhibit C52, pages 2-3
[63] Exhibit C52, page 3
[64] A known side effect of Risperdal Consta is symptomatic hyperprolactinaemia
[65] Transcript, page 938

zuclopenthixol, and fortnightly 400mg quetiapine nocte. At his request the depot was ceased and he was prescribed an oral dose of 400mg quetiapine. With the lapsing of the CTO and the change to an oral medication only, Mr Lowah was trusted to maintain the oral antipsychotic. Unfortunately, it was plain from the mental health records that Mr Lowah's mental state stability was quick to deteriorate with the change in the medication regime and his subsequent non-compliance. I will detail this deterioration below.

67 In January and March 2016 Mr Lowah was conveyed to the Lyell McEwin Health Service (LMHS) with concerns in relation to his mental health. On the first occasion he threatened suicide to his mother, but then informed police he had no intentions of following through, rather he intended to lay the phone on the train tracks while his mother was listening. This was on the background of her refusing to allow him to reside with her. The second occasion, Mr Lowah presented with evidence of psychosis including paranoid delusional beliefs. Mr Lowah had informed his carer that he was starting to have paranoid thoughts and was feeling agitated in the context of cannabis use. He was detained under a Level 1 ITO and transferred to Boylan Ward where he remained for three days.[66]

68 On 1 July 2016, Mr Lowah was seen by consultant psychiatrist, Dr Geetha Giri in the community for review. He was accompanied by his care coordinator (CC), Leon. Leading up to this review advice had been sought by Dr Giri from Dr Watson (who was no longer Mr Lowah's treating psychiatrist). Dr Watson responded with concern that Mr Lowah was displaying signs reflective of his relapse signature and that an urgent review was indicated.[67] At the commencement of the review Mr Lowah declared to Dr Giri that he had stopped taking all his medication. He stated that his illness was solely related to cannabis use, and he had ceased smoking it. Accordingly, he had thrown out all his medication as he considered he did not need it in the absence of cannabis use. It was evident to Dr Giri during the review that Mr Lowah knew his CTO had lapsed and that he could not be forced to take fortnightly depot injections. At one point during the appointment, Mr Lowah became hostile and tried to take his file from Dr Giri.

69 In a letter to Mr Lowah's GP about the review, Dr Giri described Mr Lowah's behaviour at times during the review as '*intense and intimidating*'. At one point he stated to both Dr Giri and Leon: '*you speak like robots, you are dogs*'.[68] Dr Giri highlighted in this letter that she was specifically concerned about Mr Lowah verbalising that he had stopped medications and noted he was a significant threat to other people when he became unwell. She recommended that he be referred to Dr Watson for assessment and management options, and that further appointments to review his mental state be conducted via telepsychiatry assessment as she was of the view that her appointments with him had not been therapeutic, and the clinical risk had significantly increased.[69] Dr Giri's letter to Mr Lowah's GP left the reader with an impression of her discomfort in Mr Lowah's presence.

70 On 15 July 2016, Mr Lowah presented to the WCH ED with a recorded several week history of self-discontinuing his oral antipsychotic medication. Mr Lowah had been

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[66] Exhibit C41, pages 328-329
[67] Exhibit C41, page 318
[68] Exhibit C41, pages 299-300
[69] Exhibit C41, page 300

residing with his father in Goolwa in this period and his father became worried as Mr Lowah was making paranoid accusations about his father allegedly taking photographs of him while asleep.[70] Upon arrival in the ED Mr Lowah was noted to be agitated and paranoid and it was thought that depot medication should be recommenced. This was a decision already being independently contemplated by the Southern Fleurieu Youth Mental Health Team (YMHT), who had been managing him in the community. A Level 1 CTO was made and confirmed on 19 July 2016 (to be reviewed by SACAT/Boylan on 12 August 2016) and depot zuclopenthixol commenced.[71] Mr Lowah was discharged from the Boylan Ward on 22 July 2016, to remain under the care of Southern Fleurieu YMHT whilst living at his father's house, with Junction Housing to be considered as accommodation in the medium term.

Depot injections reinstated

71 The clinical records reflected that there was an immediate angered response to the reinstitution of the depot antipsychotic from Mr Lowah. On 5 August 2016 Mr Lowah refused to have his depot and visited his mother who was a mental health inpatient on the Morier Ward, Noarlunga Hospital. On that day he threatened to harm consultant psychiatrist Dr Newman, who formed the opinion that Mr Lowah was psychotic. Mr Lowah was detained and transferred to the Boylan Ward where he received his missed depot. He was discharged the following day. Over the next six months, between August and December 2016, Mr Lowah declined the administration of depot on at least three occasions and was noted to be angry, irritable and insightless.[72] His Level 1 CTO expired on 16 August 2016. Accordingly, an application was made for a Level 2 CTO, which was listed for hearing on 7 September 2016.

72 Between January and July 2016, when Mr Lowah was not receiving depot injections, there was a well-documented escalation in Mr Lowah's behaviour with active non-compliance, poor insight, threatening and paranoid behaviour, hospital presentations and admissions under ITOs. This was the exact scenario predicted by Dr Watson in his handover letter to Dr Hooper and the psychiatric opinion he provided to the Court in January 2015. Dr Watson referred to this as Mr Lowah's '*relapse signature*'. On this occasion it was quickly realised that Mr Lowah required more structured treatment and the depot medication was reinstated.

73 Upon Mr Lowah's discharge from Boylan Ward in August 2016, the Noarlunga MAC team became involved with his care. The MAC team was part of the Noarlunga Community Mental Health Service (NCMHS) based at Adaire Clinic, Noarlunga Centre. Mr Lowah also moved into Junction Housing in Morphettville on 17 August 2016.[73] The CTO application heard on 7 September 2016 confirmed a Level 2 CTO effective until 6 September 2017. Pursuant to that Order, Mr Lowah was administered aripiprazole (300mg) every four weeks by way of depot and 20mg oral aripiprazole daily. Importantly, that regime commenced on 26 August 2016 and remained in force until Mr Lowah saw Dr Giannakoureas on 11 April 2017, at which time the antipsychotic depot medication was ceased. The CTO authorised treatment be given despite refusal or

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[70] Exhibit C41, pages 322-323
[71] Exhibit C41, pages 326-327
[72] Exhibit C41, pages 215, 225, 268-269 and 311
[73] Exhibit C41, page 275

the absence of consent to the treatment and required that the treatment and care of Mr Lowah be governed by a treatment and care plan. Order 6 is extracted below:

> 'Note: As a result of this order, and if required, an authorised officer or police officer may take Jayden Tane Lowah into the officer's care and control for the purpose of transport to a treatment centre or other place for mental examination or treatment in accordance with the provision of the Mental Health Act 2009.' [74]

The Noarlunga MAC team

74 When initially under the care of the MAC team, and residing at Junction Housing, it was recorded that Mr Lowah developed a rapport with his support worker and was accepting of the support offered. This, along with his accommodation at Junction Housing, was recorded to be a 'protective factor'.[75] Mr Lowah was noted to be cooperative with receiving his depot in January and February 2017, although did voice concerns about his physical health. While short-lived, this was a documented period of time where Mr Lowah was responding to treatment and the supports that had been put into place.[76] On 10 March 2017, Mr Lowah refused the administration of depot. He was assessed as experiencing paranoid ideation about the potential for unqualified staff to be diagnosing and treating him.[77] The depot was administered on 16 March 2017 with the support of the CTO.

75 On or about 22 March 2017, Mr Lowah was approved for an IPRSS package, a service offered through United Care Wesley[78] (UCW) providing psychological support, domestic assistance, outings, socialisation, and re-engagement with the community. A meeting was arranged between UCW and the MAC team to facilitate this service. It is important to acknowledge the particular significance this proposed package had for Mr Lowah. As described by A/P Sullivan, with an unusually early diagnosis of schizophrenia (teenage years) there was a high risk of the illness interrupting very vital developmental stages including education, interpersonal relationships with friends and family, and employment. With later onset schizophrenia these protective factors are often in place.[79] It was not difficult to see that the early diagnosis and treatment (both medication and involuntary in-patient and custodial detention) had already impacted on Mr Lowah in these important developmental areas. The program offered by UCW could have provided Mr Lowah with aspects of his formative years that his illness deprived.

76 On or about 7 April 2017, the role of Mr Lowah's CC was handed over to Ms Tamar Allner, with a case note dated 12 April 2017 reflecting this.[80] On 11 April 2017, Mr Lowah attended the Morier Ward for his monthly depot injection. I have found that what occurred following this appointment was the '*destabilising event*' in the mental state of Mr Lowah.

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[74] Exhibit C55a, page 237
[75] Exhibit C55a, page 12
[76] Exhibit C55a, pages 10-13; Exhibit C41
[77] Exhibit C55a, page 31
[78] Now called Uniting SA
[79] Transcript, page 939
[80] Exhibit C55a, page 43

11 April 2017

77 In April 2017, Dr Angelos Giannakoureas was employed at the Noarlunga Health Service as a consultant psychiatrist. He had been in this employ for nine years. By way of training, Dr Giannakoureas was conferred with his medical degree in 1995 and commenced psychiatric training in the two years following his basic medical training (intern and RMO year). He received his fellowship with the Royal Australian and New Zealand College of Psychiatrists (RANZCP) in 2006. Dr Giannakoureas provided two affidavits to the Court and gave oral evidence at the Inquest.

78 Mr Lowah's mother, Sharon Buer, was a private patient of Dr Giannakoureas and had been so for a number of years. Ms Buer had spoken of her son to Dr Giannakoureas and his understanding of Mr Lowah (prior to their first meeting on 11 April 2017) was that he exhibited behavioural difficulties which caused conflict at home and necessitated a restraining order at times. He was aware that Ms Buer found this very difficult as she wanted to support her son but was often frightened of him.[81] Ms Buer asked Dr Giannakoureas to become Mr Lowah's psychiatrist. Dr Giannakoureas was initially reluctant, stating '*we don't usually see two members of the same family*'.[82] Although Mr Lowah was not physically seen by Dr Giannakoureas before 11 April 2017, the case notes reflected that Dr Albert Matti independently discussed Mr Lowah with him on two occasions regarding his management plan.[83] Dr Matti was a senior psychiatric registrar working in the MAC team and Dr Giannakoureas was his supervising consultant.

79 As it happened, quite by chance, on 11 April 2017 Dr Giannakoureas was contacted as Mr Lowah was causing a disruption on the Morier Ward, unhappy about receiving his scheduled depot injection. In his first affidavit, Dr Giannakoureas explained that he would often see patients that his colleagues preferred not to, including complex cases. He therefore did not consider it unusual to be called if there was a behavioural disturbance on the ward.[84]

80 Dr Giannakoureas was notified that Mr Lowah was in the Morier Ward HDU by someone from the MAC team. It was reported that Mr Lowah was being verbally abusive to staff. Dr Giannakoureas attended and calmed Mr Lowah down and walked with him on his way to the clinic. Dr Giannakoureas spent some time talking to Mr Lowah, during which Mr Lowah expressed feelings of sadness and that he was not in control of his future, which made him think of suicide.[85] This appeared to Dr Giannakoureas to be in part due to being forced to have depot injections, which Mr Lowah was of the view he did not need in the absence of illicit substance use. Mr Lowah repeated his long-held belief that his psychosis was linked to cannabis use, and he would remain well if he abstained from this illicit drug use. Dr Giannakoureas noted that the aggression he had seen in the Morier Ward appeared to be directed solely at female staff members, and he formed the view that he might have a better rapport with Mr Lowah because he was male.[86] While Dr Giannakoureas accepted that there was a potential for conflict with him treating Mr Lowah's mother, he denied that this compromised his decision to commence treating

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[81] Exhibit C15, paragraphs 35, 63, 65
[82] Exhibit C15, paragraph 38
[83] Exhibit C15a, paragraph 15; Exhibit C55, page 181
[84] Exhibit C15, paragraph 40
[85] Exhibit C55a, page 41
[86] Transcript, page 706

Mr Lowah, or to cease his depot medication on that day, which both Mr Lowah and Ms Buer (previously) had asked him to do.[87]

81 Dr Giannakoureas made an entry in Noarlunga Health Service Notes reflecting his comments, assessment and plan for Mr Lowah:

> 'Was at the HDU Morier, creating a scene
> Verbally abusive
> Wanted to know why he was having depot there, instead of Adaire
> Eventually calmed down
> Told me he was unhappy about the depot Aripiprazole
> Acknowledges becoming psychotic, but attributes this to Cannabis use
> States he would be 'fine' if he ceased using
> After some initial carry on, became reflective and told me he was sad
> Feeling like he's not in control of his future makes him think of suicide
> Said being forced to have an injection contributes to this
> Denied voices, ideas of reference, thought interference
> Reactive in affect
> No current evidence of psychosis
>
> ASST
> Angry young man with borderline traits and a predisposition to becoming psychotic, in the context of substance abuse
> Survivor of an unhappy childhood
> Finds it difficult to contain his emotions
>
> PLAN
> Depot ceased
> Will do his best to refrain from illicits
> Review in three weeks' [88]

82 Dr Giannakoureas' oral evidence largely supported the above entry in the clinical records. An important clarification in his oral testimony was that upon accepting Mr Lowah as his patient at that time, he was not dismissing the previous diagnosis of schizophrenia. Rather, he considered there were other things going on, including borderline traits, thereby questioning rather than dismissing the diagnosis. He also considered that Mr Lowah was at risk of suicide if the depot regime continued. This consideration was armoured by the distress Mr Lowah's mother had expressed that her son may commit suicide if not taken off the depot medication.[89] Dr Giannakoureas made the decision at his first appointment with Mr Lowah to cease the depot medication. He stated in making this decision he considered the dilemma, '*Do I continue with the depot, on the assumption it is treating an underlying illness, and risk causing so much distress the patient commits suicide*?'[90] The other factor that influenced Dr Giannakoureas' decision was that he viewed the continuation of depot medication to be an impediment to establishing a therapeutic relationship with Mr Lowah. He had formed the preliminary view that Mr Lowah's agitated and aggressive behaviour in the absence of psychosis was driven by environmental factors and substance abuse.[91]

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[87] Transcript, page 713
[88] Exhibit C55a, page 41
[89] Transcript, page 709
[90] Exhibit C15, paragraph 46 (page 10)
[91] Transcript, page 675

83 Dr Giannakoureas stated that he took Mr Lowah off the depot on 11 April 2017, '*with caution*'. He recalled making '*a deal*' with Mr Lowah that he was to stop taking drugs and behave himself and, in return, he would give Mr Lowah a trial without the depot injection and see him regularly.[92] Mr Lowah did receive the depot injection on that day,[93] but thereafter the agreement reached was for him to be trialled without any antipsychotic medication, in particular the depot injection. It was Dr Giannakoureas' plan to review Mr Lowah in three weeks. Dr Giannakoureas stated the following:

> 'My agreement with Jayden was that I would pause his depot medication on a trial basis, provided he stopped using illicit substances and attended appointments made by the MAC team. I emphasised that if he continued using drugs and became psychotic, I would recommence depot antipsychotic. My plan was not to abandon Jayden or rule out treatment with depot in future. I assumed consultant responsibility for managing his care and insisted that he would continue being our patient. It was simply not my intent to discharge him from the MAC team. Jeanette Moir was designated his clinical coordinator. The MAC team would closely monitor Jayden's mental state in regular reviews.' [94]

84 Prior to ceasing the depot, Dr Giannakoureas did not review Mr Lowah's recent mental health history from the records.[95] Had he chosen to undertake this task, the records would have been readily available to him by way of Noarlunga Hospital case notes. Critically, that would have included Dr Marshall Watson's referral letter to Dr Hooper dated 2 February 2015, with the caution that Mr Lowah may minimise his psychotic symptoms, leading to a false sense of security and reduction of treatment intensity, which in turn would increase his risk.[96] A copy of this letter had been placed in Volume 1 of the Noarlunga Heath Service notes along with multiple discharge summaries from his various admissions to the Boylan Ward, including when he was first diagnosed with schizophrenia after expressing intentions to kill his father.[97] In addition, there were entries relating to his recent admission to the Boylan Ward following his self-discontinuation of his oral antipsychotics bringing about a psychotic episode after the first trial of ceasing depot. As detailed above, the latter admission saw his depot injections reinstated, and the Level 2 CTO put into place.[98] This episode was proximate in time to the MAC team receiving and accepting Mr Lowah's referral to their service. It was also a very recent example of an unsuccessful attempt to take Mr Lowah off depot medication and a potential predictor of what might happen if this was to occur.[99] Dr Giannakoureas' claim that he took Mr Lowah off the depot '*with caution*', was unsupported by his failure to review the clinical records.

85 The two expert psychiatrists called to give evidence during the Inquest agreed that Dr Giannakoureas' decision to cease the depot injections, in the circumstances as they presented on the day, was '*not unreasonable*'.[100] Neither expert expressed any real concern about the decision by Dr Giannakoureas to assume consultant responsibility for Mr Lowah, at the same time as treating his mother. Their criticism of this aspect of

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[92] Transcript, page 708
[93] Exhibit C55a, page 211 (date entered 10.4.17 – this was clearly in error as he attended on 11.4.17 for depot); C55b
[94] Exhibit C15a, paragraph 38
[95] Transcript, page 710
[96] Exhibit C55, page 319
[97] Exhibit C55, page 249
[98] Exhibit C55, page 65
[99] Exhibit C55, page 155 – Dr Giannakoureas was part of the clinical review meeting where Mr Lowah's referral was discussed and accepted
[100] A/P Sullivan, Exhibit C51a, paragraph 36; Dr Furst, Transcript, page 618

Mr Lowah's treatment was the lack of a structured management plan to deal with non-compliance after the cessation of the depot injection and the change in narrative around his illness.[101] I will deal with this below.

86 It was evident that Mr Lowah displayed antisocial and aggressive behaviours even when receiving depot medication. However, the effect of ceasing the depot medication saw a relaxing of forced structure that had previously required Mr Lowah to attend the Morier Ward for depot injections, which had the underlying benefit of providing supervision and assertive follow up if required. While the CTO remained in place in principle, the focus of the CTO, being the depot injection and the structure around ensuring Mr Lowah received it, essentially became obsolete. The other consequence of ceasing the depot injection was a moving away from the approach toward the underlying illness for which Mr Lowah had been receiving antipsychotics. It became apparent, as will be set out below, that when the antipsychotic medication was stopped, members of the MAC team saw Mr Lowah in a different diagnostic light.

87 I pause here to provide some context in relation to Ms Allner's involvement which was detailed in her affidavit dated 27 February 2025 and provided after the close of oral evidence for reasons detailed above.

88 Ms Tamar Allner was a Registered Nurse who has worked in several different fields of nursing from the beginning of her career in 1993. In 2007, Ms Allner undertook further studies in mental health at Flinders University and continued her career as a mental health nurse. In May 2015, she commenced employment at the Adaire Clinic, originally in Team A.[102] In late 2016, Ms Allner moved to Team B of which there were two sub-teams, 'Transitional Care Team' and 'Mobile Assertive Care' (MAC) Team. Ms Allner worked in both sub-teams at different times, but relevantly worked with Mr Lowah while undertaking duties in the MAC Team.

89 Ms Allner explained in her affidavit that she was temporarily allocated as Mr Lowah's CC on 7 April 2017, as his former CC Ms Sian James reportedly felt at risk of harm from him. The case note of the handover of Mr Lowah's care does not reflect Ms James' apparent fear of Mr Lowah, or the temporary nature of Ms Allner's role.[103] Although I note that one would not necessarily expect to see details of this in such an entry.

90 Ms Allner's role as CC was formalised on 12 April 2017 at a Case Review with the case note recording '*ongoing care co-ordination via Tamar MAC*'.[104] Ms Allner was not present at this meeting and was apparently not consulted about taking over the role of sole CC.[105] In her affidavit, Ms Allner expressed her discontent with not being consulted about the decision. She stated:

> 'Transfer of Jayden's care to me should have involved a meeting between Jayden, his former care co-ordinator, Sian, and me so I could formally introduce myself to him as his new care

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[101] A/P Sullivan, Exhibit C51a, paragraph 36; Dr Furst, Transcript, page 619
[102] Team A was tasked with undertaking emergency assessments of consumers and triaging incoming referrals to be actioned immediately or presented to the Multi-Disciplinary Team for further discussion and review (para 23)
[103] Exhibit C55a, page 39
[104] Exhibit C55a, page 43
[105] Affidavit, paragraph 58

co-ordinator. This would have assisted me in building rapport and a therapeutic relationship with Jayden.'[106]

91 Prior to this time, Ms Allner knew only of Mr Lowah by reputation. From her affidavit it appeared that this information came primarily from Ms James, that Mr Lowah had a significant family history of domestic violence, reported illicit substance use, dysfunctional family unit and was considered a risk to staff safety due to aggressive behaviour.

92 Ms Allner expressed the view that she was left to piece everything together herself in relation to Mr Lowah in the context of an upcoming four-week period of annual leave, an excessive caseload and a lack of leadership and staffing issues. She affirmed in her affidavit that due to these factors, she was unable or found it difficult to escalate her concerns. [107]

93 It was apparent from Ms Allner's affidavit that she had formed certain views of Mr Lowah prior to meeting with him, and was unhappy about having been allocated as his CC. While the information she received from Ms James was factually correct, it was evident that Ms Allner's perception of Mr Lowah was coloured before she had taken the opportunity to form her own clinical assessment.

94 Even before having met Mr Lowah, Ms Allner arranged for Mr Lowah to have his scheduled depot medication on 11 April 2017 in a different location due to concerns raised by Ms James about staff safety. Instead of the GP Plus clinic, Ms Allner arranged for Mr Lowah to be brought to the Morier Ward of the Noarlunga Hospital and receive the injection in the High Dependency Unit (HDU). Ms Allner arranged security and members of the MAC Team to be in attendance.[108] It is unclear whether Mr Lowah was notified of the change in arrangements in advance. This demonstrated that Ms Allner had a pre-conceived view of Mr Lowah that was subsequently reinforced by his outburst on the day.

95 Ms Allner did not meet Mr Lowah on 11 April 2017. It was only because a Code Black was called in response to Mr Lowah's volatile behaviour that Ms Allner attended and witnessed some of the incident. I do not consider this a meeting in the true sense, where they were introduced to one another. With Ms Allner being formally allocated to the role of CC on 12 April 2017 and speaking with Mr Lowah over the phone on five occasions following that, it was not until 11 July 2017 that they met for the first time.[109] I consider this to be an unacceptable timeframe, particularly given what occurred in this three-month period. However, I accept there were mitigatory factors involved where Ms Allner was concerned, not the least of which being the absence of a structured management plan.

Following the cessation of depot

96 Predictably, following the cessation of depot, there was an almost immediate disengagement with the MAC team and an escalation in Mr Lowah's erratic behaviour which saw his supports and protective factors either fall away or withdrawn. Arguably,

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[106] Affidavit, paragraph 59
[107] Affidavit, paragraph 60
[108] Affidavit, paragraphs 98-99
[109] Affidavit, twice on 28/04/17 (para 150), 24/05/17 (para 210), 13/06/17 (para 232) and 03/07/17 (para 263)

the most important of those included Mr Lowah's accommodation at Junction Housing and his support package from UCW. While Dr Giannakoureas gave evidence of what he thought was the understanding between himself and Mr Lowah on 11 April 2017, there was no established plan to ensure Mr Lowah remained on track. As Dr Watson had predicted, Mr Lowah had minimised his symptoms which saw the relaxing of treatment options, which increased his risk. In his oral evidence, Dr Giannakoureas accepted that he had made an inaccurate assessment of Mr Lowah on 11 April 2017.[110] He remarked that in retrospect, the level of manipulation by Mr Lowah was very surprising to him. He did not believe at the time that Mr Lowah was '*sophisticated enough to be that deceitful*'.[111] Dr Giannakoureas placed emphasis on this conclusion being made in retrospect. However, had he thought to review Mr Lowah's medical history before making the decision, he may have had cause for genuine caution given the historical pattern displayed by Mr Lowah, as well as Dr Watson's prediction.

97 While not exhaustive, below were the documented events following the cessation of Mr Lowah's depot, noting that the expert evidence heard at Inquest was that the therapeutic benefit of the depot Mr Lowah received on 11 April 2017 would have worn off by mid-May 2017.[112]

- On 28 April 2017, Mr Lowah attended an appointment with Dr Neild and it was recorded that he had abstained from cannabis use for ten days but had then used a number of times 'but little per occasion'. Dr Neild formed the impression that Mr Lowah's awareness and insight appeared to be good and there was improved engagement but noted an ongoing risk of developing psychosis due to drug use, and the reduced circulating antipsychotic.[113]

- On 22 May 2017, Ms Allner noted a phone conversation with Rebecca from Junction Housing during which she was advised that Mr Lowah's mother considered Jayden to be mentally unwell, using cannabis again, and had become agitated, having damaged his property by punching the walls. Rebecca suggested that Jayden should be on depot again. In her entry, Ms Allner queried whether Rebecca was a qualified mental health clinician.[114]

- In Ms Allner's affidavit, she stated that she did not know Rebecca and was therefore uncertain as to her qualifications. She stated that Rebecca's qualifications would be relevant to the weight to be given to her suggestion that Mr Lowah recommence his depot. Ms Allner asserted that she asked Rebecca questions to ascertain whether Mr Lowah was exhibiting behaviours consistent with psychosis, such as pulling cables out of the walls or television. As Rebecca was apparently unable identify any such behaviours, Ms Allner noted '*did not identify any acute MH issues*'. Ms Allner asserted the belief that if Ms Buer was of the view that her son should recommence the depot medication that she would have advised herself, Dr Giannakoureas or her own CC.

- At some point in this time frame, Dr Giannakoureas became aware that Ms Buer had expressed to a member of the MAC team that she believed her son should be

[110] Transcript, page 741
[111] Transcript, page 741
[112] Transcript, page 897
[113] Exhibit C55a, page 51
[114] Exhibit C55a, page 67

back on depot medication. This was a change in her position from only a few months before.[115]

- In her affidavit, Ms Allner asserted that she had an undocumented conversation[116] with Ms Buer to follow up on the information from Rebecca. She stated that Ms Buer was unable to identify any symptoms of psychosis and described her son becoming aggressive in the context of cannabis use. Ms Allner did not state that she explored with Ms Buer her concern that her son was '*mentally unwell*', as reported by Rebecca. It is likely that this conversation was that where Ms Buer suggested that the depot medication be reinstated. Dr Giannakoureas recalled a member of the MAC Team telling him this at some stage.

- On 23 May 2017, the Junction Housing Case Manager, Ms Meg Hastings phoned MAC duty worker and advised that Mr Lowah was unwell and could not keep the appointment with Dr Giannakoureas. Ms Hastings advised that he was paranoid and aggressive, and she could not bring him.[117]

- On 24 May 2017, the Noarlunga Hospital phoned the MAC duty worker and advised that Mr Lowah had seen a nurse practitioner following intentional self-inflicted burns.[118] Ms Allner expressed the view that this was not indicative of psychosis, rather, it was consistent with Borderline Personality Disorder or Post Traumatic Stress Disorder[119].

- On 25 May 2017, Ms Allner noted a phone conversation with Mr Lowah that he had '*smashed walls after being pissed off at Junction Housing*'. Ms Allner also recorded in this entry that there was '*nil indication of agitation or hostility, nil perceptual disturbances identified, nil thought disorder evident*'.[120] It appeared that this assessment of Mr Lowah was made from the phone conversation.

- On 25 May 2017 an email was received from Trevor Old of UCW. The email confirmed the damage to Mr Lowah's accommodation and the laceration to his index finger, self-inflicted burns on his left hand and that he was annoyed and distressed that Ms Meg Hastings had looked at his Facebook page.[121]

- On 25 May 2017, Ms Allner made an entry in the Noarlunga Health Service notes recording that Ms Hastings from UCW contacted the MAC team and spoke to a duty worker to report her belief that Mr Lowah was mentally unwell. Ms Allner recorded underneath:

> 'Not assessed as being psychotic, thought disordered or mentally unwell as suggested by Junction Housing. Unannounced home visit therefore not indicated.' [122]

Ms Allner explained in her affidavit that she did not form the view that Mr Lowah was psychotic based on this information from Ms Hastings as Mr Lowah had been seen at the Noarlunga ED and they did not report to her or record on CBIS any

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[115] Exhibit C15a, paragraph 45; Transcript, pages 687-688, 719
[116] Ms Allner stated that this note may be on Ms Buer's CBIS records [190]
[117] Exhibit C55a, page 69
[118] Exhibit C55a, page 71
[119] Allner, [215]
[120] Exhibit C55a, pages 73-74
[121] Exhibit C55a, pages 73-74
[122] Exhibit C55a, page 77

acute mental health issues.[123] She stated that if Mr Lowah had been psychotic, this would have been identified during his assessment at Noarlunga ED and recorded on CBIS, and the MAC team would have been notified.[124]

- It appears that Ms Allner considered the lack of corroboration of Ms Hastings' concern for Mr Lowah's mental health as proof to the contrary. Further, Trevor Old did not report psychotic behaviour to her.[125]

- Also on 25 May 2017, Ms Buer contacted Noarlunga Health Service in her capacity as a client of the service. She spoke to Kristina Juraja who made a case note of the conversation. This case note was not available during the Inquest as it was part of Ms Buer's confidential file. Following the receipt of Ms Allner's affidavit, specifically those matters referred to in paragraphs [187]-[190] those acting on behalf of Southern Adelaide Local Health Network (SALHN), provided the case note to the Court. In addition to information about her own mental health, Ms Buer was recorded as telling Ms Juraja:

  > 'Concerned about son Jayden. Stated that he is not weel (sic), is angry and ***paranoid***, smashed his house up, threatened workers.' [126]

  There was no corresponding case note in Mr Lowah's records, but Ms Allner did depose to a memory of speaking with Ms Buer on this occasion when Ms Jaraja (Kris) handed the phone over. Ms Allner's memory of her conversation with Ms Buer was that she informed her that Mr Lowah had been '*acting aggressively after smoking a few bongs but had eventually calmed down*'.[127]

- On 30 May 2017, Ms Allner attempted to conduct a home visit with UCW. It was apparent that someone was home but did not answer the door.[128]

- On 8 and 9 June 2017 phone calls to Mr Lowah went unanswered.[129]

- On 9 June 2017, a note of a case conference recorded an unanswered phone call to Mr Lowah, as well as a home visit by UCW on 8 June 2017 during which Mr Lowah conveyed that he did not want contact with mental health services and that he had been failing to attend community services. Further damage to his unit and regular use of cannabis was noted. The UCW worker, Mr Old, was recorded by Ms Allner in this entry to express the view that Mr Lowah was not confused, disorientated or psychotic.[130]

- On 12 June 2017 a phone call to remind Mr Lowah of an appointment with Dr Giannakoureas went unanswered.[131]

- On 13 June 2017, Ms Allner recorded that Ms Hastings sent an email to her, enquiring whether Mr Lowah had been engaging with any supports, as he had

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[123] Allner, [196].
[124] Allner. [199].
[125] Allner, [209].
[126] Exhibit C40a, Noarlunga Health Service Notes of Sharon Buer, dated 25 May 2017, emphasis added
[127] Exhibit C71, paragraph 188
[128] Exhibit C55a, page 79
[129] Exhibit C55a, pages 83, 85
[130] Exhibit C55a, page 85
[131] Exhibit C55a, page 89

disengaged with her and she was keen to keep him housed and for him not to be breached by Job Prospects as he would lose his income.[132]

- A Summons to Produce was issued for Ms Allner's emails on 5 September 2024 which were tendered to the Court on 20 November 2024. Within this bundle of emails was Ms Allner's response to Ms Hastings' query, which was to inform her that Mr Lowah was '*engaging well*'. Her advice to Ms Hastings was to have Mr Lowah charged for the damage to his unit or to warn him about eviction.[133] Ms Hastings responded shortly after to express her concern that Mr Lowah's mental health had declined significantly since the depot had ceased and that she and Mr Lowah's mother were concerned about him.[134] Ms Hastings' concern relating to Mr Lowah's decline in mental health was not included in Ms Allner's note of this communication in the Noarlunga Hospital notes, or any subsequent entry, nor did it appear to have been communicated to Dr Giannakoureas.

- Despite speaking with Mr Old from UCW and agreeing to attend the appointment to see Dr Giannakoureas, Mr Lowah was not at his address at the scheduled pickup time.[135] Accordingly, Mr Lowah did not attend his appointment with Dr Giannakoureas on 13 June 2017. This was recorded by Ms Allner in a progress entry along with '*nil acute concerns re MS voiced*'.[136]

- Unsuccessful home visits were conducted on 16 and 20 June 2017.[137]

- On 16 June 2017 Junction Housing indicated that they would not be renewing Mr Lowah's lease in July 2017 due to '*thousands and thousands of dollars*' worth of damage which would not be repaired until his lease expired and he had left the property.[138]

- On 22 June 2017, the IRPSS Package provided by UCW was withdrawn due to non-engagement by Mr Lowah.[139]

- On 26 June 2017, Ms Allner emailed Dr Giannakoureas and another mental health staff member to inform them that she was putting Mr Lowah up for clinical review that week as he was not engaging, but still under a CTO. She noted that Mr Lowah had failed to attend any appointments since having depot ceased, but there were no grounds to go in with SAPOL and do an urgent assessment (as the CTO would allow if acted upon).

- A clinical review conducted on 5 July 2017 detailed Mr Lowah's non-adherence with the agreement made with Dr Giannakoureas, his failure to attend scheduled appointments and his evasion of MAC team staff.[140]

98 Notwithstanding this well-documented disengagement with services and an escalation in behaviour from Mr Lowah, with at least four reports (from those with whom he ***was***

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[132] Exhibit C55a, page 93
[133] Exhibit C63, page 232, email sent on 13 June 2017 at 1:25pm
[134] Exhibit C63, page 231, email sent on 13 June 2017 at 1:42pm
[135] Exhibit C63, page 230
[136] Exhibit C55a, page 91
[137] Exhibit C55a, pages 95, 99
[138] Exhibit C55a, pages 95, 105
[139] Exhibit C55a, page 105
[140] Exhibit C55a, pages 117-121

having contact) that his mental health was unstable and he was still abusing illicit substances, the clinical review entry astonishingly recorded the following:

> 'No concerns voiced by other services involved re: MS [mental state] nil indication for CC [case coordinator] to attend with SAPOL to check welfare or assess Jayden. Nil concerns for MS indicated during phone calls with CC. Nil perceptual Dx [disorder] identified. Jayden had good recall of events, well orientated.' [141]

99 A palpable observation of the above entry from the clinical review meeting was that there had been little to no contact with Mr Lowah between the cessation of depot and the clinical review by the MAC team to have gained any reassurance that Mr Lowah's mental health was stable or otherwise. Furthermore, there had been no face-to-face contact between Mr Lowah and the MAC team between 28 April 2017 and the clinical review being held. A/P Sullivan described the assessment of Mr Lowah's mental state over this period as based on incidental observations and not structured assessments.[142] Perhaps most concerningly, the comment that '*no concerns [were] voiced by other services*' was plainly wrong.

100 Ms Allner explained in her affidavit that it was understood by those in the MDT (presumably the MAC team) that the mental state symptoms they were assessing were specifically psychotic symptoms.[143] However, this was not put to Dr Giannakoureas for his comment as the affidavit of Ms Allner was received following the closure of the evidence. Further, it is difficult to reconcile this explanation given the report of paranoia from Ms Hastings.

101 Ms Allner was present at the clinical review. She did not elaborate in her affidavit as to the discussion pertaining to reports from other services, or as to Mr Lowah's mental health more generally. She stated, rather, that the main topic of conversation was whether the CTO would be allowed to lapse.[144] The notes indicated that Dr Giannakoureas would likely allow it to lapse on 6 September 2017.

102 Either way, the information recorded in the note of the clinical review that no concerns had been raised by other services was incorrect, and there had been no reliable in-person assessment of Mr Lowah's mental state following cessation of the depot, with the exception of his review with Dr Neild on 28 April 2017.

103 The day following the clinical review Ms Allner unsuccessfully attempted to speak with Mr Lowah. On 10 July 2017, a duty worker from the MAC team was again unsuccessful in reaching Mr Lowah to advise him of the appointment with Dr Giannakoureas the following day. Later the same day, a mental health nurse at Noarlunga ED contacted the MAC team advising that Mr Lowah had presented with a bone fracture and inquired as to whether they wanted to speak with him while he was there. A phone call received a short time later conveyed the news that Mr Lowah had left the ED and was believed to be making his way to the Flinders Medical Centre (FMC) Plastics Department.[145]

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[141] Exhibit C55a, pages 119
[142] Transcript, page 884
[143] Allner, [255]
[144] Allner, [270]
[145] Exhibit C55a, page 127

104 Mr Lowah did not attend the FMC on 10 July 2017, rather he presented at the Marion GP Plus Health Care Centre[146] with his mother, Ms Buer, and saw duty worker Jenny Hoyle. The entry made by Ms Hoyle indicated that when he was told to go to FMC, he expressed reluctance as he '*didn't want to go under*'. He had reportedly been provided with the '*green whistle*'[147] the day before for pain and that had freaked him out.[148] Ms Hoyle encouraged Mr Lowah to attend FMC to have his finger treated. She also recorded her observation that he was expressing some signs of paranoia with the remark that '*you need to make sure you tell people everything*'.[149] Ms Hoyle recorded that Mr Lowah then left with his mother, '*hopefully to go to FMC plastics department*'.[150] Ms Hoyle also recorded in the same case note that Steve, a mental health nurse from Noarlunga Hospital, had observed Mr Lowah as '*a little irritable and suspicious prior to leaving*' the hospital.[151]

105 It is apparent that Ms Allner effectively disregarded the information from Steve (as recorded by Ms Hoyle) that Mr Lowah appeared to be suspicious during his attendance. Further, she was not prepared to infer from the note of Ms Hoyle, which referred to signs of paranoia, that she was concerned about Mr Lowah's mental state.[152]

106 It appeared that Ms Allner was not prepared to accept information from others, regardless of their qualifications, if that information was suggestive of a re-emergence of psychosis. The reason for this reluctance cannot be known with certainty, however it may be that Mr Lowah's threatening behaviour led to a conscious or unconscious desire to interpret his conduct as being personality driven rather than a re-emergence of his psychosis. A personality driven cause would justify a lapse of his CTO and result in no further contact with the MAC team.

Dr Giannakoureas sees Mr Lowah for the first time since 11 April 2017

107 The following day, being 11 July 2017, Mr Lowah attended at the Noarlunga Health Service with his mother for his scheduled appointment with Dr Giannakoureas. Ms Allner was present at this appointment. This was the first face to face contact with the MAC team since 28 April 2017 and the first time Dr Giannakoureas had seen him since he ceased his depot medication, three months before. It was also the first time Ms Allner had met Mr Lowah in person. The entry in the clinical notes is as follows:

> 'Attended with mother
> Eating and sleeping OK
> Ongoing angry outbursts
> Says he's doing OK
> Hypervigilant to slights
> Worries about what people think of him
> No ideation of suicide, or harm to others
> Burns himself to relieve tension
> Cannot rule out self-injury
> Occasional Cannabis use (acknowledges it makes him 'paranoid')

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[146] An adult community mental health service provided by the SA Health
[147] Methoxyflurane – commonly referred to as the 'Green Whistle'
[148] Exhibit C55a, page 129
[149] Exhibit C55a, page 129
[150] Exhibit C55a, page 129
[151] Exhibit C55a, page 129
[152] Allner, [273]-[275]

> MSE
> Casually dressed
> Doesn't like using phones
> Not overtly delusional or thought disordered
> Reactive in affect
>
> Recent fracture of left index finger
> in FMC ED yesterday
> Left just prior to surgery
> 'I was tripping out on laughing gas'
> Acknowledged being scared
>
> ASST
> Stable mental state
> Redirected to ED for surgical reduction, as per plastics, with letter
> Review in four weeks' [153]

108 Even though Mr Lowah had returned to illicit drug use and had effectively disengaged with supports (he had broken '*the deal*'), Dr Giannakoureas did not reinstate the depot medication at this time. He was of the view that Mr Lowah was not thought disordered or delusional. However, the following day, Mr Lowah was detained under a Level 1 ITO for apparent psychotic behaviour, which I will detail below. During oral evidence, Dr Giannakoureas was challenged about whether he considered it possible that Mr Lowah was psychotic at the appointment based on the events of the following day. Further, he was asked why he did not reinstate the depot medication at this appointment. Dr Giannakoureas explained that he decided to give Mr Lowah another chance to stay off the depot.[154] Apparently Ms Buer also advocated for her son to remain off the depot medication, despite having expressed a different view at an earlier time to a member of the MAC team and to Junction Housing staff members.[155] One available inference is that Ms Buer, who was at times frightened of her son, did not feel comfortable expressing her true opinion in his presence. Dr Giannakoureas conceded that it was possible that Mr Lowah was psychotic at the time of the appointment, but stated the following:

> 'You know for someone to know that others perceive them as unwell and be organised enough to maintain a conversation without giving away any evidence of psychosis, especially if they're reactive and conversational, demonstrates an element of control, manipulation and deceitfulness but I didn't get that impression when I saw him the day before. What I suspect might have happened, and again I'm only speculating, is that after the appointment with myself he might have thought 'I'm in the clear now' so he used heavily the evening before, but I can only speculate.'[156]

109 Mr Lowah attended the FMC to undergo surgery on his hand that evening and was discharged home with his mother on 12 July 2017. Later that day, Mr Lowah's behaviour escalated resulting in Ms Buer contacting SAPOL and SAAS. Ms Buer reported that Mr Lowah had visited a friend and while away had taken a hammer to his hand. He used the hammer to smash the cast that had been applied the day before, damaging his fingers. Upon his return home, his behaviour was so threatening that Ms Buer locked herself in a room of her house due to fears for her own safety. Mr Lowah was taken into the care and

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[153] Exhibit C55a, page 115
[154] Transcript, page 679
[155] Transcript, page 679
[156] Transcript, page 737

control of SAAS pursuant to section 56 of the Mental Health Act (powers less restrictive than an ITO). The clinical records reflected that he was happy to be transferred to hospital in the safety net, was unsure as to why he had removed his cast or hit his hand with a hammer and that he appeared vague and was slow to respond, looking around at things.[157] Mr Lowah denied hearing voices or hallucinating. It was recorded that Ms Buer told the ED staff upon arrival:

> 'Jayden had been smoking THC for past few days and has become increasingly agitated, pacing, cursing and responding to internal stimuli … said psychiatrist agreed to cease the depot because Jayden would not smoke THC anymore.' [158]

110 Once in the FMC ED, Mr Lowah was noted to be guarded, hostile and paranoid. His speech was difficult to follow at times and described as '*tangential and derailing when attempting to answer some questions*'.[159] He was chemically restrained (with droperidol, midazolam and olanzapine) after a Code Black was called. This enabled medical staff to safely conduct x-rays on Mr Lowah's left hand. The treating medical officer, Dr Kjaer, recorded that Mr Lowah appeared psychotic and paranoid[160] on presentation and placed him under a Level 1 ITO. The recorded plan of management for Mr Lowah included closed ward management and to liaise with CMHT/psychiatrist Dr Giannakoureas.[161] On 13 July 2017 he was transferred to the secure unit of the Margaret Tobin Centre (MTC). Consultant psychiatrist Dr Michael Nance attempted to interview Mr Lowah on 13 July 2017 at 11:15am with resident medical officer, Dr Zhao Wang. However, Mr Lowah became hostile very quickly and the interview was terminated. Dr Nance confirmed the ITO and recorded on the Order that Mr Lowah had a history of schizophrenia, recent drug use and agitated bizarre behaviour.[162]

The expert opinion on the decision to cease depot injections on 11 April 2017

111 I pause here to discuss the expert evidence on the decision making of 11 April 2017 and what followed thereafter. As outlined above, Dr Furst and A/P Sullivan were of the same general view that it was not unreasonable for the depot injections to be ceased on that day. Dr Furst opined that it was not unreasonable for a psychiatrist to try and withdraw treatment, as it was often a good practice to revisit a diagnosis.[163] However, what Dr Furst observed from his review of the clinical notes was a change in narrative around Mr Lowah's illness. He expressed the following view:

> 'I think that it's not unreasonable for psychiatrists to try withdrawing treatment, you know, and that's often a good thing. We don't like patients to be on medication forever without potentially revising your diagnosis, being prepared to be wrong. I think the difficulty lies - it seemed like from that assessment, it very much went on a pathway of "he doesn't have schizophrenia" as opposed to "he might not have schizophrenia, let's try taking him off the medication and be prepared to review it, and if it's not going well, let's get him back on it" … I mean, I think that there's two different ways to approach the withdrawal of treatment, and generally with someone with a history of violence, I would suggest you should withdraw

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[157] Exhibit C58, page 43; Exhibit C58a for A3 size version of same document
[158] Exhibit C58, pages 53-54
[159] Exhibit C58, pages 53-54
[160] Exhibit C58, page 81
[161] Exhibit C58, page 65
[162] Exhibit C58, page 26
[163] Transcript, page 618

> treatment carefully with ongoing monitoring. And he did have further appointments with Dr Giannakoureas but I didn't get the sense from the case notes that there'd really been a dedicated plan around the withdrawal of treatment, and the risks that that might pose, and what the risk management plan was if those risks were starting to be identified, ie reports from junction housing, "Well, he's not doing very well", "actually, Mum says he's talking to himself", you know. These are the sorts of things that you might go "Okay, that's part of our risk management plan, we've identified that, let's change the treatment".' [164]

112 While Dr Furst acknowledged that time had proven his assessment correct, he also observed the existence of Dr Watson's letter which was based on a longitudinal history of Mr Lowah's mental illness (schizophrenia) that had historically persisted in the absence of drug use and did respond to treatment. Dr Watson's opinion was set out in a careful and considered manner in the letter that Dr Giannakoureas would have had available to him but did not review.[165] While Ms Allner deposed to the location of volume 1 of the clinical notes being stored in archives, I do not accept that this was an impediment to having reviewed them. Clinical records are often stored offsite and can be called for without difficulty. Further, Dr Giannakoureas did not raise any such issue as preventing him from having read Mr Lowah's mental health history. He accepted that he did not review Mr Lowah's notes prior to ceasing the depot medication.[166]

113 A/P Sullivan was also of the view that a more definitive management plan should have been put into place at the time of ceasing the depot. He opined that an aspect of this plan should have been regular urinalysis which had a number of benefits; it was a deterrent to drug use, it could be used to persuade Mr Lowah to attend drug and alcohol counselling, and it was an increased opportunity for mental health staff to observe Mr Lowah when he attended for urinalysis. A/P Sullivan was of the opinion that the plan should have been developed by the multidisciplinary team with the view of including Mr Lowah's family and his mental health team. During cross-examination, A/P Sullivan was taken to an earlier mental health care plan that had been created for Mr Lowah in 2015 and revised in 2016.[167] A/P Sullivan opined that a similar plan should have been created (or the earlier plan revised) for Mr Lowah and agreed to on 11 April 2017, when the depot medication was ceased.[168]

114 Following the numerous reports of drug use, non-attendances at scheduled appointments, damage to property and self-inflicted injuries, it was A/P Sullivan's opinion that the MAC team would have been justified in revoking[169] the CTO to have Mr Lowah brought to hospital for a brief admission in order to review his mental state and consider reinstitution of medication.[170] On balance, it is open on the evidence to find that had a mental health care plan been drafted, with Mr Lowah's signed agreement to its terms, his ensuing non-compliance would have been more visible to those in the team, particularly Dr Giannakoureas, who would likely have taken responsibility for the plan and its enforcement. The mental health plan would have worked in harmony with the CTO either

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[164] Transcript, page 618
[165] Transcript, page 697
[166] Transcript, page 710
[167] Exhibit C55a, pages 7-13
[168] Transcript, page 948
[169] A/P Sullivan explained that by 'revoking' he meant the enforcement of a condition in the CTO and not the cancelling of the Order
[170] Transcript, page 875

by working as a deterrent to Mr Lowah's behaviours, or as a trigger for the conditions of the CTO to be activated. Of course, none of this happened.

115 At the meeting on 11 July 2017, A/P Sullivan expressed the opinion that Dr Giannakoureas ought to have considered recommencing Mr Lowah on depot medication. He qualified this opinion by accepting that if Dr Giannakoureas had not detected a relapse in Mr Lowah's condition (which was his evidence), he may not have seen this as justifiable.[171] A/P Sullivan did suggest that at the very least, this was an opportunity to introduce a requirement for urine drug screening or enrolling Mr Lowah in counselling. Another compounding feature at play was that, based on the information recorded in the Noarlunga Health Service notes, particularly by Ms Allner, the more concerning reports of Mr Lowah's behaviour were not being shared with Dr Giannakoureas, or at least not being recorded in the clinical records. With that said, Dr Giannakoureas was aware of Mr Lowah's broken promises in the form of a continued failure to attend his scheduled appointments and his use of cannabis in the preceding period, from which he had promised to abstain. Dr Giannakoureas' justification of ceasing the depot injections with the hope of establishing a therapeutic relationship had by this stage proven to be unsound.

116 An available observation from an analysis of the Noarlunga Health Service records when compared to Ms Allner's emails, was that Ms Allner appeared eager to minimise the negative reports relating to Mr Lowah. In doing so, she queried the qualifications of those who made them,[172] and ultimately refused to respond to Ms Hastings (from Junction Housing) entirely following her concerns about Mr Lowah's mental health which had been expressed on more than one occasion.[173]

> 'From: Russell, Catherine (Health)
> Sent: Tuesday 13 June 2017
> To – Tamar Allner
> Subject: Meg from Junction Housing
> **Please phone Meg from Junction Aust re: Jayden Lower**
>
> From Tamar Allner (Health)
> Sent: Tuesday 13 June 2017
> To: Russell, Catherine
> Subject: Meg from Junction Housing
> **Nope**' [174]

117 As Ms Allner was at the coal face with other services and agencies, she therefore had the ability to re-engineer the narrative or omit certain important concerns when reporting back to those who had less direct contact with Mr Lowah, such as Dr Giannakoureas. It was difficult to understand exactly what Ms Allner's motivations were, however her fear of him, apparently passed on from the last CC, Ms James, may have contributed. There was an available observation that from the time Ms Allner became involved with Mr Lowah's care, his best interests were not well-served and those in the community were at a heightened risk of experiencing the impact of his declining mental health.

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[171] Transcript, page 888
[172] Exhibit C55a, page 67
[173] Email refusing to return Ms Hastings phone call to another colleague
[174] Exhibit C63, page 46, emphasis added

118 Another possible explanation was provided by A/P Sullivan during his expert evidence. He was asked to comment on the difference in available supports for those who have been diagnosed with a personality disorder as opposed to a diagnosis of schizophrenia. He explained that there was often a stigma associated with a primary diagnosis of a personality or behavioural disorder:

> 'Certainly, many services, public services and many private practitioners will be reluctant to take on a person who has a primary diagnosis only of personality disorder and in many cases mental health legislations nationally specifically exclude personality disorder itself as the basis of compulsory treatment under restrictive frameworks. So there is a stigma and it's also perhaps associated with a reduced access to services if the diagnosis is seen as the main issue.' [175]

119 While a question mark remained over the motivations of Ms Allner, Dr Giannakoureas was asked directly about his decision making relating to his treatment of Mr Lowah between 11 April 2017 and his discharge from the service in November 2017.[176] While he agreed he had not had regard to Dr Watson's opinions in his letter dated 2 February 2015, it was the evidence of Dr Giannakoureas that he reached similar conclusions to Dr Watson, organically.[177] He explained that this was in relation to Mr Lowah being a complex patient and that he would have preferred for him to remain on depot if suicidal ideation had not been expressed. Dr Giannakoureas clarified that while other staff (health workers) may have been lured into Mr Lowah minimising his psychotic symptoms risking treatment complacency, that was not his approach with Mr Lowah. He stated:

> 'A. That was certainly a possibility with other staff, that they would look at Mr Lowah's behaviour and drug use and assume that that was the sole cause of his problems without taking into account that the drug abuse would actually cause a psychotic episode.
> Q. You mentioned that might be the problem for other health workers.
> A. Yes.
> Q. Do we assume from that, that that was not the approach you took.
> A. No, it's not the approach I took.' [178]

120 While this may have been a permissible approach to take on 11 April 2017, by 11 July 2017, the landscape had changed with the agreement reached between Mr Lowah and Dr Giannakoureas being fundamentally broken. Furthermore, the possibility of other staff members assuming that Mr Lowah's behaviour and drug use was related to a personality disorder gathered momentum without documented correction from Dr Giannakoureas.

121 In his oral evidence, Dr Giannakoureas accepted that, following his decision to cease Mr Lowah's depot medication in April 2017, there was a deterioration in his mental state. Moreover, he considered that the assaults perpetrated by Mr Lowah on two unknown

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[175] Transcript, page 865
[176] Dr Giannakoureas was no longer working at the Noarlunga Hospital in November 2017, having left in September of that year. It is acknowledged he was not the psychiatrist who discharged Mr Lowah from the service.
[177] Transcript, page 694
[178] Transcript, page 695

individuals in late August 2017 (detailed below) may have been causal to this deterioration.[179]

122 I accept the evidence of Dr Furst and A/P Sullivan. Accordingly, I find that while the decision by Dr Giannakoureas on 11 April 2017 to cease the depot was made in haste, it would not have been unreasonable in and of itself due to the circumstances as they presented on the day, if appropriately implemented. However, I find that a failure to review Mr Lowah's mental health history, set out in records accessible to Dr Giannakoureas, and the lack of a structured management plan to set clear goals of expectation, saw a resurgence of psychotic symptoms which the depot medication had been holding at bay. The failure was not so much the cessation of the depot medication, but the failure to watch closely for the need to reinstate it when it became apparent that it was a destabilising event. Had Dr Giannakoureas set structured goals and a management plan on 11 April 2017 (or at a later time after having reviewed Mr Lowah's clinical records), the reports of cannabis use and the disengagement from the MAC team (for almost three months) would likely have been followed up by Dr Giannakoureas himself. This could have potentially ameliorated the impact of the omission of certain concerning behaviours from the clinical records. The fact that this serious decision was made so quickly and without an adequate implementation plan, leads to an inference that Dr Giannakoureas had taken the opportunity to make a decision which pleased both of his patients (Mr Lowah and Ms Buer), but was not well thought through. Dr Giannakoureas' '*deal*' with Mr Lowah was optimistic, particularly given that depot is used in cases where compliance was questionable. It was inappropriate to act with such hope without a comprehensive support plan in place. This is not something realised in retrospect. Non-compliance with the '*deal*' was always a potential and arguably an inevitable outcome. This should have been appreciated by Dr Giannakoureas. It was not.

123 Furthermore, I find that Ms Allner did not accurately document the deterioration in Mr Lowah's mental state, which saw his health deteriorate to a dangerous point. The way in which Ms Allner recorded information was subjective and appeared coloured by her own assessment of the validity of that information. That carried with it the risk that those reading her documentation would be infected by any erroneous assumptions made by Ms Allner. I accept the context in which this occurred contributed to this undesirable state of affairs, namely that Ms Allner had no management plan to follow and had formed a view of Mr Lowah from negative accounts of him and his behaviour.

Admission to the Margaret Tobin Centre

124 Returning to Mr Lowah's admission to the MTC, the Noarlunga Health Service notes reflected that Ms Allner had been notified of Mr Lowah's attendance at the FMC ED on 12 July 2017 by email from a clinical nurse. The information contained in the email to Ms Allner was that Mr Lowah had been brought in by SAAS/SAPOL in an agitated and paranoid state, he had trashed his unit and also re-injured his hand by deliberately hitting it with a hammer. His mother reported that he had been smoking large quantities of cannabis.[180] Ms Allner replied to the clinical nurse the following day notifying her that she had attended at the MTC to see Mr Lowah that morning (13 July 2017).

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[179] Transcript, page 741
[180] Exhibit C63, pages 267-268

125 The FMC clinical notes reflected that Dr Wang spoke with Ms Allner on 13 July 2017 to obtain collateral information. It is likely that this conversation took place via telephone, although there is also a record of Ms Allner having attended in person as well. Unfortunately, Dr Wang had no independent memory of the conversation or where it took place. He did however make a contemporaneous entry in the clinical records of the conversation. The salient features of this entry were:

- That the depot had been ceased because it was thought that all presentations were likely secondary to personality disorder and behavioural misconduct; and
- That this presentation was not out of character for Mr Lowah and antipsychotics had not helped in the past.[181]

126 There are a number of observations to be made about this entry in the clinical records. In doing so I accept Dr Wang's evidence that he while he did not remember, it is likely he made this entry shortly after speaking with Ms Allner and that it represented a summary of their conversation rather than a verbatim account.[182] Ms Allner also accepted that this was a reasonable recount of the information provided by her.[183] By way of examination, there was no corresponding record of the discussion with Dr Wang in the Noarlunga Health Service case notes, except to document that a discussion took place. Secondly, the information relating to the cessation of the depot injection did not align with the evidence given by Dr Giannakoureas, namely that it was incomplete. Finally, the statement that antipsychotics had not helped in the past was factually incorrect. The latter inconsistency was also observed by Dr Furst when he assessed Mr Lowah in James Nash House only a few months later, on 2 September 2017. He recorded, '*reported that antipsychotics hadn't helped. NB this seems in contrast to admission in March 2016 where reported he had done well on Quetiapine 800mg*'.[184] The recorded '*narrative*' provided by Ms Allner left little to no room for consideration of anything but a personality disorder. This is an example of the point made by Dr Furst in his oral evidence; that the narrative around Mr Lowah's illness had changed.

127 Ms Allner explained in her affidavit that her opinion that antipsychotics had not helped in the past was based in part on the absence of an entry in his mental health plan from 2016. This plan included a section entitled '*what medication has helped me in the past*?'. The section was blank. From this, Ms Allner apparently inferred that antipsychotic medication had not been effective in the past. This was despite Mr Lowah being in receipt of the antipsychotic depot medication at the time of the mental health plan which was clearly recorded within the document. Ms Allner also referred to reports of aggressive behaviours and ongoing suicidal ideation while Mr Lowah was receiving depot Aripiprazole in support of this inference. I reject Ms Allner's explanation.

128 With that information having been collected by Dr Wang from Ms Allner, and relayed to Dr Nance, Dr Nance attempted to reinterview Mr Lowah on 14 July 2017 at 10:39am.[185] This time he did so successfully. During the interview Mr Lowah reported having difficulty recalling events and felt a '*bit jumbled*'. He reported self-harming because he

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[181] Exhibit C58, pages 47-48
[182] Transcript, page 969
[183] Allner, [293]
[184] Exhibit C59, page 123
[185] Exhibit C58, page 51

did '*bad things*' and felt the need to punish himself. The clinical records reflected that Mr Lowah asked Dr Nance not to look at him because he did not know what he was thinking and he did not like it. Mr Lowah explained that it was hard to communicate as no one understood the way he did. The entry reflected that Dr Wang (who made the entry in the clinical records of the interview) observed Mr Lowah's left hand to be swollen with open sutures on his fourth finger as well as burn marks to his left forearm. It was Dr Nance's recorded assessment that Mr Lowah had a '*complex history with multiple diagnoses*' but his impression that day was '*most consistent with poor impulse control and emotional dysregulation secondary to borderline personality disorder/anti-social personality disorder (BPD/ASPD), [with] no current evidence of psychosis*'.[186] Mr Lowah's ITO was revoked by Dr Nance. The plan was to liaise with the Plastic Surgery Department and follow up with the community mental health team.

129 During his oral evidence Dr Nance accepted that there was a possibility that the symptoms displayed by Mr Lowah during this interview were consistent with psychosis. However, he noted that they were consistent with other diagnoses as well,[187] and he did not assess Mr Lowah as suffering from a relapse of schizophrenia.[188] He was asked about Mr Lowah's level of sedation at the time of the interview and whether this may have impacted on his ability to assess for psychosis. Over the course of his admission to the MTC, Mr Lowah had been administered mood stabilisers and sedatives including midazolam, lorazepam and olanzapine.[189] Dr Nance agreed that Mr Lowah would still have been experiencing the effect of olanzapine at the time of his interview as it had been administered at 6:45am that morning. He did not consider however that this would have directly impacted on his assessment.[190]

130 Dr Nance could not be precise about the weight he assigned to each of the factors under consideration, but it was clear there were three main components; the clinical presentation, the face-to-face mental state examination, and the collateral information. Dr Nance told the Court that while it was possible Mr Lowah was psychotic at the time of the assessment, his overall conclusion of Mr Lowah on the day was that he was not suffering a relapse of schizophrenia. Unfortunately, but not inappropriately, Dr Nance placed weight on Dr Giannakoureas' assessment on 11 July 2017, which concluded that Mr Lowah's mental state was stable. Also unfortunately, he placed weight on Ms Allner's '*clear and definitive*' information. Dr Nance explained that:

> '….in coming to the final conclusion, you have to weigh up all of these factors. And sometimes, the whole is more than the sum of the parts.' [191]

131 Dr Nance was entitled to rely on the information provided by Ms Allner (likely conveyed through Dr Wang) which was in keeping with his understanding of the assessment by Dr Giannakoureas a few days earlier (which was infected with the same information from Ms Allner). He was also entitled to rely on its accuracy. Unfortunately, the information was neither accurate, nor complete. Dr Nance gave evidence that while he had no independent recollection of being present when collateral information was provided by

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[186] Exhibit C58, page 51
[187] Transcript, page 803
[188] Transcript, page 804
[189] Exhibit C58, page 80
[190] Transcript, page 800
[191] Transcript, page 811

Ms Allner, he would have had regard to the information as communicated by Dr Wang and taken it into account when assessing Mr Lowah.[192] Dr Nance believed he would have placed a '*fair amount of weight*'[193] with '*particular importance*'[194] on the information obtained from Ms Allner. Dr Nance explained that Ms Allner's views, as part of the MAC team, provided a longitudinal perspective on Mr Lowah's mental health history.[195] When giving evidence, Dr Nance stated that he was probably not aware that Ms Allner had only met Mr Lowah on one occasion at the time this information was provided, or that Dr Giannakoureas had ceased the depot medication at his first meeting and assessment.[196] Therefore, this decision-making by Dr Nance was based on incomplete information.

132 It was Dr Furst's opinion following Ms Foster's death that Mr Lowah was most likely continuously psychotic from at least July 2017, if not as far back as May (when the effect of the last depot administered in April had worn off).[197] This opinion was provided in the report he prepared for the Supreme Court. Dr Furst confirmed his opinion when giving oral evidence, and confirmed that this included Dr Nance's assessment on 14 July 2017. It was also the evidence of A/P Sullivan[198] and Dr Giannakoureas (after reviewing the clinical records of the assessment)[199] that Mr Lowah was experiencing psychotic symptoms at the time of Dr Nance's assessment. As touched on above, Dr Nance did accept that this was a possibility.

133 Dr Furst made the following comment:

> 'Interestingly, despite the history of a marked increase in agitation and aggression, the observation of his mother that he had been responding to internal stimuli, which was consistent with the ambulance report and his report to nurses that he had intrusive thoughts, as well his history of schizophrenia confirmed at Boylan Ward and recent cessation of treatment, combined with his seemingly bizarre self-harm, he was determined to be presenting with symptoms consistent with Borderline and Anti-social Personality Disorder … Interestingly, despite the report of jumbled thinking coupled with intense agitation and violence consistent with previous psychotic episodes, he was considered not to be psychotic and presenting with personality-based behavioural problems.' [200]

134 I did not understand Dr Furst to be critical of Dr Nance's ultimate diagnosis, rather retrospectively quizzical. However, it was A/P Sullivan's evidence that diagnostic overshadowing provided a plausible explanation for the factors mitigating against the identification of a psychotic state in Mr Lowah. A/P Sullivan explained that diagnostic overshadowing, or the tendency to interpret symptoms in line with a previous diagnosis, may have played a role in the diagnosis of Mr Lowah by Dr Nance. He explained that the questioning of the diagnosis of schizophrenia by Dr Giannakoureas, interpreted by Ms Allner as a re-diagnosis of antisocial personality disorder and behavioural misconduct, likely influenced Dr Nance's interpretation of Mr Lowah's presentation.

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[192] Transcript, page 778
[193] Transcript, page 808
[194] Transcript, page 813
[195] Transcript, page 828
[196] Transcript, page 807
[197] Exhibit C56, page 44
[198] Exhibit C51a, pages 7, 9
[199] Transcript, pages 682-683
[200] Exhibit C56, pages 10-11

Dr Nance readily accepted that he placed importance on the information provided by Ms Allner.

135 From information produced at Inquest, it also appeared on its face that Ms Allner actively discouraged the reinstating of depot medication. In email communication from Ms Allner to Dr Giannakoureas on 14 July 2017, on the topic of Dr Nance's decision to revoke the ITO, she stated '*I popped down there yesterday to make sure they didn't go back down the Depot path*'.[201] Dr Giannakoureas, who did not remember receiving this email and therefore could not put it into context, had indicated in a previous email that he agreed with the ultimate assessment of Dr Nance, namely that Mr Lowah's symptoms were not due to a relapse of schizophrenia.[202] Ms Allner did not give oral evidence to explain why she would need to convince those assessing Mr Lowah not to reinstate the depot medication. In her affidavit, Ms Allner stated her email was poorly worded and open to misinterpretation. She asserted that she was trying to convey that the depot should not be ***unnecessarily*** reinstated.[203]

136 A/P Sullivan was asked whether it was unusual for a case coordinator to advocate for a particular position in relation to treatment. His evidence was that it would not be unusual if that was the considered view of the team. A/P Sullivan explained the difficulty he saw with Ms Allner's actions on that day was that the decision being relayed by Ms Allner was that it was not part of any printed management plan which was available and showed evidence of planning and consideration about the management trajectory of Mr Lowah.[204]

137 Finally, Dr Nance acknowledged that Mr Lowah's mother was not contacted for collateral information. He gave evidence that he was unsure why this did not occur as it would usually be part of their routine.[205] It was the evidence of Dr Wang that he would only contact family members for collateral information if the patient was unable to give a history, or if there were no care workers allocated, or none available to speak with. Dr Wang placed more importance on the information of case workers as this was provided with a clinical lens.[206] However, had Ms Buer been spoken to for the purpose of obtaining collateral information on 14 July 2017, it was probable that she would have relayed the same concerning information that she provided to the paramedics and the ED clinicians two days before, as well as expressing her view that her son should be back on depot medication (as she had conveyed to the MAC team and other community based support workers).[207] Dr Nance stated that if he was aware Ms Buer thought her son should recommence depot medication, he would have given that some weight, particularly given her previous request to Dr Giannakoureas for the depot medication to cease.[208] Dr Nance agreed that Ms Buer should have been contacted.

138 It was submitted by Counsel Assisting, Ms Roper, that the failure to contact Ms Buer appeared to result from an assumption (on Dr Wang's part) that clinical information was the most valuable source of collateral information. She submitted that this Inquest had highlighted the flaws with that assumption and demonstrated the value of collateral

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[201] Exhibit C63, page 264
[202] Exhibit C63, page 264
[203] Allner, [327]
[204] Transcript, page 904
[205] Transcript, page 826
[206] Transcript, page 973
[207] Exhibit C15a, paragraph 45
[208] Transcript, page 827

information obtained from those closest to the patient, who ordinarily have more frequent contact with the patient over a longer period and who are more attuned to fluctuations in their mental state. I agree with Ms Roper's submission and find that the failure to contact Ms Buer was a missed opportunity for highly relevant information to have been obtained detailing a decline in Mr Lowah's mental state. Had this occurred, there was a distinct possibility of a different treatment outcome, whether or not Dr Nance revoked the ITO. After all, the CTO was still in place.

139 On the topic of Dr Nance's psychiatric assessment of Mr Lowah, overwhelmingly the evidence supported a finding that Mr Lowah was experiencing psychotic symptoms at the time. Furthermore, as opined by A/P Sullivan, I find that the questioning of Mr Lowah's diagnosis of schizophrenia by Dr Giannakoureas was misinterpreted by Ms Allner to be a re-diagnosis of a personality disorder, with the focus thereafter away from the possibility of a resurgence in psychotic symptoms. This in turn led to an altered narrative being shared with Dr Wang and Dr Nance. Ultimately, this influenced Dr Nance's assessment of Mr Lowah due to diagnostic overshadowing. In making these findings I am not rejecting the evidence of Dr Nance. I accept that he undertook a careful and thorough examination of Mr Lowah and relied on certain information gathered from what he thought (and was entitled to think) was a reliable source. I formed the view that Dr Nance was a credible and reflective witness. Furthermore, I am not critical of Dr Nance or Dr Wang for their assessment of Mr Lowah, based on what appeared to be strong support for Mr Lowah remaining off the depot medication. I do however find that Ms Buer should have been contacted to obtain collateral information, and that the failure to do so was a missed opportunity to gather insight from a more direct source which may have seen a different outcome. Had Ms Buer been contacted at this time, it is probable that she would have communicated her view that Mr Lowah be reinstated on depot injections, as she had expressed to at least one member of the MAC team and members of Junction Housing.

140 Mr Lowah was released back into the community on 14 July 2017 and returned to his accommodation at Junction Housing, despite having been notified that his lease would likely not be renewed. The period following Mr Lowah's release from the MTC saw the completion of his already advanced disengagement from the MAC team, with multiple unsuccessful attempts to contact Mr Lowah,[209] missed appointments with his community service obligations,[210] and ultimately his eviction from Junction Housing for the '*intentional damage*' done to the house totalling approximately $20,000.[211] The MAC team were also notified by Mr Lowah's mother that he was attempting to contact her despite an intervention order being in place.[212] Further, that she was concerned he may be using illicit substances and that he had sold or given away most of his household items. He had also removed his stitches from his hand which caused an infection requiring hospital treatment.[213]

141 Following his eviction from Junction Housing, Ms Buer informed the MAC team that she had observed her son sleeping on a park bench located across the road from her house and attempting to gain access. Mr Lowah was charged with breaching his bond and

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[209] Exhibit C55a, pages 137, 151, 153, 161, 265
[210] Exhibit C55a, page 147
[211] Exhibit C55a, pages 145, 155; Exhibit C41, page 242
[212] Exhibit C55a, pages 139, 173
[213] Exhibit C55a, page 139

contravention of an Intervention Order (relating to his mother) on four occasions[214] between 13 and 27 August 2017. On 27 August 2017, he was convicted for contravening the Intervention Order for the fourth time and sentenced to 17 days imprisonment, which was suspended upon him entering into a further bond.[215]

142 On 28 August 2017 a further case conference was held with Tamar Allner, Sian James and two other employees of the MAC team. The entry noted that Mr Lowah was considered to be a '*client of concern*' with his whereabouts unknown, although it was possible he may be at his mother's house despite a current intervention order in place. Once again, and despite the numerous accounts of Mr Lowah's further disengagement since 14 July 2017, the reports of illicit substance use, removing his own stitches from his injured hand, giving away his belongings and repeatedly contravening the Intervention Order, it was recorded that:

> '[Mr Lowah] is currently not on any prescribed medication as MS (mental state) stable. He does not need to attend ED and there has been no collateral to suggest MS has declined since last review by Dr Giannakoureas. Depot was ceased. For clinical review to close if DNA (does not attend) next appointment with Dr Giannakoureas.'[216]

143 It was simply astounding that the events over a relatively confined period of time (five weeks) were not viewed as concerning, without at least raising the suspicion of a change in Mr Lowah's mental state. Equally as surprising was the determination made on multiple occasions in the clinical records, presumably by Ms Allner, that Mr Lowah's mental state was stable when she had not seen him or spoken with him at all during this period of time. While some events had been set in train before he was hospitalised at MTC (the damage to the Junction Housing property and likely eviction), there was now homelessness, more self-harm, and intimidating actions towards his mother from whom he was restrained from contacting, and recent criminal charges for assaulting a police officer.[217] It is important to again note that the MAC team still had the effect of the powers of the Level 2 CTO in place at this time (expiring on 7 September 2017), to compel Mr Lowah to attend for treatment had they seen his behaviours in a different light. Unfortunately, the die had been cast for Mr Lowah with the MAC team and they were foreshadowing a discharge from their service, which followed shortly thereafter on 2 November 2017.[218]

144 Ms Allner asserted reliance upon on the assessment of Dr Nance and Dr Giannakoureas that there was no evidence of psychosis as at July 2017. It appears that in the absence of a structured management plan developed by Dr Giannakoureas, Ms Allner was under the mistaken impression that the only relevant observations of Mr Lowah's mental state were observations by trained mental health clinicians of acute psychosis. She attributed his attendance to the FMC on 13 July 2017 as an episode of drug induced aggression and paranoia. In the absence of any guidance to the contrary, this appeared to cement in Ms Allner's mind the belief that only non-drug induced psychotic behaviours reported by qualified mental health clinicians would justify a notation other than 'MS stable'.

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[214] Exhibit C34b Annexure B, pages 2, 4-5
[215] Exhibit C39, page 33
[216] Exhibit C55a, page 169
[217] Exhibit C55a, page 165
[218] Exhibit C55a, page 201

145 This reinforced the significance of the failure to formulate a structured management plan, on either 11 April or 11 July 2017. If a structured management plan had highlighted the primary aspects of 'the deal' reached between Mr Lowah and Dr Giannakoureas, including cannabis use, non-attendance of appointments and aggressive and violent behaviours, Ms Allner may have had cause to act on the information she was receiving from external agencies. Ultimately the management plan was Dr Giannakoureas' responsibility. It was apparent from Ms Allner's affidavit that her reference to 'MS Stable' meant '*established psychotic behaviour as witnessed by a mental health professional'*. The use MS Stable was vague and open to misinterpretation. Had she been required to identify specific behaviours indicative of his relapse signature, by way of a structured management plan, it is possible that the reports of aggression, property damage, paranoia and non-compliance with court ordered appointments would have triggered a re-assessment of the need for depot medication. In addition, had Dr Nance had access to a management plan which identified Mr Lowah's relapse signature, he would have been in a better position to assess Mr Lowah and the agreement reached in April, of which there was a well-documented contravention.

Arrested and charged for two assaults

146 On 31 August 2017, only three days after the case conference was held by the MAC team, Mr Lowah was arrested for assaulting two individuals, unknown to him, at different times and locations. On the first occasion, Mr Lowah assaulted a young woman at McDonalds on Hindley Street by approaching her from behind, grabbing her hair and throwing her to the ground. This occurred at approximately 2:20am. The victim was waiting in the restaurant to collect her food order when he assaulted her. Mr Lowah exited the store after the assault and when apprehended by police stated that he thought he knew her, and she had been saying something about him losing a fight the night before. He then told police that he did not care if he knew the female or not and did not really care if he had hurt her. Mr Lowah was arrested, charged with Common Assault and then granted police bail.[219]

147 Later in the afternoon of the same day, Mr Lowah approached a male legal practitioner on Gouger Street from behind and hit him over the head with a chair. Once again, this individual was not known to Mr Lowah and was simply sitting at an outdoor eating area of a city café going about his business. Mr Lowah was again arrested by police and this time refused police bail. Mr Lowah was charged with Aggravated Common Assault. He told police that he had assaulted the man because he had a problem with the way the man looked at him.[220] Mr Lowah was conveyed to the Royal Adelaide Hospital (RAH) due to concerns regarding his mental state.

148 The RAH clinical records reflected that Mr Lowah was assessed in the ED by a psychiatric registrar named Dr Michael Hartstone, who noted that his manner was quite concerning with the suspicion that he was paranoid and might be disassociating. Mr Lowah was noted to be initially calm during the review, but quickly became paranoid and irritable. He had difficulty answering questions and forgot who the doctor was during the assessment. He was also distracted by noise outside the room and mumbled under his breath. The assessing doctor noted the two assaults on unknown victims without

[219] Exhibit C39, page 33
[220] Exhibit C39, page 33

provocation and, seemingly unbridled by the false understanding of a re-diagnosis, recorded the following:

> 'I suspect that this young man is currently psychotic although he is not able to provide me with any subjective information to support this. **Given that his depot was ceased in April and he has had previous psychiatric admissions for psychosis I suspect that he does have schizophrenia but this is complicated by antisocial personality traits**. He continues to pose a significant risk to the public in the near future. SAPOL have indicated that they are concerned about his risk and they are unwilling to bail him.' [221]

149 The plan was for Mr Lowah to be nurse specialled (one-on-one nursing care), sedated and transferred to James Nash House. He was detained under a Level 1 ITO at 5:40pm on 31 August 2017.[222]

150 While still in the RAH awaiting transfer, Mr Lowah was assessed by Dr Paul Davis, senior consultant psychiatrist, on 1 September 2017, for the purpose of reviewing the ITO as required by Section 21(5) of the Mental Health Act. Dr Davis was not called to give evidence at the Inquest. However, it was clear from his entry that the assessment of Mr Lowah left an impression on him, with him recording that it was '*a tense interview*'.[223] Dr Davis made the following record of his mental state examination (MSE):

> 'Eventually awake, aware he was in hospital. Aware he had been change [sic] with assault offences, **very hostile, and menacing but in a cold, calm, calculated way. Able to provoke strong feeling of being unsafe in his company**. Difficult to determine, presence of degree of formal thought disorder and extent of paranoia. Clearly he is not mentally well.' [224]

151 Dr Davis noted Mr Lowah's past psychotic illness and that he had been hospitalised in the Boylan Ward as a teenager, that he had displayed antisocial behaviour and family had taken out an intervention order against him, and that his current CTO was for review in September 2017. Dr Davis also made the following note of Dr Giannakoureas' assessment a few days before – '*stable mental stte [state] assessment recently*'.[225] He concluded that as Mr Lowah was clearly not mentally well, he required inpatient psychiatric ward evaluation in a secure setting.[226] Dr Davis confirmed the Level 1 ITO and noted that forensic mental health, the duty nurse manager and the RAH ED mental health nursing unit manager were all aware.

152 Later that evening while awaiting a bed at James Nash House, a Code Black was called due to an escalation in Mr Lowah's behaviour. From an irritable and threatening demeanour, Mr Lowah's symptoms intensified, becoming suspicious of staff and hypervigilant. Mr Lowah was also recorded to be spitting at staff. He was administered 1mg of olanzapine and 2mg of clonazepam intramuscularly and then shackled to his barouche. A decision was made to transfer Mr Lowah to a specific ward with a nurse special as there was no bed available at James Nash House. This was recorded as being

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[221] Exhibit C60, pages 5 and 99-100, emphasis added
[222] Exhibit C60, pages 11-12
[223] Exhibit C60, page 83
[224] Exhibit C60, pages 83-84, emphasis added
[225] Exhibit C60, page 28
[226] Exhibit C60, page 28

approved as the '*least inappropriate option*'.[227] The following morning Mr Lowah was reviewed by consultant psychiatrist Dr I Nielsen who made the following observations:

> 'Seen in C3 – shackled to barouche … looking dishevelled and dirty … either didn't answer or said 'what's that got to do with you'. Looked intently at me with a menacing look. Told me '*people pissed me off so I assaulted them*'. Refused to say how they pissed him off. At times stared intently at the ceiling smiling inappropriately at times. Appeared to be responding to internal stimuli. Refused to answer re perceptual disturbances. Said '*I can't have schizophrenia*' – wouldn't elaborate. Appeared suspicious – intense staring with refusal to answer questions. No FTD (formal thought disorder). Lacking insight. No rapport.
>
> Assess – 19-year-old man, homeless with history of ASPD (antisocial personality disorder) and schizophrenia, arrested for assault. ***Difficult to assess but likely psychotic (particularly in view of negative drug screen).*** Significant history of aggression.
>
> Plan – Requires a JNH bed for further assessment and review.' [228]

153 Mr Lowah was transferred to James Nash House on the afternoon of 2 September 2017 and reviewed by Dr Furst the same day. This was the first occasion that Dr Furst met Mr Lowah. After noting his history and the days preceding his transfer to James Nash House, Dr Furst recorded his impression as follows:

> '19 year old. Hx (history) of schizophrenia but diagnosis questioned by adult services. Background of developmental trauma, conduct disorder and violence.
>
> Suspect cannabis related psychosis with DDx (differential diagnosis) – ASPD (antisocial personality disorder). Frequent user of cannabis and episodes of care after associated with cannabis use. Presents as aggressive and very uncooperative. Recent history of assault + current state indicates he is a high risk of violence at present. Not safe for ward access at present.' [229]

154 During his admission to James Nash House (2-7 September 2017), Mr Lowah spent most of his time in seclusion due to his aggressive and unpredictable behaviour. On 5 September 2017, he assaulted a mental health nurse by reaching through the trap of the seclusion room door and pulling out a moderate amount of her hair.[230] Consultant psychiatrist Dr Craig Raeside assessed Mr Lowah twice during this admission. Ultimately, Dr Raeside's assessment on 7 September 2017 was '*antisocial personality disorder – no psychotic illness - with likely drug induced psychosis last week*'. That was despite a clear drug screen six days earlier. Dr Raeside was not able to detect clear evidence of psychosis, although Mr Lowah was observed as being vague and guarded at times.[231] Accordingly, the ITO was allowed to lapse, and Mr Lowah was discharged from James Nash House without medication. The day before he was discharged the Level 2 CTO expired. As Mr Lowah had not been granted bail for the second assault, he was transferred to Yatala on remand.

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[227] Exhibit C60, page 88
[228] Exhibit C60, pages 88-89, emphasis added
[229] Exhibit C59, page 124
[230] Exhibit C59, page 132; Exhibit C57, page 25
[231] Exhibit C59, page 142

Readmission to James Nash House

155 It was evident from the clinical records of the South Australian Prison Health Service (SAPHS) and the Department for Correctional Services (DCS), that whilst on remand in Yatala between 7 September and 15 November 2017 for the assault offences and the breaches of bond, Mr Lowah's mental health continued to deteriorate. On 15 November 2017, two months after being discharged from James Nash House, he was readmitted. This was on a background of prison staff noting that he was responding to internal stimuli, appearing distracted, thought disordered and perplexed. Notably, this was despite spending over a month in HDU and G Division, which was seen to indicate his behaviour was attributable to a mental illness rather than a drug induced psychosis. Mr Lowah had also refused to restart medication within the prison and as a result was transferred to James Nash House, where he was reviewed by Dr Oliver Burgess who undertook an MSE.

156 Dr Burgess observed that Mr Lowah had an intensity of eye contact, at times appearing distracted and muttering. His speech was noted to be brief and he was hostile with significant offence taken to benign wording. Dr Burgess also noted significant latency and relative poverty of content, but no otherwise gross thought disorder. He also observed Mr Lowah to appear to be responding to internal stimuli. Dr Burgess' impression was a '*relapse of schizophrenia secondary to planned cessation of antipsychotic*'[232] with underlying antisocial personality disorder, substance abuse disorder (THC predominantly), in remission in a controlled environment.[233] Dr Burgess recommended Mr Lowah be commenced on the antipsychotic medication aripiprazole to be administered by way of a depot injection.[234] He detained Mr Lowah on a Level 1 ITO (which was followed by a Level 2 ITO) and foreshadowed an application for a Level 2 CTO.

157 Mr Lowah was noted to rapidly improve following the recommencement of the depot injection on 20 November 2017. Five days after his first assessment, Dr Burgess recorded that he was dramatically less distractable and less hostile and did not appear to be responding to internal stimuli.[235] Dr Burgess made the observation that his relapse in a drug free setting (G Division and HDU of Yatala) ruled out a purely drug-induced illness which had remained a differential whilst in the community. Perhaps most importantly, Dr Burgess placed significance on treating Mr Lowah's psychotic illness to assist with maintaining his abstinence from cannabis and addressing social factors such as homelessness and unemployment. These observations were summarised in the application for the Level 2 CTO which Dr Burgess indicated would allow for medication to be started and monitored whilst in custody or the community, with the aim of assisting

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[232] Exhibit C59a, page 73
[233] Exhibit C59a, pages 71-73
[234] Exhibit C59a, page 151
[235] Exhibit C59a, page 109

Mr Lowah engaging with a community team once released.[236] In the undated application for the Level 2 CTO, Dr Burgess expressed the following view:

> 'Mr Lowah has a history of violence including assaults on staff, his illness schizophrenia with disorganised features is one in there (sic) is clear evidence that treatment reduces this risk.' [237]

158 While Dr Burgess had the benefit of hindsight in relation to Mr Lowah's recent mental health journey, his assessment and plan for Mr Lowah saw an almost complete reversal of the approach and underlying philosophy taken by Dr Giannakoureas and the MAC team earlier in the year. This was particularly so in relation to the treatment for his illness to support him to abstain from cannabis use, rather than stopping the treatment in the hope that he would abstain from cannabis use (as was his broken promise).

159 After Mr Lowah repeatedly expressed a desire to return to Yatala where he would have been permitted to smoke cigarettes,[238] the Level 2 ITO was revoked by Dr Raeside on 27 November 2017.[239] Mr Lowah was released from James Nash House on the same day and readmitted to the HDU of Yatala. The separation summary from James Nash House stated that while Mr Lowah appeared to be mildly thought disordered and at times appeared to respond to internal stimuli, he repeatedly stated that he preferred the prison environment rather than the psychiatric environment and he was transferred back to the YLP HDU environment.[240]

Depot medication reinstated

160 From this point onwards in the timeline (20 November 2017), Mr Lowah received regular depot medication without interruption, until Ms Foster's death. He was therefore receiving the treatment as prescribed. However, it was Dr Furst's opinion that the treatment was not having its full therapeutic benefit. Following the cessation of the depot injections in April 2017, Mr Lowah's mental state had deteriorated to such a point that even when the depot was reinstated, it was not containing his illness. Dr Furst gave this evidence with the benefit of hindsight as he had treated Mr Lowah in James Nash House following the death of Ms Foster. Over this period he described Mr Lowah remaining in James Nash House for an extended period of time, continuously observed and repeatedly assessed by skilled senior consultant forensic psychiatrists. Even with this intensive treatment he remained very unwell for a long time until clozapine was introduced. It was the observation of the progression of Mr Lowah's recovery following Ms Foster's death, that suggested he had been unwell for a long time.[241]

161 Dr Furst explained:

> 'The issue was that he was getting the treatment as prescribed, it just wasn't working very well and that - it was working well enough that it wasn't very obvious to people that he was sick; it was probably just containing him enough that it hid the more florid, you know, presentation that would've really declared him as being unwell. So I'm not sure - I mean, the

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[236] Exhibit C41, pages 256-258
[237] Exhibit C41, page 258
[238] Exhibit C59a, page 97
[239] Exhibit C59a, page 171
[240] Exhibit C59a, page 159
[241] Transcript, page 615

> community team potentially could've seen him a little bit more often but that wouldn't necessarily have improved his mental state. I think when we look at his treatment history, it didn't matter what medication he was on, it only got him so far. It kind of got him a bit better; not a lot, but a bit, and it really wasn't until he spent a long time in James Nash House on clozapine that he really started to get a bit better'.[242]

162 Dr Furst acknowledged that in coming to his opinion as set out above, he also had the luxury of all the information provided by the Courts, plus the SA Health records which he had sought, including discharge letters and case notes. He was able to put together a chronology to demonstrate a clear sense of when Mr Lowah's mental state began to deteriorate, which dated back to the cessation of the antipsychotic depot treatment. Dr Giannakoureas was obviously not in this position when he took over the psychiatric care of Mr Lowah. The criticism that Dr Furst made (as did A/P Sullivan) was that Dr Giannakoureas did not have in place an adequate management plan to monitor non-compliance, with the narrative of diagnosis then having been changed by other members of the MAC team. While I accept that Dr Furst had the benefit of voluminous records, as well as the ability to forensically examine the period of time following the cessation of the depot medication, it is difficult to overlook the availability of Dr Watson's letter to Dr Giannakoureas at the time he assumed consultant care of Mr Lowah. For reasons outlined above, I have accepted the evidence of Dr Furst.

Sentence of imprisonment

163 On 12 December 2017, Mr Lowah was sentenced for the two assaults occurring on 31 August 2017[243] in the Adelaide Magistrates Court. Mr Lowah received a sentence of 12 months and 14 days with a non-parole period set at 6 months, backdated to 31 August 2017, when he had been taken into custody after being refused bail.[244] The sentencing magistrate, Deputy Chief Magistrate Cannon, in his sentencing remarks noted the serious and violent nature of the offending and Mr Lowah's homelessness at the time. His Honour stated:

> 'I have fixed an unusually short non-parole period to make sure he is under a relatively long period of supervision attendance in the community.' [245]

164 Despite Mr Lowah's significant mental health history and having been diagnosed with a relapse of schizophrenia only a month before, during an inpatient stay at a forensic mental health facility under a mental health detention order and a Level 2 CTO having just been reinstated, Mr Lowah (or his legal representatives on his behalf) did not commence an investigation into his mental competence to commit the offences. There was no request for any psychiatric reports to investigate his mental competence or fitness under section 269K of the CLCA. I am unaware of the reason why an investigation of this kind was not initiated. There are a number of plausible explanations however this was not an issue that was examined at Inquest. While I make no criticism of Mr Lowah's legal representative, having no information relating to the circumstances in which he was

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[242] Transcript, page 617
[243] As well as other offences – Contravene Intervention Order x 2
[244] Exhibit C39, pages 33, 62
[245] Exhibit C69

retained or the information available to him at the time, I am of the view that Mr Lowah should have undergone this assessment.

165 Had an investigation been initiated, there were a number of compelling and proximate events to suggest that a finding of mental incompetence would have been reached. They included the bizarre nature of the offending, the transfer to the RAH by SAPOL following the second assault due to their concerns for Mr Lowah's mental state, the recent assessment of Dr Burgess (20 November 2017) that Mr Lowah's schizophrenia had relapsed secondary to depot cessation, the recommencement of antipsychotic depot medication and the application and granting of a Level 2 CTO to ensure Mr Lowah continued to take his depot medication. I acknowledge that there were fluctuations in the assessments by different senior consultant psychiatrists preceding this sentencing, however investigations in relation to mental competence are not undertaken in a treatment setting. On balance I find that had a mental health investigation been undertaken, Mr Lowah would have been found not guilty by reason of mental impairment.

166 Dr Furst gave expert evidence about whether a finding of mental incompetence following a Court ordered investigation would have impacted on Mr Lowah's custodial sentence, and the circumstances surrounding his later release into the community. Dr Furst gave detailed evidence on this topic and remarked that Mr Lowah's status as a sentenced prisoner had a significant effect on both factors. He explained that there was a '*whole raft of things that might have been triggered had he been declared or investigated for his mental competence at that time*'.[246] These were as follows:

> 'Mr Lowah would have spent his entire sentence (and possibly longer) in James Nash House as a forensic patient under close psychiatric observation for the limiting term, with the obvious benefit of an ongoing assessment of his mental state by mental health clinicians. The focus of the term would have been his rehabilitation, and there would have been discretion to delay release into the community if there was no accommodation;[247] and
>
> There would have been a more structured plan in the form of a Licence following his release from the custody of the Minister of Health. The Court would have ordered reports under sections 269Q and T of the CLCA, which would have involved the preparation of a treatment plan, second opinions, and recommendations about supervision either in custody or in the community. These reports would have coordinated a collaboration between the local Community Mental Health Service with oversight from the Forensic Community Mental Health Service, the Parole Board, and the Department for Correctional Services. It would also have involved conditions such as urinalysis (for illicit substance use) and enforceable sanctions for breach of conditions.' [248]

167 As will be detailed below, without the above structures in place, those caring for Mr Lowah in Yatala had serious concerns for the risk he posed to himself and others as his sentence came to an end, and went to considerable effort to ameliorate this risk. Unfortunately, these efforts were ultimately unsuccessful and Mr Lowah was released into the community and was essentially homeless. While a Level 2 CTO was still in place requiring him to have a monthly depot injection, Mr Lowah had no allocated community mental health team as he had no fixed place of address. He killed Ms Foster six weeks after his release. I will now detail what I consider to be the valiant efforts of the prison

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[246] Transcript, page 560
[247] Transcript, page 559
[248] Transcript, pages 559, 560-562

health staff (in particular Ms Zulian and Mr Williams) to prevent Mr Lowah from being released from prison and when that failed, their attempts to see Mr Lowah's safe return into the community with adequate support networks. These frustrated attempts highlighted system failings that have given rise to recommendations, as detailed later in the Finding.

Sentence of imprisonment in Yatala

168 In the nine months (approximately) following his custodial sentence being imposed, Mr Lowah was moved around between the general prison population (E Division), G Division[249] and the High Dependency Unit.[250] The Court heard evidence from two prison health staff who were involved with Mr Lowah's care in the HDU. Social worker, Ms Stephanie Zulian, and forensic psychologist, Mr Luke Williams. Mr Williams had also been the manager of the HDU since its inception in 2016.[251] Mr Williams explained that the HDU had six camera observation cells which were used primarily to manage prisoners who were deemed to be at acute risk of suicide or self-harm. They were also used to manage prisoners who had displayed aggressive behaviour when it was deemed to be mental health related.[252] The evidence of Mr Williams revealed that the HDU beds were in high demand and there was a waiting list for admission. Consideration for admission was therefore on a daily triage basis to ensure the service was made available to everyone suffering from mental health issues.[253]

169 Mr Williams expressed the view that Mr Lowah's ability to cope in the mainstream prison environment was limited due to his serious mental health issues and his risk to others.[254] He and other staff members tried to keep Mr Lowah in the HDU for as long as possible, but this was not always achievable due to the demand for the service. While in HDU, Mr Williams observed Mr Lowah often display non-compliant and aggressive behaviour and was therefore moved between the acute and therapeutic units. On occasion he was transferred to G Division.[255] Mr Williams formed the opinion that Mr Lowah's risk of violence fluctuated with his mental health; when his mental health was not well controlled with antipsychotic medication his risk of violence would increase. Even with the depot medication being reinstated on 15 November 2017, Mr Lowah's mental health was unstable at times. However, Mr Williams identified the greater cause for concern was Mr Lowah's impending release; being the risk of homelessness. He explained:

> 'Whilst he did not undergo formal assessment of his risk of violence, I understood that release into the community was likely to be a significant risk for him. This was due to the fact that this was likely to be a destabilising situation that would likely increase the risk of substance use and decrease his ability to appropriately manage his mental health through engagement with mental health services. Alternatively, if he was released to a stable situation where he had his needs met and was in receipt of ongoing support for his mental health, this would reduce somewhat.' [256]

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[249] For high-risk prisoners (including violent behaviour and suicide risk)
[250] A Statewide Mental Health 38 bed facility for acute and high needs prisoners (including mental health and aged care) with multi-disciplinary staff (social workers, psychologists, occupational therapists and aged care workers)
[251] Exhibit C44
[252] Transcript, page 6
[253] Transcript, page 60
[254] Transcript, page 60
[255] Exhibit C44, paragraph 4
[256] Exhibit C44, paragraph 6

170 There was significant force to Mr Williams' observations. These opinions had been previously expressed by other mental health professionals, including Dr Watson and Dr Burgess who acknowledged the ongoing chronic risk Mr Lowah posed which escalated when he was unwell. Dr Burgess noted that Mr Lowah would be unlikely to maintain abstinence from cannabis use unless his psychotic illness had been treated and would be unlikely to address social factors such as homelessness and unemployment, particularly with his disorganised thoughts.[257]

171 Ms Zulian had day-to-day contact with Mr Lowah when he was admitted to the HDU. She noted that he always presented with blunt affect, did not engage well in conversations and was guarded when asked questions.[258] Mr Lowah was also monitored intermittently by the High Risk Assessment Team[259] (HRAT) for reported thoughts of self-harm, concerning behaviour and unwillingness or inability to engage with clinical and custodial staff. Ms Zulian recalled a number of concerning incidents during Mr Lowah's frequent admissions to the HDU. They included:

- Fashioning a noose from his bed sheet and attempting to hang himself in his cell on 18 January 2018; and
- Damaging his cell including kicking windows, urinating on the door of his cell and yelling abuse from his cell; and
- Threatening to assault staff including a threat to cause a laceration to the neck of a prison officer.[260]

172 On 8 January 2018, Mr Lowah applied for parole in anticipation of his non-parole period ending on 28 February 2018. Mr Lowah's application was considered on 5 April 2018 and he was interviewed by the Board on 26 June 2018. The Presiding Member of the Parole Board, Ms Frances Nelson KC, provided a statement to the Coroners Court detailing the Parole Board's consideration of Mr Lowah's application in accordance with section 62 of the *Correctional Services Act 1982*. Ms Nelson noted Mr Lowah's extensive mental health history, his violent offending, and his lack of post-release plans. It was also noted that Mr Lowah's mother had a current intervention order against him and he had no supports in the community that he could identify. In her statement, Ms Nelson detailed her understanding of Mr Lowah's past non-compliance with medication, his abusive behaviour towards staff and his threats to kill '*staff*' on 13 March 2018 and his threats to kill '*someone*' on 15 March 2018.[261]

173 During the interview of Mr Lowah conducted by the Parole Board, he told them that he was '*pretty much delusional*' when he committed the subject offences. He denied using illegal drugs or alcohol and went on to say that '*if I were to say why I committed the offences then I'd be going into my delusions*'.[262] The Parole Board noted that his head sentence came to an end on 14 September 2018, at which time the Board would have no

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[257] Exhibit C41, page 258
[258] Exhibit C43, paragraph 4
[259] The HRAT – Prisoner's deemed to be of high risk of self-harm or suicide during their admission process are assessed by HRAT to determine whether they are low, moderate or high risk in order to establish appropriate arrangements to be made for their accommodation in prison
[260] Exhibit C43, paragraph 5
[261] Exhibit C52, paragraphs 4-9
[262] Exhibit C52, paragraph 11

power to impose any conditions on his release. Notwithstanding, the Board formed the view that Mr Lowah was not suitable for parole in June 2018. Ms Nelson stated:

> 'The Parole Board considered that Mr Lowah was such a significant risk to the community as to be unsuitable for release on parole. We also considered that he would not comply with parole supervision.' [263]

174 With that decision made, Parole Board members turned their attention to the end of Mr Lowah's sentence. Ms Nelson stated:

> 'We were concerned that [Mr Lowah] would present a management issue when he was released at the end of his sentence. As a result, the Parole Board asked Community Corrections to explore the possibility of referring Mr Lowah for semi-structured accommodation and see if they could facilitate a management plan for his ultimate release by way of involving the Forensic Mental Health Team, possibly Disability SA and also perhaps the Exceptional Needs Unit. It was the view of the Parole Board a multi-agency approach was necessary in the future.' [264]

175 In response to the view held by the Parole Board, contact was made with NDIS, the Exceptional Needs Unit, and an Aboriginal Liaison Officer to assist Mr Lowah with both eligibility and application for supported accommodation and supports in the community. On each occasion Mr Lowah refused to either participate in an assessment, or sign consent forms required for these services.[265]

176 In addition to the above efforts directed by the Parole Board, Ms Zulian attempted to arrange an in-prison appointment with Centrelink for Mr Lowah, but this was unable to be facilitated. Mr Lowah also refused to allow Ms Zulian to disclose his mental health history, thereby preventing her ability to complete applications for multiple agencies and organisations in the community on Mr Lowah's behalf. Both Ms Zulian and Mr Williams acknowledged in their evidence that one of the biggest barriers the HDU faced in attempting to put appropriate services in place, was Mr Lowah's refusal to engage.[266] Ms Zulian recalled that when declining to engage with her efforts, Mr Lowah had expressed a preference to be homeless upon release.[267] An available inference is that Mr Lowah was aware that the consequence of his refusal to engage would be his release at the end of his sentence with no obligations. Accordingly, Ms Zulian applied to SACAT for a Guardianship and Administration Order.[268] At an urgent hearing on 10 September 2018, the Office of the Public Advocate (OPA) was appointed as limited guardian of Mr Lowah. With this in place, Ms Zulian contacted five organisations seeking accommodation for Mr Lowah, but was informed there were no vacancies. Mr Lowah was not eligible to stay in a hotel funded by DCS following his release as he would have served his full sentence. One service required an upfront amount of $660 which, unsurprisingly, Mr Lowah as a prisoner, did not have. The only support Ms Zulian was able to organise was the Helping Young People Achieve Program (HYPA). While this would have provided Mr Lowah with emergency supplies, these supplies were to assist

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[263] Exhibit C52, paragraph 18
[264] Exhibit C52, paragraph 12
[265] Exhibit C52, paragraph 13
[266] Transcript, page 63 (Williams), pages 32, 33, 35-37 (Zulian); Exhibit C43, page 2
[267] Transcript, page 36
[268] Transcript, page 37

him in a sleeping rough environment. This was the exact scenario that Ms Zulian was working so hard to avoid.

177 With housing options looking bleak and the end of Mr Lowah's head sentence approaching, Ms Zulian and Mr Williams organised for Mr Lowah to be seen by visiting forensic psychiatrist, Dr Ian Jennings. In doing so, they were hopeful that Mr Lowah may have met the criteria for an ITO, thereby preventing (or at least delaying) his release into the community. Mr Williams gave the following evidence:

> 'Well certainly we did have concerns regarding his mental health, and we referred him to the Prison Health Service for an assessment of his suitability for an inpatient treatment order. So really that would have been the only way that we were aware of to prevent his release into the community, given that he was being released completely sentence served and there was no period of parole, there was no scope for either us or Community Corrections to remain involved in his care. As you said, we referred him to the SMU to see if there was scope to place him on an extended supervision order and the advice was that there wasn't. So in our mind, that would have been the only other option in terms of preventing his release.' [269]

178 Mr Williams, as a forensic psychologist, told the Court he believed Mr Lowah met the criteria for the imposition of an ITO. He clarified that he was of the view that Mr Lowah appeared to meet the criteria of a mental health disorder and presented a risk to himself or to others. Mr Williams gave evidence that he and other clinicians (with whom he had spoken) formed the opinion that Mr Lowah was or might have been reacting to internal stimuli.[270] Had Mr Lowah been assessed by a psychiatrist as meeting the criteria for an ITO, it would have resulted in him being subject to a period of involuntary treatment, most likely in a psychiatric facility.[271]

Dr Jennings' assessments of Mr Lowah

179 On 5 September 2018 Dr Jennings saw Mr Lowah. Dr Ian Jennings had graduated from his medical degree at Flinders University in 1976 and obtained his psychiatric fellowship in 1982. In his early career, Dr Jennings worked in both the public and private sector in South Australia and the Northern Territory. Around 1990 he cared for inpatients at James Nash House for a period of two years and then returned to the private sector. Dr Jennings continued to hold forensic mental health clinics in most prisons in South Australia on a two sessions per week basis until he retired, including Yatala. Dr Jennings retired from psychiatry in February 2019, just five months after his last of the three consults with Mr Lowah. Following his retirement, he described '*disconnecting*' from his professional life. He gave evidence at the Inquest on 20 September 2022. As his contact with Mr Lowah came at the end of a long career in forensic psychiatry, it was not unsurprising that Dr Jennings had no memory of seeing Mr Lowah on this occasion or any prior occasion.[272] He could not recall any conversations with either Mr Williams or Ms Zulian about Mr Lowah in 2018. Accordingly, Dr Jennings relied entirely on his entries recorded in the SAPHS file of Mr Lowah when giving evidence.

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[269] Transcript, page 75
[270] Transcript, page 78
[271] Transcript, page 76
[272] Transcript, page 86

180 As mentioned above, there were three occasions that Mr Lowah saw Dr Jennings in 2018. The first was on 18 April 2018 when a referral marked as '*urgent*' by Dr L Noakes, and dated 26 March 2018, was submitted asking for Mr Lowah to be assessed for psychosis as he appeared to be responding to internal stimuli and was on a waiting list for James Nash House.[273] The referral listed the reasons for seeking the consult and the management assistance as:

> 'Management Plan – angry, risk to others, was transferred to division. Recent unprovoked assault on prisoner to get to G Division.'[274]

181 Dr Jennings told the Court that while he could not remember the consult, his entry reflected that he did not detect any psychosis on this occasion, rather viewed the reported behaviours as a '*not uncommon*' ploy to be transferred to James Nash House. He also placed less weight on the referring doctor's opinion of psychosis as he was not a psychiatrist.[275] Noting Mr Lowah was on a regime of antipsychotic medications, he added a trial of olanzapine and valproate and recorded the plan to review him in one months' time, believing (as documented) that his behaviour issues appeared to be dominant in his presentation.[276]

182 The second consult was on 30 May 2018 with Dr Jennings' entry noting that Mr Lowah was '*going well*' with a review date in two months' time. However, the records reflected that the next assessment of Mr Lowah by Dr Jennings was not until 5 September 2018. Dr Jennings could not explain why there had been a three-month interval instead of two. Dr Jennings could also not recall being asked to review Mr Lowah on this occasion by either Ms Zulian or Mr Williams. With reference to the entry in the SAPHS notes,[277] Dr Jennings initially queried whether there had been a request by Ms Zulian or Mr Williams to assess Mr Lowah's mental state for the purpose of a mental health detention, based on what he had written in the records. His usual entry in the case notes following such a request would be: '*being reviewed with regard to mental state with regard to detention*', or something along those lines.[278] Instead, Dr Jennings' entry commenced with '*Going well'* which he interpreted in his evidence as meaning he did not detect any active psychotic state.[279] Dr Jennings conceded that he did not have the best memory in the world and was not asserting that the HDU staff had not spoken to him about their concerns for Mr Lowah on this occasion. He simply did not remember it taking place. Dr Jennings commented that had Mr Williams expressed concerns for Mr Lowah's mental state, he would have taken this more seriously than concerns expressed by a GP or general nurse. He placed weight on Mr Williams' experience as a psychologist who had worked in the forensic area for a long time and was actively involved in running the HDU.[280]

183 Dr Jennings' entry on this occasion focused on Mr Lowah's psychosocial situation as his prison sentence was coming to an end. He noted the importance of Mr Lowah having suitable accommodation in order to be linked with an appropriate community mental

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[273] Exhibit C38, page 95
[274] Exhibit C38, page 95
[275] Transcript, page 97
[276] Exhibit C38, Volume 1, Part I, pages 47-48
[277] Exhibit C38
[278] Transcript, page 150
[279] Transcript, page 104
[280] Transcript, page 151

health service. As demonstrated by Ms Zulian's and Mr Williams' evidence, the numerous entries in the prison health records, and Ms Zulian's detailed '*Timeline for Throughcare Planning*' document,[281] this issue was already at the forefront of the minds of HDU staff. That had been the primary reason HDU staff wanted Mr Lowah assessed by Dr Jennings, to prevent him being released into the community with no accommodation and therefore with no ability for a community mental health team to monitor his mental health. There were a number of questions that were unable to be answered in relation to Dr Jennings' reviews of Mr Lowah due to Dr Jennings' inability to remember. I am not critical of Dr Jennings' lack of memory. I do however observe a notable disconnect between the entries made by Dr Jennings and the observations of prison health staff of Mr Lowah's behaviour, including (as mentioned above) threats to harm, threats to kill, responding to internal stimuli, and urinating and smearing faeces on the wall of his cell. As will be detailed below, there was a concerning reason for this disconnect; Dr Jennings did not have access to the Justice Information System when undertaking his clinics at the gaol.

184 When giving his evidence, Dr Jennings candidly explained the sub-optimal conditions of the psychiatric clinics that he ran at the prison. He described the clinics as always being full and having limited time to talk to each prisoner that he saw.[282] Dr Furst gave similar corroborative evidence on this topic.[283] Dr Jennings also described the referral process as problematic. On occasion prisoners were referred to him and neither he nor the prisoner knew why. Sometimes the reviews took place in G Division and he was required to conduct the consultation through a glass screen which added complexity to the process and another barrier to effective engagement. Dr Jennings stated that the review of Mr Lowah conducted on 18 April 2018 would have been conducted through a glass screen as Mr Lowah was in G Division at the time.[284] Dr Jennings described the process of arriving at the prison, being given a pile of notes and looking through the medical files for psychiatric reports to get a feel for the issues that required addressing. Following that, Dr Jennings was required to locate a room to conduct his reviews as one was not allocated to him.[285] This evidence went some way to explaining the limitations on an adequate mental health assessment being undertaken for mentally unwell prisoners. It also provided no comfort that there was a thorough assessment of Mr Lowah on 5 September 2018.

185 It was the evidence of Mr Williams that he had concerns about the decision of Dr Jennings not to detain Mr Lowah, although he did not think he raised his concerns with Dr Jennings as the psychiatrist was only an irregular visitor at the prison.[286] Ms Zulian had a memory of being told that Mr Lowah did not meet the criteria for an ITO following Dr Jennings' review.[287] She stated in her affidavit (sworn approximately 18 months after the death of Ms Foster) that '*it was basically put back to me that I would have to manage him and try to do as much as I can prior to his release*'.[288] Ms Zulian and Mr Williams had a clear memory of asking Dr Jennings to review Mr Lowah and the reasons for requesting the review. Dr Jennings did not dispute their evidence, he simply could not remember that

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[281] Exhibit C43a
[282] Transcript, page 118
[283] Transcript, pages 586-587
[284] Transcript, page 135
[285] Transcript, pages 91, 132
[286] Transcript, page 81; Exhibit C43, page 9
[287] Exhibit C43, paragraph 19
[288] Exhibit C43, paragraph 19

conversation, or really anything relating to Mr Lowah. Overwhelmingly, the evidence supports a finding that Mr Williams and Ms Zulian did request a review of Mr Lowah by Dr Jennings for his consideration of the imposition of an ITO. I further find that this request was made based on their concerns for Mr Lowah's mental state and the risk he posed to himself and others upon his looming release.

186 It was the opinion of Dr Furst that Mr Lowah was '*quite unwell*' at the time of the assessment by Dr Jennings on 5 September 2018, and that he would not have described Mr Lowah's mental health as '*stable*'. He explained:

> 'Well, it was stable in the sense that it was consistently poor, but clearly I think he was quite unwell and I wouldn't have described it as stable in the sense that its ok for him to continue, you know, with whatever treatment he is having, yes.' [289]

187 Dr Furst expressed the opinion in his addendum report (requested by the Coroners Court in anticipation of his oral evidence) that it was reasonably possible Mr Lowah was experiencing psychotic symptoms at the time of Dr Jennings' review. Dr Furst came to this opinion based on his review of the documents contained within the JIS. He opined that from the time Mr Lowah assaulted the nurse at James Nash House on 5 September 2017 right through to his release (and therefore including all three reviews by Dr Jennings, but most importantly the last review), the notes were strongly suggestive that he was psychotic.[290] However, Dr Furst highlighted the inability of prison mental health staff (or visiting specialists) to access information from other departments, despite those departments having direct involvement with the prisoner and that involvement occurring within the prison environment. Dr Furst held the opinion that this was the '*key issue*' in Ms Foster's death. He made the following comment:

> 'This brings me to the key issue with this case, which is the fragmented medical records system for Mr Lowah. Whilst his OACIS files documented his admissions to hospitals, his James Nash House medical records were not on Sunrise, his SA Prison Health Services records were not on Sunrise and his Correctional Services records were not available to health practitioners involved in his care. I note there is the dedicated sharing of HRAT minutes, but this is not always obvious during a busy clinic and may not have been available on the day. Had there been improved information sharing, it is possible that Dr Jennings may have reached a different conclusion in regard to whether Mr Lowah's schizophrenia was 'stable'. [291]

188 Dr Furst gave evidence that the information contained within the JIS records for the time following Mr Lowah's second discharge from James Nash House (28 November 2017), were 35 separate concerning entries that Dr Jennings would not have had access to in his role as the visiting psychiatrist, but were suggestive of psychosis (irritable, aggressive, unreasonable and paranoid behaviour).[292] While by no means exhaustive, these included:

- Being observed playing an imaginary piano;[293]
- Stating he thought the prison officers were '*off their faces*';[294]

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[289] Transcript, page 577
[290] Exhibit C56a, paragraph 13
[291] Exhibit C56a, paragraph 13
[292] Transcript, page 572
[293] Transcript, page 919
[294] 26/1/2018

- Stating that he was delusional and asked whether other prisoners heard voices;[295]
- Complaining that other prisoners were listening to his conversations and were '*too aware*' that he was on the unit;[296]
- Multiple threats to '*kill any cunts'* (directed towards prison guards and other prisoners);[297]
- Concerns that the staff could try and kill him by staring at him and could not be reassured that no one had been staring at him;[298]
- Reporting that the prisoner next door could see into his mind and knew what was going on in his head.[299]

189 Dr Furst explained that, had Dr Jennings been privy to this information, he could have challenged Mr Lowah during the assessment. For example, during the assessment on 5 September 2018, Dr Jennings recorded that Mr Lowah informed him that he had '*no particular problems with inmates or staff*''. Had Dr Jennings had access and then reviewed the JIS entries, he would have seen multiple entries of Mr Lowah swearing and threatening prison guards and exhibiting violent, aggressive and paranoid behaviour. Dr Furst noted that if Dr Jennings had challenged Mr Lowah on this inconsistency, it may have unravelled Mr Lowah's attempts to hide his psychosis which would not occur with superficial questioning.[300]

190 It is evident from Dr Jennings' note that he did not assess Mr Lowah's mental state as unstable. Even though Dr Furst was of the view that Mr Lowah was most likely psychotic at that time, he did not go so far as to say that Dr Jennings had incorrectly assessed Mr Lowah. I find that Dr Jennings did not have available to him the highly concerning information that was most relevant to assess Mr Lowah's mental health, namely the entries from the prison officers with whom he had day to day contact. While I accept the evidence of Dr Jennings in relation to the clinics he conducted being overbooked, rushed and disorganised, by far the principal impediment to undertaking a reliable assessment was the inadequate information sharing capabilities across the different agencies working within the prison system. It is simply unfathomable that a specialist doctor tasked with assessing a prisoner's mental state would not have immediate access to collateral information about the prisoner's day to day behaviour.

191 Dr Furst was asked the following question:

> 'Q In terms of Dr Jennings' assessment and the information that he did not have available to him, is it reasonable to conclude that Dr Jennings would have reached a different conclusion about whether Mr Lowah's schizophrenia was stable, than the conclusion he reached if he had that information.
>
> A I wouldn't go so far as to say that it would have made it - that he would've made a different conclusion; he might have. He might have. He would've had more information to consider, the weight that he put on different things I can't say but it

[295] 13/3/2018
[296] 27/3/2018
[297] 24/1/2018, 15/3/2018, 10/4/2018, 12/4/2018, 7/8/2018
[298] 19/5/2018
[299] 12/7/2018
[300] Transcript, page 590

> certainly would've given him more information to consider, might've … changed the outcome of his assessment.' [301]

192 However, Dr Furst was more definitive about the pathway available to Mr Lowah and the subsequent implications of an assessment that Mr Lowah was psychotic with the imposition of an ITO under the Mental Health Act. He explained that if this had happened, Mr Lowah would have (ideally) been returned to James Nash House for treatment and stabilisation of his mental state to a level where he was not aggressive, thought disordered and threatening people. Perhaps, most relevantly to his situation at this time, a period of inpatient psychiatric treatment would have allowed further time to improve Mr Lowah's decision-making capacity and his ability to engage with those attempting to find accommodation for him. He explained that schizophrenia is not just a psychotic condition, but also a neurological condition that affects the sufferer's ability to think and make decisions. A/P Sullivan gave similar evidence about the effects of schizophrenia on cognition.[302] It was Dr Furst's evidence that '*it might have been quite a different outcome if [Mr Lowah] had been returned to James Nash House, rather than being released*'.[303] I agree with Dr Furst's evidence and find that the inadequate information sharing capabilities within the prison system hampered Dr Jennings' ability to make an informed assessment of Mr Lowah's mental state. This was another missed opportunity and has highlighted the need for urgent consideration of this issue.

193 Dr Furst was supportive of the need for improved information sharing processes. He explained during his oral evidence that there was a joint systems protocol (JSP) awaiting approval which details how prison health and corrections will work together in order to share information.[304] On 23 June 2023 an amended *Joint Systems Protocol* was approved. The previous version of this policy was approved in May 2010. Both documents are complex and it is difficult to imagine an easy application in a practical setting. However, it has been confirmed that JSP only allows the provision of medical information from SAPHS to DCS.

194 The more applicable document to the circumstances arising in this Inquest is the *Protocol for the Exchange of Information between SA Health and the DCS* dated 5 May 2015.[305] The object of this protocol is to guide information disclosure for the 'treatment care or rehabilitation of a prisoner' and ensures appropriate disclosure of information between SA Health and Correctional Services staff for the proper management of a prisoner overcoming confidentiality requirements.[306] However, despite the stated object of this Protocol, visiting psychiatrists still do not have access to the JIS. I will return to this topic under the heading of Recommendations.

Ms Zulian's email to the SAPOL Corrections Unit

195 When it became apparent that attempts to find accommodation for Mr Lowah, or engage him with services in the community were futile, Ms Zulian sent an email to the SAPOL Corrections Unit after receiving advice from the Sentencing Management Unit (SMU).

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[301] Transcript, page 594
[302] Transcript, page 943
[303] Transcript, page 596
[304] Transcript, page 593
[305] Exhibit C73, Protocol for the Exchange of Information between SA Health and the DCS, 2015
[306] Exhibit C73, page 3, section 1

Ms Zulian explained that she was concerned that Mr Lowah would reoffend, not due to his history but rather due to his behaviour in custody. She observed that when in the HDU there was little to no warning that Mr Lowah would display violent behaviour. She noted that due to his history of impulsivity, and extremely poor frustration tolerance with poor emotional regulation, he would lash out without warning.[307] Ms Zulian had herself observed Mr Lowah behave violently and in an emotionally dysregulated way.[308] She wrote:

> 'Good Afternoon,
>
> Prisoner Jayden Lowah #172502 D.O.B 08/08/1998 is being released from custody tomorrow 14.09.2018 on straight release with no supervision from DCS.
>
> Prisoner Lowah has been diagnosed with Schizophrenia, Borderline Personality Disorder and has Antisocial traits. He has a history of suicide attempts and self-harming behaviour where on many instances he attempted suicide by laying down on train tracks. While incarcerated on 18.01.2018, he twisted and knotted a sheet and placed it around a chair in his cell and neck.
>
> I have concerns in relation to Prisoner Lowah's release and it was recommended by SMU that I email SAPOL Corrections to notify you of my concerns. While he has been incarcerated he has refused to consent to any community support including ENU and NDIS as he would benefit from supported accommodation due to his limited coping ability. I applied for SACAT for a Guardianship order and an urgent hearing was heard on Monday 10.09.2018 where this was granted. Due to the short timeframe between when the guardian was granted and when he is being released, I am in the process of attempting to find accommodation for him and it appears that his only options are emergency housing.
>
> ***Prisoner Lowah is at high risk of reoffending and harming others due to his significant history of making threats towards others, poor frustration tolerance, impulsivity and emotional dysregulation. He has displayed violent behaviour at James Nash House late last year where he pulled the hair of a nurse through the trap on his door. He has had multiple incidents during his incarceration including refusing to return to his cell, kicking the windows and doors, yelling abuse at staff, urinating on the door of his cell, damaging cell property and threatening to assault staff such as threatening to cause lacerations on the neck of an officer.***
>
> Should police come into contact with Mr Lowah, he may require mental health treatment and monitoring as I believe he will be non-compliant with his medication because of his disorganised thinking, paranoia, and poor planning skills. Mr Lowah is currently prescribed a depot and is on a Community Treatment Order.
>
> If you could please distribute the above concerns to the relevant team that would be greatly appreciated.
>
> If you have any questions in relation to Prisoner Lowah, please feel free to contact me.' [309]

196 Upon receipt of Ms Zulian's email, Senior Constable Paul O'Donnell from the Public Protection Branch of SAPOL sought advice from Acting Detective Sergeant Jason Olsen, who instructed him to raise a street check report (SCR) on Shield. Senior Constable O'Donnell was also advised to email the intelligence sections of the four main districts advising them about Mr Lowah and the street check, and to update SHIELD with an address when they became aware of one. Detective Sergeant Olsen contacted HYPA on

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[307] Transcript, page 52
[308] Transcript, page 53
[309] Exhibit C43, Annexure A, emphasis added

Monday 17 September to enquire as to Mr Lowah's whereabouts and was advised that he had left their headquarters without securing accommodation.[310] This information was passed on to Ms Zulian. These were all appropriate steps, but ultimately fruitless.

197 On the topic of this email and the response it generated, the Inquest heard from Detective Superintendent Adam Blandford (DSU Blandford) and Detective Chief Inspector Denise Gray (DCI Gray) of SAPOL. DSU Blandford was, at the time of giving oral evidence, the officer in charge of the Public Protection Branch of SAPOL. This branch had been created in 2018 and acted as a conduit between Correctional Services and the Parole Board.[311] At the time of its creation, a few weeks following Mr Lowah's release from Yatala, DCI Gray was appointed as the officer in charge (18 October 2018).[312] Both police officers provided affidavits to the Court and gave oral evidence at the Inquest.

198 When learning of Ms Foster's death from the executive leadership team of SAPOL, DCI Gray became aware of the SCR[313] raised by Senior Constable O'Donnell in response to Ms Zulian's email to SAPOL Corrections Unit of the same date. DCI Gray had not previously been aware of Ms Zulian's email or the SCR, having commenced her new role approximately a month after they were generated. The summary of the SCR was as follows:

> 'Prisoner Jayden Lowah #172502 D.O.B 08/08/1998 is being released from custody tomorrow 14.09.2018 on straight release with no supervision from DCS. Prisoner Lowah has been diagnosed with Schizophrenia, Borderline Personality Disorder and has Antisocial traits. He has a history of suicide attempts and self-harming behaviour where on many instances he attempted suicide by laying down on train tracks. While incarcerated on the 18.01.2018, he twisted and knotted a sheet and placed it around a chair in his cell and neck. DCS have concerns in relation to Prisoner Lowah's release and it was recommended by SMU that I email SAPOL Corrections to notify you of my concerns. While he has been incarcerated he has refused to consent to any community support including ENU and NDIS and he would benefit from supported accommodation due to his limited coping ability. I applied for SACAT for a Guardianship order and an urgent hearing was heard on Monday the 10.09.2018 where this was granted. Due to the short timeframe between when the guardian was granted and when he is being released, I am in the process of attempting to find accommodation for him and it appears that his only options are emergency housing. Prisoner Lowah is at high risk of reoffending and harming others due to his significant history of making threats towards others, poor frustration tolerance, impulsivity and emotional dysregulation. He has displayed violent behaviour at James Nash House late last year where he pulled the hair of a nurse through the trap on his door. He has had multiple incidents during his incarceration including refusing to return to his cell, kicking the windows and doors, yelling abuse at staff, urinating on the door of his cell, damaging cell property and threatening to assault staff such as threatening to cause lacerations on the neck of an officer. Should police come into contact with Lowah, he may require mental health treatment as it believed he will be non-compliant with medications.' [314]

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[310] Exhibit C19
[311] Transcript, page 228
[312] The Public Protection Branch was created and brought under the Offender Management Unit along with the SAPOL Corrections Section - It acts as a conduit between Correctional Services and the Parole Board
[313] Exhibit C47a
[314] Exhibit C47a, page 1

199 DCI Gray explained that with her ex-homicide detective background she had particular insight into how murder affects family, the offender's relatives and the community. She gave the following evidence:

> 'This situation obviously worried me so I undertook a lot of steps to try and rectify that from happening again, so I researched legislation, applicable legislation - Sentencing Act, Criminal Law, High Risk Offenders Act. I looked at our being new to the section, the SAPOL systems and processes in managing high-risk offenders the Department for Corrections systems of managing high-risk offenders. Supporting structures that may assist like the Offender Management Team, serious offender committee with Department for Corrections, agency interaction and tried to look at how I can improve those processes. I also had a debrief meeting with two members of DCS if I can call them that, a sentencing management unit and to try and get early notification of a release of such a person particularly if they've got no conditions or homeless. So to try and bring some services together to try and put in a plan to try and manage those people when they walk out of prison.' [315]

200 DSU Blandford described the timing of Ms Zulian's email as '*unhelpful*', given that it was sent a day before Mr Lowah's release. I understood this comment was made in the context of a potential missed opportunity to arrange a case conference with DCS in order to mitigate risk.[316] Counsel Assisting Ms Roper submitted that the email was sent as an option of last resort, having exhausted all other avenues to try to delay his release and in the alternative to support Mr Lowah in the community upon release. I agree with this submission. Furthermore, had Ms Zulian thought to email SAPOL Corrections at an earlier time, it is unlikely to have made any material difference due to Mr Lowah's continued refusal to engage with any services. Furthermore, without any orders in place, police would have no power to arrest Mr Lowah unless he was committing an offence.

201 As touched on in the passage of evidence above, DCI Gray organised a debrief with Luke Williams and Emma Roesch from DCS. Present at the meeting were members from SAPOL Corrections Unit. The purpose of the debrief was to reassess the actions taken with respect to Mr Lowah with a view to improving processes such as early notification to SAPOL when a high-risk offender is released, and developing an interagency case management approach to best address the risk. DCI Gray explained that it was more difficult to put appropriate arrangements in place for a person who is not the subject of an Extended Supervision Order (ESO), particularly if they are homeless. She gave the following evidence:

> 'As I said, it makes it very difficult if they're homeless and they've got no conditions. Generally, I would be having that pre-meeting with Department for Corrections, trying to plan and change the situation of having no conditions or no home.' [317]

202 Both DSU Blandford and Mr Williams from the HDU described the systems reforms implemented following DCI Gray's review after Ms Foster's death, as assisting with positive relationships between DCS and SAPOL, as well as the implementation of case conferencing of high-risk offenders being released into the community to ensure an interagency and multi-agency approach.[318] While unlikely to have assisted Mr Lowah

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[315] Transcript, page 264
[316] Transcript, page 249
[317] Transcript, page 268
[318] Transcript, page 61 (Williams); Transcript, pages 245-246 (Blandford)

given his refusal to engage with services and subsequent release into homelessness, these changes were both timely and appropriate.

Extended Supervision Orders

203 DSU Blandford and DCI Gray gave evidence about ESOs. This was an avenue considered by Ms Zulian and Mr Williams, but quickly discarded due to their (correct) assessment that Mr Lowah would be ineligible. The objective of an ESO is to provide the means to protect the community from being exposed to an appreciable risk of harm posed by various serious offenders.[319] As will be detailed below, this would have been a particularly effective way of managing Mr Lowah in the community, especially in the absence of another mechanism by which to monitor him (a Licence or parole conditions). However, Mr Lowah was not eligible for an ESO as the offences for which he was imprisoned did not meet the first limb of the criteria under the relevant Act.

204 The Court heard evidence about the mechanics of an ESO from DSU Blandford. He explained that the Serious Offender Committee (SOC) is chaired by an executive from DCS and attended by members of SAPOL (and other agencies) and can make recommendations to the Attorney-General about which prisoners may be considered for an ESO.[320] On the basis of the recommendations the Attorney-General may apply to the Supreme Court for an ESO with respect to a person who is a high-risk offender.[321] Proceedings are governed by the *Criminal Law (High Risk Offenders) Act 2015* (SA), the *Criminal Law (High Risk Offenders) Regulations 2015* (SA) and Chapter 3 Part 5 of the *Uniform Special Statutory Rules 2022* (SA). The application must be made within 12 months of the end of the offender's sentence (including on release on parole or home detention) or existing ESO, or after the sentence is wholly satisfied (for life imprisonment).[322] The Supreme Court must consider at least one report from a prescribed health professional which includes an assessment of the person's likelihood of reoffending with similar offences.[323] The Court may make an ESO if satisfied that the high risk offender poses an appreciable risk to the safety of the community if not supervised under the order.[324] When considering whether or not to make an ESO, the Court's paramount consideration is the safety of the community.[325] ESOs can remain in force for up to five years and a further order may be made following a further application from the Attorney-General.[326]

205 Importantly, once an order is made, the ESO can include conditions that the offender not commit further offences, not take illicit substances and be under the supervision of a Community Corrections officer. Parole-like conditions can be imposed by the Court and varied if necessary, including the requirement to wear an electronic monitor, live at a certain address and undertake programs or activities.[327] If conditions are breached, the offender may be placed on a Continuing Detention Order.[328]

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[319] Criminal Law (High Risk Offenders) Act 2015 (SA), s 3
[320] Transcript, page 249
[321] Criminal Law (High Risk Offenders) Act 2015 (SA) s 7(1)
[322] Criminal Law (High Risk Offenders) Act 2015 (SA) ss 4, 7(2)
[323] [s 7(3)]
[324] [s 7(4)(b)]
[325] [s 7(5)]
[326] [see s 12]; https://www.lawhandbook.sa.gov.au/ch13s08s05.php
[327] Criminal Law (High Risk Offenders) Act 2015 (SA), ss 10(1)(a)-(c), (d), (e), (3) (4), (2), 11
[328] Criminal Law (High Risk Offenders) Act 2015 (SA), s18 (2)

206 An ESO can only be made in relation to a person classified as a '*high risk offender*'. Focusing on violent offenders (as was relevant to Mr Lowah), under section 5 of the Criminal Law (High Risk Offender) Act (the Act), a '*high risk offender*' is defined, inter alia, as a '*serious violent offender*' who was sentenced to a period of imprisonment in respect of a '*serious offence of violence'*. The Act defines a '*serious offence of violence*' as a '*serious offence*' which in turn is defined as an indictable offence that is punishable by imprisonment for life, or for a term of five years, or where the conduct constituting the offence involves:

- The death of, or serious harm to, a person, or a risk of death of, or serious harm to, a person; or
- Serious damage to property in circumstances involving a risk of death of, or harm to a person; or
- Perverting the course of justice in relation to any conduct that, if proved, would constitute a serious offence of violence.

207 Recent amendments to the Act saw the definition of a '*high risk offender*' broadened to include assisting principal offenders of serious offences of violence or serious sexual offences.[329] This was in response to a notorious prisoner who had served his full sentence and was re-entering the community without any supervision. The recent amendments, made after the Inquest was closed, would not have changed Mr Lowah's eligibility at the time of his release from prison in September 2018.

208 DSU Blandford explained that Mr Lowah did not meet the first limb of the eligibility criteria in the legislation as he had not been sentenced to imprisonment carrying a maximum statutory penalty of five years or more, arising from the assaults on 31 August 2017. Consequently, he was not considered to be a '*high risk offender*'. He was therefore not eligible for consideration under the second limb which would have almost certainly been satisfied; that he posed an appreciable risk to the safety of the community if he was not supervised under the order. As DSU Blandford explained, '*the Act is very specific as to who can actually fit the criteria of an extended supervision order*'.[330] He also told the Court that a submission was filed by DCI Gray on 15 March 2019, and endorsed by the Commissioner of Police, that the definition of a '*high risk offender*' should be broadened beyond serious sexual offenders, serious violent offenders and counter-terrorism offenders to include a public interest and public risk clause. This submission was sent to the Attorney-General in the form of a Commissioner's Briefing Paper on 22 March 2019. His evidence was as follows:

> 'So DCS and SAPOL are of the same view that there should actually be a public interest, public risk clause within the High Risk Offenders Act that can be considered, not just a serious violent offender or a sexual offence or a counter-terrorism type offence.' [331]

209 On the topic of ESOs, DCI Gray shared the same view as DSU Blandford that the inclusion criteria to be considered a '*high risk offender*' for the purposes of the Act was quite restrictive in that it only applied to certain categories of offences. DCI Gray's evidence on this topic was informed by her research of this legislation following the death

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[329] Criminal Law (High Risk Offenders) Act 2015 (SA), section 5 (cb) – 29/2/2024
[330] Transcript, page 250
[331] Transcript, page 251

of Ms Foster. In considering the legislation against the circumstances of Mr Lowah's release into the community with no supervision, DCI Gray stated:

> 'I think there should be a discretion and I think if you look at the objects of that Act it is about the protection of the community from high-risk offenders. If you look at the obligation of the judge to apply those ESOs it is for the safety of the community is paramount. I think there's a number of other sections that are limiting on that legislation. So, for example there were two offenders that were very high-risk, were incarcerated, but at the time of the conviction they were sentence served. So I could not apply any ESO to them because they're not serving a sentence. So there's a number of intricacies to that legislation that prevent people going on to those orders including the sort of catch all public interest phrase.'[332]

210 There was considerable force to the evidence of both DSU Blandford and DCI Gray on the topic on ESOs. An ESO was considered as a possible avenue by the HDU staff at Yatala, but correctly not pursued due to ineligibility. Had Mr Lowah been eligible, and an ESO applied for and granted, he would have been subjected to a much higher level of scrutiny upon release from prison than he ultimately was. A regime of supervision would have been structured, similar to that seen in 2015 when Mr Lowah was released on a Licence, following his attempt to act on homicidal plans to kill his father. Perhaps the condition with the most importance would have been for Mr Lowah to reside at a certain address. That would have enabled a community mental health team to be allocated and provide monitoring, for a Community Corrections officer to supervise his day-to-day activities and ensure he was engaging with the imposed conditions, and provided him with a place to live so he was not vulnerable to negative influences such as drugs and alcohol. Of all the possible interventions, and in the absence of a Licence, an ESO would have provided Mr Lowah with considerable structure and support in the community with a level of supervision to reduce the risk to others.

Ms Zulian's advice and Mr Lowah's release from Yatala

211 Ms Zulian stated that she felt it necessary to provide Mr Lowah with an emergency strategy just prior to his release. She explained in her affidavit and oral evidence that if he felt at risk of self-harm or harming someone else, he was to go immediately to an hospital ED, call police, or call the mental health triage service.[333] As will be detailed below, Mr Lowah followed this advice less than 24 hours after being released from Yatala.

212 On 14 September 2018 Mr Lowah was released from prison. From the SAPHS case notes, it was apparent that three nights of emergency accommodation had been tentatively arranged at Scotty's Motel.[334] However, it appears that this did not eventuate. Mr Lowah was instead conveyed from Yatala to the HYPA office in Adelaide city by a volunteer with the view to having emergency accommodation secured, or provisions to sleep rough provided. This did not occur as Mr Lowah left HYPA and made his way to the Noarlunga train station via train. At about 2:15am the following morning, Mr Lowah called an ambulance from a public phone box at the Noarlunga interchange. He reported that he wanted to go to hospital because he felt as if he was going to start hurting people.

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[332] Transcript, page 274
[333] Exhibit C43, paragraph 18; Transcript, page 54
[334] Exhibit C38, Volume 2, Part 1, page 8

Mr Lowah waited in the vicinity of the phone box until an ambulance arrived, which was not until 4:35am.

213 Upon arrival the paramedics noted that Mr Lowah was calm and compliant but appeared hypervigilant. He had been sitting in the cold for an extended period in a t-shirt. The patient clinical record recorded that Mr Lowah's past medical history included a diagnosis of schizophrenia and that he had been released from prison the day before. It was recorded by one of the paramedics that Mr Lowah repeated the assertion that he felt he could start hurting people. The paramedics placed Mr Lowah under a Care and Control Order (pursuant to section 56 of the Mental Health Act) and conveyed him to the Noarlunga Hospital ED, arriving a short time later.[335]

Attendance at the Noarlunga Hospital Emergency Department

214 When Mr Lowah arrived at the ED of the Noarlunga Hospital on 15 September 2018 he was initially assessed by ED medical officer, Dr Siang Ding. The notes of Dr Ding reflected that when he assessed Mr Lowah at approximately 6am, he was guarded and not engaging, that his eye contact was poor and that he had regressed under the blanket. Mr Lowah requested to speak with a psychiatrist and wanted a mental health review.[336] When asked why he had presented to hospital, it was recorded that Mr Lowah stated '*I don't know … it's pretty much what I told the ambos …. I want to speak to a psychiatrist …. now I just want to sleep*'.[337] Dr Ding observed a paucity of speech which was limited to mumbling brief answers as well as a blunt affect, but was unable to assess his insight or judgment. He did note that Mr Lowah did not appear to be responding to internal stimuli. After speaking with the ED consultant and a mental health nurse, Dr Ding continued the Care and Control Order pending a mental health assessment '*given alleged intent to harm others and current refusal to engage with ED staff for assessment*'.[338]

215 Dr Andrew Taylor, a first-year registrar undertaking his psychiatric rotation and Dr Tushar Singh, a consultant psychiatrist, reviewed Mr Lowah at approximately 9:40am. Both Drs Taylor and Singh were interviewed by Detective Brevet Sergeant Carman on 25 September 2020 in relation to their involvement with Mr Lowah as part of the coronial investigation and provided an affidavit almost two years after Ms Foster's death. It was their evidence that this was the first time they became aware that the young man who they assessed on the morning of 15 September 2018, after claiming that he would kill someone, had been responsible for the death of a woman six weeks after their assessment. This delay was clearly an undesirable state of affairs, particularly when Ms Foster's death was in relatively close proximity to the attendance at the Noarlunga Hospital ED. When giving evidence, both Drs Taylor and Singh relied solely on the clinical notes and their affidavits as they had no independent memory of Mr Lowah. This was despite Dr Taylor affirming in his affidavit that his recollection of Mr Lowah's attendance was limited.[339] Dr Taylor moved away from this assertion in his oral evidence and I ultimately understood that he claimed to have had no memory of Mr Lowah when interviewed by Detective Carman. Either way, Dr Singh was the consultant psychiatrist present at the assessment and the doctor in charge of the decision making. Dr Taylor's role was

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[335] Exhibit C40, page 33
[336] Exhibit C40, page 15
[337] Exhibit C40, page 15
[338] Exhibit C40, page 16
[339] Exhibit C48

primarily as the scribe. He was also a very junior doctor. Fortunately, the assessment notes made by Dr Taylor were comprehensive and given the paucity of memory of both assessing doctors, the only reliable account.

216 The salient features of the assessment as recorded by Dr Taylor were as follows:

- Mr Lowah made a call to SAAS for homicidal ideation. Mr Lowah stated: '*I'll probably kill someone, I may as well kill someone*'.
- The target of Mr Lowah's homicidal ideation was not identified, he said '*any cunt*'.
- Mr Lowah could not identify the reason for the homicidal ideation and stated '*it's because I have different beliefs*'.
- Mr Lowah indicated that if he does kill someone it would not be his fault and inferred a mental impairment defence pursuant to section 269 of the CLCA.
- Mr Lowah complained about prison and being released into homelessness the previous day and said he was in a worse position than before he was imprisoned.
- Mr Lowah again expressed that he wanted to harm someone, possibly by cutting their throat. This was in response to perceived mistreatment.
- Mr Lowah stated that he wanted to have a home and it did not matter if he had to tell the mental health service, he just did not want to be homeless.[340]

217 Both Drs Singh and Taylor gave evidence that, based on the entry in the case notes, a conclusion was reached that Mr Lowah was not exhibiting any Axis 1 pathology, meaning he was not suffering from a major mental illness such as schizophrenia.[341] Further that their assessment of Mr Lowah's presentation was that it was for '*secondary gain*'. Dr Taylor explained that secondary gain was '*when a patient has some involvement with the health service and the function isn't in itself to achieve treatment for a particular health condition, be it psychiatric or physical, but rather to obtain something else secondary to this process*'.[342] In Mr Lowah's case, the secondary gain was perceived to be his desire not to be homeless. It appeared that the assessment reached by Dr Singh, that there was nothing in Mr Lowah's presentation to warrant psychiatric input, was based on the following:

- The mental state assessment of Mr Lowah revealing no acute illness; and
- An entry located on CBIS from Dr Jennings that he had assessed Mr Lowah's mental state as '*stable*' only a few days earlier; and
- That the threats to kill were not directed towards a specific person.[343]

218 As Ms Foster's death had been at the hands of someone unknown to her, Dr Singh was asked how he reconciled that information with the reassurance he gleaned from Mr Lowah's threats to kill not being directed towards a specific individual. Dr Singh

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[340] Exhibit C48, page 2
[341] Transcript, page 380 (Singh), Transcript, page 357
[342] Transcript, page 297
[343] Transcript, page 383

expressed the view that there must have been an intervening culmination of factors influencing a change in Mr Lowah's mental state. He explained:

> 'So between the time when we saw Mr Lowah and the actual event a number of things could have gone wrong. Mr Lowah could have been non-compliant with his treatment, may have been lost to follow up, may have indulged in drug use or may have been intoxicated at the time which may have affected his judgment and that may have led to him acting in the manner that he did.' [344]

219 Dr Singh was asked to comment on whether the factors he postulated as causative in the lead up to Ms Foster's death were foreseeable risks on the day of the assessment, given that Mr Lowah was being released from the hospital into homelessness. Dr Singh agreed that releasing Mr Lowah into homelessness was a '*vulnerability*' however he had an expectation that the community mental health team would follow up with Mr Lowah and noted that there were a number of positive prognostic factors at the time of assessment including a current CTO, a local mental health team in place and up to date depot medication, which provided a level of reassurance.[345] Interestingly, as will be detailed below, none of the factors that Dr Singh considered likely in the lead up to Ms Foster's death were at play on the day she was killed. Mr Lowah was up to date with his prescribed medication, there was no evidence of drug use, nor was he demonstrably affected by alcohol. While Mr Lowah had been lost to follow up initially, the efforts of a family friend connected him with a local community mental health service.

220 On its face, the decision to discharge Mr Lowah into the community from the ED, with a history of schizophrenia after having expressed an intention to hurt or kill someone, appeared fundamentally flawed particularly in light of Ms Foster's violent death six weeks later. However, it was necessary to examine the presentation to the Noarlunga Hospital ED in isolation from the tragic events that followed. Accordingly, the expert psychiatric witnesses were asked to comment on the appropriateness or otherwise of the assessment of Mr Lowah on the morning of 15 September 2018, with the focus on their assessment and the information they had to hand that morning.

221 As detailed above, Dr Furst's evidence was that Mr Lowah was continuously psychotic from at least July 2017 and possibly earlier when the effects of the last depot injection on 11 April 2017 wore off a month later. That meant that Mr Lowah must have been psychotic at the time he was assessed by Drs Singh and Taylor, however the psychosis was not detected. Dr Furst was not ultimately critical of their decision to release Mr Lowah, but did question aspects of their assessment. In the report prepared for the Supreme Court hearing, Dr Furst noted that despite references by Mr Lowah to having '*different beliefs*', he was assessed as not having any delusional thinking and to be seeking secondary gain.[346] He went on to note that the:

> 'different beliefs … were apparently not explored … Sadly, despite his history of mental illness and extreme violence associated with psychosis, he was not kept in hospital for observation and further assessment.' [347]

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[344] Transcript, page 424
[345] Transcript, page 425
[346] Exhibit C56, page 28
[347] Exhibit C56, page 43

222 In oral evidence, Dr Furst stated that it would have been useful to know the degree to which Dr Singh tried to uncover the nature of the '*different beliefs*', which to him '*sounded like a red flag about: this is possibly someone who's got delusional beliefs or beliefs that he knows are not shared by other people*'.[348] Beyond the notes made by Dr Taylor, this could not be further analysed as Dr Singh had no memory of his assessment of Mr Lowah. In any event, Dr Furst clarified in oral evidence that he could not go so far as to say that Mr Lowah ought to have been admitted for observation, based on the information that they had available to them at the time. Dr Furst again raised the issue of access to relevant information across different agencies. He explained:

> 'So I think it's - it was one of those situations where the clinicians had limited information available to them, they had CBIS, so they could see that Dr Jennings had said that he was stable, they were able to access OACIS, which would've shown that he was discharged from James Nash House, not kept in on a - under an inpatient detention order; and that would indicate that the treating doctors at James Nash House believed that he was mentally stable enough to be discharged from hospital back to the prison.' [349]

223 A/P Sullivan commented on this issue as well. In a more general sense, he referred to '*very frequent*' shortfalls in information available to psychiatrists pertaining to a patient's criminal history. He explained that access to this would enable the psychiatrist (or mental health clinician) to determine which treatment had been effective and whether cessation in treatment had been accompanied by an increase in criminal offending.[350] However, A/P Sullivan was of the opinion that an ED is not the place to peruse hundreds of pages of material about a patient to resolve the dilemma of whether the patient is seeking accommodation through admission, or is genuinely making statements suggestive of a deteriorated mental state. The assessment should be based on '*a little bit of information [with the rest] based upon the clinical assessment you make at the time to determine the person's needs*'.[351] He also agreed with Dr Singh's evidence that it would be more difficult for the psychiatrist to assess the non-specific threats and whether he would actually act on them, than with a specific target. A/P Sullivan opined that it would require a '*nuanced assessment based upon the clinical presentation at the time as well as the specifics of the threat*'.[352]

224 Ultimately, A/P Sullivan expressed the view that while a voluntary admission to undertake a comprehensive assessment would have been helpful with the knowledge of Ms Foster's death only weeks later, he was not critical of the decision not to admit Mr Lowah given that he was on a depot medication and a further admission would not necessarily change the trajectory of treatment. Dr Furst opined that a voluntary admission was not inappropriate and may have allowed a more in-depth assessment and gathering of collateral information. However, he was of the view that it was a matter for clinical judgement and the gathering of further information may not have been more illuminating for their purposes.[353] This was because the information obtained from SAPHS would have included the same records that Dr Jennings had access to, as well as the psychiatric assessments of Dr Jennings. This would have reinforced the idea that Mr Lowah should

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[348] Transcript, page 606
[349] Transcript, page 607
[350] Transcript, page 848
[351] Transcript, page 461
[352] Transcript, page 464
[353] Exhibit C56a, page 10

have been discharged. Dr Furst was of the opinion that it would not have made a difference.[354]

225 I understood that Dr Furst and A/P Sullivan were very much in agreement on the issue of information sharing among the different agencies. Dr Furst looked further back to Dr Jennings' inability to access the JIS and his ultimate assessment of Mr Lowah had a flow on effect with the assessment in the Noarlunga ED by Drs Singh and Taylor. It was reasonable therefore for Drs Singh and Taylor to rely on the recent assessment by Dr Jennings who they understood conducted the assessment while Mr Lowah was still a prisoner. They could not be expected to know of the limitations that affected his assessment. They were also reassured with the knowledge that Mr Lowah was in receipt of an antipsychotic depot medication in the community. However, the information Drs Singh and Taylor relied upon was fragmented and incomplete. This was the same difficulty faced by Dr Jennings when he reached the conclusion that Mr Lowah was mentally stable as detailed earlier in the Finding. Like Dr Jennings, Drs Singh and Taylor did not have access to the JIS relating to the recent concerns by prison officers, nor the HDU notes detailing the concerns of Ms Zulian and Mr Williams. Reliance on this system prevented a conversation with those who had longitudinal knowledge of Mr Lowah and the way in which he presented when unwell. Dr Furst's concern about inadequate information sharing highlighted a significant gap in the management of violent and mentally unwell individuals in the prison system with deleterious flow-on effect once released into the community.

Mr Lowah is released from Noarlunga Hospital ED

226 Upon release from Noarlunga Hospital, Mr Lowah contacted his father (Shaun Lowah) who picked him up at some point later on 15 September 2018. Shaun Lowah was aware that his son had been in prison, but had not expected his imminent release. When he received the phone call, he travelled from his home in Goolwa to Noarlunga to collect him. Shaun Lowah became aware that Mr Lowah had no money or identification and in the period of time he remained at his father's house (approximately five weeks), Shaun Lowah did what he could to support his son while he awaited Centrelink payments to commence. Shaun Lowah provided an affidavit to police in the hours following Ms Foster's death. He told police that he had not detected anything out of the ordinary with his son in the weeks he had been staying there. He observed ongoing tension between Mr Lowah and his brother (who resided permanently at the Goolwa address) but that was not unusual between the siblings.[355]

227 In the five weeks he stayed at Goolwa, Mr Lowah also received assistance from Shaun Lowah's friend, Ms Gloria May. Ms May became aware that Mr Lowah was staying with his father and observed him to be a quiet young man who avoided eye contact when meeting for the first time.[356] Ms May kindly offered to take Mr Lowah to the local offices of the government agencies in order for him to get back on his feet with income and medications. Ms May took Mr Lowah to Centrelink to apply for Newstart allowance, to Service SA to obtain identification and then to Bank SA to establish an account. She also rang the prison to enquire what medication he was taking and how to get a script. The

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[354] Transcript, page 611
[355] Exhibit C45, paragraph 21
[356] Exhibit C53, paragraph 7

SAPHS notes reflected that Ms May contacted the prison on 28 September 2018 enquiring about Mr Lowah's Centrelink number and informing them of his current address, and leaving her mobile number as a contact. This information was passed onto the Southern Fleurieu Community Health Service (SFCHS) via facsimile, to the attention of '*Nurses*'.[357] At some point Ms May recalled speaking to a female mental health worker. This was registered mental health nurse, Ms Jennifer Moore from SFCHS.

228 In her affidavit, Ms May did not recall any concerns that she had about Mr Lowah's behaviour with the exception of one occasion. She explained that she had observed Mr Lowah looking at her with a smirk or a grin which she described as unnerving. At the time she wondered what he was thinking. Beyond that one occasion, Ms May did not witness any inappropriate behaviour.[358] Prior to Ms May's benevolent efforts, Mr Lowah had been completely disconnected from community supports, including the community mental health team.

229 Through the efforts of Ms May, a meeting was organised between Ms Moore and Mr Lowah, and a script for his antipsychotic depot medication was obtained. Ms Moore provided an affidavit and gave oral evidence at the Inquest. This was in relation to the very short period of contact with Mr Lowah in her role as mental health nurse, while he was staying with his father. Annexed to her affidavit were SFCHS progress notes relating to Mr Lowah. Commencing on 22 October 2018, Ms Moore contacted Ms May who had nominated herself as a recent referral for Mr Lowah as a family friend. The entry for this date recorded the assistance Ms May had been providing Mr Lowah and the living arrangements in Goolwa, including that Mr Lowah and his brother were not getting along well. Ms Moore's recorded plan was to organise a one-on-one visit with Mr Lowah and to reimburse Ms May for the prescription medication she had purchased on Mr Lowah's behalf. Ms Moore then contacted Mr Lowah and he was noted to reluctantly agree to meet her at his father's house.[359] From her entry in the note, Ms Moore did question whether Mr Lowah was hearing voices when he alluded to people (other than his brother) being at the house. Mr Lowah told Ms Moore, '*I'm not hearing voices you know*'.[360]

230 Ms Moore attended the Goolwa address with a mental health occupational therapist from SFCHS on the same day. As he had conveyed on the phone, Mr Lowah repeated his intention was to travel to Onkaparinga as soon as he had money as he did not like living with his brother. On further questioning of this plan, it became apparent to Ms Moore that he had nowhere to live, and it was unlikely that he had any friends in the area. Mr Lowah was however insistent upon going. Ms Moore suggested that she could give him his depot injection (which was due on 26 October 2018) before he left Goolwa. Mr Lowah looked through his belongings but could not find the prescription, so Ms Moore took him to the Goolwa Medical Clinic and obtained a script for both depot aripiprazole and olanzapine from a local doctor. The pharmacy did not have the depot medication in stock but indicated they would order it in for the following day. Ms Moore was aware that Mr Lowah still had some olanzapine tablets which helped with his sleep, so neither script was filled, and she dropped Mr Lowah back to his father's house. Mr Lowah assured Ms Moore that he would collect the scripts and attend the Adaire Clinic to have his depot administered. Ms Moore's plan was to follow up in a couple of

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[357] Exhibit C38 Volume 2, Part 1, page 4
[358] Exhibit C53, paragraph 17
[359] Exhibit C46, Annexure A, page 1
[360] Exhibit C46, Annexure A, page 1

days. Her notes reflected that she attempted to contact Mr Lowah twice over a two-day period with no response. She then spoke to Ms May on 25 October 2018 and was informed that Mr Lowah had caught the bus to Adelaide despite encouragement from his father to stay.[361]

231 In her affidavit, Ms Moore noted her observations of Mr Lowah on the day she met him for the first time. She recalled that at one point she did wonder whether he was responding to auditory hallucinations when he laughed to himself a couple of times during their conversation. She asked him what he was laughing about but he did not admit to anything. Ms Moore did not observe any other sign that Mr Lowah was unwell. The last entry in Ms Moore's case notes relating to Mr Lowah was a record of a telephone call between her and Ms May on 26 October 2018. The text of the entry was as follows:

> 'Returned call made by Gloria May to work mobile last night. Gloria said she rang because she didn't know if clinician was yet aware that Jayden had been arrested and charged with murder of a woman in Noarlunga. She said that his father Shaun and brother Jarrad were notified by police yesterday afternoon - police went to their home where only Jarrad was home, then rang Shaun at work to let him know. Gloria said that she was there with Shaun and Jarrad last night and cooked them tea. She said Shaun was debating about taking the day off work today to try to see Jayden, but she knows that he went to work today, as he needs the pay. She thanked clinician for recent contact, said that she thinks though that "the system" has let Jayden down "for a long time".' [362]

232 Returning to the period of time before Mr Lowah left Goolwa, on 24 October 2018, Shaun Lowah recalled driving to the shops and seeing his son waiting at a nearby bus stop. Mr Lowah told his father that he was getting on a bus and '*might go to town*'.[363] Shaun Lowah unsuccessfully attempted to talk him out of leaving but then suggested that if he was going somewhere he should leave his important documentation in a safe place (birth certificate, identification). Mr Lowah refused. It was clear that Mr Lowah had finally received his Centrelink payment as he had left some money for his father and for Ms May at the house. Shaun Lowah then drove to the shops and on his return saw his son again, still waiting for a bus. He tried again to talk him out of leaving, but Mr Lowah was determined. In his affidavit, Shaun Lowah explained:

> 'I couldn't change his mind. He said it twice, then I went to the shops and I drove back again, like ten minutes later. I tried to persuade him a couple of times, not for any other reason than he didn't have that much money and he didn't have anywhere to stay. I couldn't understand why he would want to come down to town. When I say town I mean the Seaford or Noarlunga areas. He did say, 'if I need to sleep I'll go to the city' in like a shelter somewhere.' [364]

233 That was the last direct evidence of Mr Lowah's movements until his fatal encounter with Ms Foster.

234 An available observation of this period of time was that Mr Lowah remained with his father in Goolwa until his Centrelink payments came through. As soon as he received his first payment, Mr Lowah was on a bus with nowhere to go, nowhere to stay and no one

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[361] Exhibit C46, Annexure A, page 2
[362] Exhibit C46, Annexure A
[363] Exhibit C45, paragraph 30
[364] Exhibit C45, paragraph 30

to visit. This was consistent with an impaired decision making capability due to his impaired mental state as described by Dr Furst.

Following Ms Foster's death

235 In the months following Ms Foster's death, Mr Lowah was interviewed on four occasions by Dr Furst. Over that time, Mr Lowah revealed to Dr Furst the extent of his delusional beliefs. He explained that while he was living with his father in Goolwa he had decided on a plan to kill himself with a gun and planned to visit a Christies Beach gun range to access a firearm. If that did not work out, he would cut his throat with a knife. He referred to this plan as Plan A. Plan B was to kill someone else to get back at the people who were controlling his mind, which he had been experiencing for years. Dr Furst recorded the following:

> 'Mr Lowah reported that he had been experiencing the same symptoms for years and that this mainly consisted of concerns about "mind control". He found it hard to answer how long he had these beliefs, other than that it was for "a long time". He reiterated that the world we lived in was "not the original reality or universe". He indicated that there was no particular piece of technology in the universe that was the source of what he called the "mind control" but said that it was "really just magic". He claimed that technology created a simulation and that the voices were not even actual real people, but most likely they were the result of what he called "the mind control'. He indicated that people other than him in this simulation were not real, but somehow manufactured. He indicated that he believed he had been born twice and that everyone other than him and the voices were like "artificial intelligences". He claimed that he had been born naturally and "out of this reality" and therefore he had concluded that all other people were "just artificial simulations".' [365]

236 With respect to Ms Foster, Mr Lowah told Dr Furst that there was no particular reason he picked her as part of his Plan B, she was just in the wrong place at the wrong time. Mr Lowah thought she had touched him inappropriately and was saying things that he thought were about mind control. Further, he reported the belief that Ms Foster was created and not a real person. When he made the decision to kill her, he thought the mind control people might have put that thought into his head and that subconsciously Ms Foster knew that he was going to kill her. Mr Lowah told Dr Furst that he killed Ms Foster due to '*bullshit*' that the mind control people were putting him through and that '*it was fair*'.[366]

237 Dr Furst's opinion expressed in his report dated 3 May 2020 was that killing Ms Foster was the breaking point of enduring months and perhaps years of what he perceived to be mental torment from alien entities from an alternate reality, forming the view that he had to do something terrible to change his situation. He viewed Ms Foster not as a real person, but an artificial intelligence and that his actions were linked to an alternate reality and events far into the future.[367]

238 It is not suggested that any of the clinicians who treated Mr Lowah between 2017 and November 2018 were aware of the information he disclosed to Dr Furst or the extent of his delusional beliefs. What it does demonstrate was the acutely psychotic state he was

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[365] Exhibit C56, paragraph 9.10
[366] Exhibit C56, paragraph 9.16
[367] Exhibit C56, paragraph 14.4

in at the time of Ms Foster's death and his ability to hide the more florid features of his psychosis from even senior consultant psychiatrists.

239 With that said, it is hard to escape the prediction of Dr Watson in his letter of 2 February 2015:

> 'Without treatment, Jayden's risk of relapse … is high as is his potential risk for violence towards those incorporated in to (sic) his delusional belief system.' [368]

Was Ms Foster's death preventable

240 This is an issue that is not free from difficulty. For reasons detailed below I have found that Ms Foster's death was not preventable on the balance of probabilities. While I have found that Dr Giannakoureas' decision to cease depot medication without an adequate plan in place to monitor non-compliance destabilised Mr Lowah's mental health and saw a deterioration in his illness that the medication had been keeping at bay, it is too simplistic to draw a direct connection between this event and Ms Foster's death, which occurred 18 months later.

241 There was a direct causal connection between Dr Giannakoureas' decision and the random assaults on 31 August 2017, as the depot medication had worn off and Mr Lowah's health had swiftly declined, seeing an increase in erratic behaviour and aggression resulting in a loss of housing and supports. This set in train a number of events where opportunities arose for the trajectory of Mr Lowah's illness to have been altered. These opportunities were lost.

242 The first opportunity was to have investigated Mr Lowah for mental competence after the assaults in August 2017. As Dr Furst indicated, had this occurred, Mr Lowah's sentence would have taken place in a therapeutic mental health environment rather than a punitive one. This would have seen intensive treatment of Mr Lowah's illness with the obvious benefit of assisting his decision-making capabilities. The second opportunity was the inability of Dr Jennings to access the JIS which contained relevant and concerning collateral information about Mr Lowah's day to day conduct. Had Dr Jennings seen these entries, he may have made a different decision about Mr Lowah's mental state. This was at a crucial point in the timeline, being just before his release. This had a flow-on effect for the ED assessment by Drs Singh and Taylor.

243 Balanced against the above missed opportunities was the reinstating of Mr Lowah's depot antipsychotic in November 2017, providing some plausible reassurance to those who assessed him in both the prison and the community. It was only after Ms Foster's death that it was realised the reintroduction of antipsychotic medication was too little and too late. This was due to a combination of the environments in which he was assessed, the fragmented information sharing capabilities and Mr Lowah's ability to hide some of the more florid features of his illness. Added to this mix was the poor prognostic outcome for Mr Lowah who was diagnosed with schizophrenia at the unusually young age of 15 and the treatment resistant illness from which (it was ultimately discovered) he suffered.

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[368] Exhibit C39, page 128

Conclusions

244 The findings I have made are set out in accordance with the issues above. I have come to these conclusions on the basis that I am comfortably satisfied each of them were established on the evidence.

1. Michelle Foster died on 25 October 2018 at Colonnades Shopping Centre. She was 36 years old.

2. The cause of Ms Foster's death was head injuries. These injuries were inflicted by Mr Jayden Lowah, causing her death.

3. Ms Foster was killed by Mr Lowah after a chance meeting. The two were previously unknown to each other and met when Ms Foster was passing through the area after catching a train to Noarlunga to visit her father.

4. Mr Lowah was a very unwell and dangerous individual from an early age. He was exhibiting signs of disordered behaviour from as early as the age of 9 years old.

5. In 2014, at the age of 15, Mr Lowah was detained under the Mental Health Act for stealing his mother's car with the stated intention of driving to his father's house to kill him. Mr Lowah believed that his father had molested him when he was younger. This notion was an aspect of Mr Lowah's delusional belief system.

6. Mr Lowah admitted to clinicians that he had been smoking cannabis the day before he voiced (and partly acted on) homicidal ideation towards his father. Over the coming years, Mr Lowah repeatedly asserted that his episodes of psychosis were solely due to cannabis use and not from any underlying disease such as schizophrenia.

7. Mr Lowah was diagnosed with first episode psychosis with the underlying condition thought to be schizophrenia and detained for a period of six weeks in a paediatric mental health facility at the Women's and Children's Hospital. He was commenced on an antipsychotic depot medication for the first time during this admission.

8. A diagnosis of schizophrenia at the age of 15 is unusual but not rare.

9. Mr Lowah was criminally charged for the offences relating to his father, but found not guilty due to mental impairment in January 2015 and placed on a Mental Impairment Supervision Licence with a limiting term of 12 months.

10. It was the expert report of Dr Marshall Watson (who had been Mr Lowah's treating psychiatrist) that was the basis for the Court's ultimate finding of mental incompetence. This report had a prophetical warning in relation to treatment complacency of Mr Lowah; namely that he would minimise psychotic symptoms, risking complacency with a relaxing of treatment options, which would increase his risk.

11. The Licence imposed a number of conditions on Mr Lowah, including that he must reside where directed and abstain from drugs and alcohol. The conditions of Licence saw Mr Lowah only remain in the community for two brief periods during the 12 months, with the rest spent in secure care due to non-compliance. This

demonstrated the effectiveness of the Licence conditions in an unwell and non-compliant individual.

12. Mr Lowah was trialled without his antipsychotic depot medication on two occasions before Ms Foster's death. This was done at the request of Mr Lowah.

13. The first occasion was in December 2015 when the depot was ceased and Mr Lowah continued with an oral antipsychotic. His CTO had recently lapsed.

14. Mr Lowah's mental health quickly deteriorated and Dr Watson (who was no longer Mr Lowah's treating psychiatrist) was notified and duly advised that his behaviour was consistent with signs reflective of his relapse signature and an urgent review was indicated. The review took place, and Mr Lowah was recommenced on depot injections in July 2016. A CTO Level 1 and then Level 2 were granted to enable compliance with the depot injections to be enforced if necessary. This was an appropriate response to the trial without depot injections.

15. In August 2016, Mr Lowah was accepted into the care of the MAC team based at the Adaire Clinic, Noarlunga Centre under the care of psychiatric registrar, Dr Albert Matti. Mr Lowah received his depot injections at the Adaire Clinic where the MAC team was based.

16. Between August 2016 and March 2017, there was a period of stability in Mr Lowah's mental health, with housing being provided by Junction Housing, a good rapport being established with his case coordinator (Leon), and approval to receive community-based supports through Uniting Care Wesley in an attempt to reintegrate Mr Lowah into society.

17. On 7 April 2017, the role of case coordinator was temporarily handed over to Ms Tamar Allner. This was confirmed at a meeting on 12 April 2017, in her absence. She did not formally meet Mr Lowah face to face until 11 July 2017.

18. Ms Allner was aware that Mr Lowah had a reputation of being aggressive before taking over as case coordinator. She did not feel that she had received an appropriate handover and was understandably apprehensive about managing such a volatile client in the circumstances. This impacted on her engagement with Mr Lowah which was at its highest, brief. Due to these concerns, Ms Allner organised for Mr Lowah to receive his depot on 11 April 2017 in a more secure environment with a number of staff present.

19. The second occasion that Mr Lowah's depot medication was ceased was on 11 April 2017. The decision to do so was made by Dr Giannakoureas after he had been alerted to a disturbance caused by Mr Lowah who was resisting his depot medication. A Code Black was called. Mr Lowah did receive his depot injection that day, notwithstanding his objections.

20. Dr Giannakoureas was the supervising consultant psychiatrist to Dr Matti and had spoken to him about Mr Lowah in clinical review meetings. Dr Giannakoureas was also the treating psychiatrist of Mr Lowah's mother (Ms Buer) and was aware of some of his background. However, he had not met Mr Lowah before 11 April 2017. On this day, Dr Giannakoureas responded to the disturbance, spoke to Mr Lowah,

assumed the role of consultant psychiatrist and ceased the depot medication. Ms Buer had also requested that her son's depot medication be stopped. Both Ms Buer and Mr Lowah expressed the view that if the depot continued he was at risk of suicide. The decision to stop the depot injections at this time was not inappropriate based on the circumstances of the day. However, the decision was not appropriately implemented.

21. Dr Giannakoureas did not reject the previous diagnosis of schizophrenia, rather he considered that Mr Lowah's behaviour at the time may have been influenced by illicit drug use and borderline traits and was prepared to trial him off the medication. This was a questioning of the diagnosis rather than a rejection.

22. What Dr Giannakoureas failed to do on 11 April 2017 was establish a structured management plan to ensure that Mr Lowah maintained his promise to abstain from drug use and attend appointments. Furthermore, Dr Giannakoureas did not review Mr Lowah's clinical records, which would have been available to him and detailed a concerning pattern when the depot medication was stopped, as prophesied by Dr Watson in his letter of February 2015. These omissions were failings on the part of Dr Giannakoureas and saw the destabilisation of Mr Lowah's mental health, putting him on a downward trajectory.

23. The consequence of this destabilisation was to place Mr Lowah at a baseline of mental illness that later interventions were not able to address, including the reinstitution of antipsychotic depot medication in November 2017.

24. On 28 April 2017, Mr Lowah attended an appointment with a doctor at the MAC team and admitted he had been smoking cannabis. That was the last appointment he attended for the next 10 weeks.

25. By mid to late May 2017, the effects of Mr Lowah's depot injection administered on 11 April 2017 had worn off.

26. Between mid-May and 11 July 2017 there were not less than 17 documented concerns raised in relation to Mr Lowah, with no eyes on him by the MAC team. These included concerns raised by outside agencies who were providing support in the community, non-attendances with the MAC team and at times active avoidance, reports of damage caused by Mr Lowah to his accommodation, threats of eviction from accommodation, reports of Mr Lowah smoking cannabis, withdrawal of the community support package and self-inflicted injuries to his hand. Ms Buer also conveyed to a member of the MAC team that she thought her son should be recommenced on depot injections.

27. These concerns should have seen the enforcement of conditions of the Level 2 CTO, which were still in place (primarily Order 6), to have Mr Lowah assessed in a treatment centre to reassess his mental state and the need for medication.

28. The response to the reported concerns (or lack thereof) revealed a pervading change in narrative around Mr Lowah's illness (from schizophrenia to behaviours brought about by borderline personality traits), particularly by his case coordinator, Ms Allner. Without Dr Giannakoureas having set certain expectations with his

team regarding Mr Lowah's non-compliance, the reports of concern were dismissed as non-mental illness related antisocial behaviour.

29. Ms Allner did not accurately record concerns of community-based teams in the clinical records available to Dr Giannakoureas and the other members of the MAC team. Ms Allner made positive assessments of Mr Lowah's mental state in the clinical records which were not based on structured assessments or face to face interactions.

30. Mr Lowah was experiencing psychotic symptoms from at least July 2017 and as early as May 2017 when the therapeutic effect of the depot injection administered on 11 April 2017 had ceased. As Mr Lowah had a level of insight into his illness, and actively masked symptoms, his psychosis was difficult to detect, even by a number of senior consultant psychiatrists who assessed Mr Lowah in different mental health settings.

31. On 11 July 2017, Mr Lowah attended an appointment with Dr Giannakoureas and Ms Allner. Ms Buer accompanied her son. This was the first appointment Mr Lowah had attended with him in three months and the first time he had formally met Ms Allner in person. Despite having demonstrably failed to adhere to the agreement made with Dr Giannakoureas in April 2017, Mr Lowah's depot medication was not reinstated, nor was a structured plan initiated to monitor compliance. Instead, Dr Giannakoureas found Mr Lowah's mental state to be '*stable*'. This response was wholly inadequate and reinforced the permeation of the narrative that Mr Lowah's behaviour was due to borderline personality traits. Mr Lowah should have been recommenced on depot medication at this time.

32. The following day, 12 July 2017, Mr Lowah was conveyed by ambulance in a mental health safety net to the Noarlunga Health Service after exhibiting agitated, paranoid and self-harming behaviours and having smoked cannabis. He was detained under an ITO and remained too unwell to be assessed until the following day. Mr Lowah was transferred to a secure ward in the Margaret Tobin Centre.

33. Prior to this assessment taking place, Ms Allner conveyed information to the clinicians at the Margaret Tobin Centre which was inaccurate and incomplete, namely that Mr Lowah's depot had been ceased as all presentations were likely secondary to personality disorder and behavioural misconduct. Further, that his current presentation was not out of character and that antipsychotics had not helped in the past.

34. Dr Nance ultimately assessed Mr Lowah's presentation as most consistent with poor impulse control and emotional dysregulation, secondary to borderline personality disorder/antisocial personality disorder with no current evidence of psychosis. The ITO was revoked and he was discharged back into the community.

35. Dr Nance placed weight on Ms Allner's incorrect information and altered narrative around Mr Lowah's illness. Dr Nance was entitled to do so, believing that Ms Allner possessed a longitudinal perspective on Mr Lowah's mental health history. Unbeknownst to Dr Nance, she did not. Dr Nance also placed weight on the assessment of Dr Giannakoureas that only a few days before, Mr Lowah's mental state was '*stable*'. This influenced Dr Nance in his assessment of Mr Lowah

on 13 July 2017. It is probable that Mr Lowah was psychotic on this day, but the diagnostic overshadowing and incorrect information clouded the assessment.

36. Ms Buer, who initiated Mr Lowah's transfer to hospital the day before, should have been contacted by Drs Wang and Nance for collateral information. That was an omission on their part.

37. Had Ms Buer been contacted at this time, it is probable that she would have communicated her view that Mr Lowah be reinstated on depot injections, as she had expressed to a member of the MAC team and a member of Junction Housing. Dr Nance would have placed importance on this information.

38. Due to the change in narrative around Mr Lowah's illness and the subsequent assessments made that he was not suffering a psychotic illness, he was discharged from the MAC team after his continued non-attendance. Mr Lowah was evicted from his housing and became homeless which further destabilised him and his mental health.

39. Mr Lowah assaulted two individuals unknown to him on 31 August 2017 at different times in unprovoked circumstances. On the first occasion, he was granted police bail and the second he was conveyed to the Royal Adelaide Hospital due to concerns that he was psychotic. He was assessed by Dr Davis and placed under a Level 1 ITO.

40. There was a direct causal link between these assaults and the cessation of the depot injections which saw a deterioration in Mr Lowah's mental health and an increase in aggression.

41. Mr Lowah was transferred from the Royal Adelaide to James Nash House and assessed by Dr Furst and then Dr Raeside. Mr Lowah remained at James Nash House for five days with the ultimate diagnosis by Dr Raeside being antisocial personality disorder with likely drug induced psychosis. Depot medication was not reinstated. The Level 2 CTO expired the day before he was discharged to Yatala.

42. Mr Lowah's mental health continued to deteriorate once in the prison environment on remand. This was reported on by the HDU staff and when Mr Lowah refused to start depot medication, he was transferred back to James Nash House.

43. Once in James Nash House, Mr Lowah was assessed by Dr Burgess to have suffered a relapse of schizophrenia secondary to planned cessation of antipsychotic. The depot medication was reinstituted, and an application was made for a Level 2 CTO.

44. Despite an improvement in his mental state and short-term reduction in his levels of hostility and aggression following the reintroduction of antipsychotic depot medication, Mr Lowah's illness had deteriorated to a point where the reintroduction did not adequately treat his psychotic symptoms which persisted in prison.

45. Mr Lowah was transferred back to the HDU of Yatala after he repeatedly expressed a desire to be back in an environment where he could smoke cigarettes.

46. Mr Lowah was sentenced to a period of 12 months and 14 days imprisonment on 12 December 2017, with his sentence being backdated to 31 August 2017 when he

was taken into custody. Mr Lowah's mental competence to commit these offences was not subject to an investigation. Had this occurred, it is probable that he would have been found mentally incompetent in relation to the two assaults on 31 August 2017 and he would have been treated in a forensic mental health setting with the focus of his term on treatment of his illness and rehabilitation. Following his release from the custody of the Minister for Health, Mr Lowah would have been released on Licence with conditions similar to that imposed in 2015. This would have ensured structure and supervision in the community.

47. Mr Lowah spent the remainder of his term of imprisonment being moved between general units, the HDU and G Division due to varying levels of irritability, aggression, paranoia and bizarre behaviour. The JIS records reflected a number of concerning events documented by prison staff. These included Mr Lowah threatening to harm and kill other prisoners and staff, a suicide attempt, comments that other prisoners and staff could read his mind or were talking about him, and that he could be killed by others staring at him.

48. In June 2018, Mr Lowah applied for and was refused parole. The Parole Board considered Mr Lowah to be such a significant risk to the community as to be unsuitable for release on parole. The Parole Board raised the need for Mr Lowah to have semi-structured accommodation upon his release at the end of his term of imprisonment, and to manage Mr Lowah in the community with a multi-disciplinary approach. This did not occur, notwithstanding considerable efforts.

49. Prison Health staff members Ms Zulian and Mr Williams valiantly attempted to find Mr Lowah accommodation and support in the community with multiple agencies and organisations being contacted. These efforts were primarily hampered by Mr Lowah's refusal to engage with the process. This was due to Mr Lowah's poor mental health which in turn affected his cognition causing him to be difficult to engage and make decisions.

50. The visiting psychiatrist, Dr Jennings, saw Mr Lowah on three occasions during this period in custody, one where he was housed in G Division. The clinics conducted by the visiting psychiatrist were overbooked and disorganised without a designated room for assessments to take place.

51. On or about 5 September 2018, Ms Zulian and Mr Williams requested that Dr Jennings review Mr Lowah in order for him to be assessed for possible detention under an ITO. Both had concerns that Mr Lowah may have been detainable due to his behaviour in the months leading up to this request. Both Ms Zulian and Mr Williams feared that Mr Lowah may pose a risk to others when released at the end of his prison term and that a period of mental health detention with treatment may be beneficial.

52. On 5 September 2018, Dr Jennings saw Mr Lowah as requested. This was the third assessment. Dr Jennings did not assess Mr Lowah as requiring detention under an ITO. His notes were brief and did not document any concerns regarding Mr Lowah's mental state. Mr Lowah, who was suffering psychotic symptoms, was able to mask these symptoms in the assessment.

53. Dr Jennings did not have access to the Justice Information System entries relating to the day to day contact Mr Lowah had with staff and fellow prisoners. This significantly impacted Dr Jennings' ability to make an informed and accurate assessment of Mr Lowah and was a missed opportunity to have considered concerning collateral information in the assessment.

54. Had Mr Lowah been detained by Dr Jennings, he would have been transferred to James Nash House for review by specialist forensic psychiatrists. This would have delayed his release into the community and assisted in improving his mental state and his ability to make informed decisions about his own wellbeing, including accommodation. This was the final opportunity to have intervened in improving Mr Lowah's mental health trajectory before Ms Foster's death.

55. Ms Zulian provided Mr Lowah with advice to implement an emergency strategy if he felt at risk of self-harm or harming someone else when released from prison on 14 September 2018. This was appropriate advice.

56. The Parole Board, Ms Zulian and Mr Williams held fears for the safety of others with Mr Lowah being released into the community with no supervisory oversight and no fixed accommodation. These fears were well founded. The efforts of Ms Zulian and Mr Williams in attempting to address these concerns were admirable.

57. On the day of release, Mr Lowah was conveyed by a DCS volunteer to the office of Helping Young People Achieve (HYPA). He was asked to wait to see someone but left the office before that could occur and travelled to Noarlunga by train.

58. In the early hours of 15 September 2018, Mr Lowah contacted SAAS from a public phone box and informed the operator that he wanted to go to hospital as he felt he was going to start hurting people. Mr Lowah waited in that location for approximately two hours for the ambulance to arrive and was conveyed to the Noarlunga Hospital ED. Mr Lowah was following the advice of Ms Zulian.

59. Mr Lowah was assessed by a psychiatric registrar and a consultant psychiatrist (Drs Taylor and Singh). They were aware that Mr Lowah had recently been assessed by a psychiatrist in prison who had found his mental state to be stable. Further, that he was in receipt of a regular depot antipsychotic and subject to a Level 2 CTO. This information was reassuring in the context of considering an ITO and admission to a mental health facility.

60. Drs Taylor and Singh assessed Mr Lowah as not suffering from a major mental illness and that his presentation was more in keeping with secondary gain, namely a place to sleep.

61. Mr Lowah was able to mask his psychotic features during the assessment. Further, the information relied upon by the assessing doctors was infected by the assessment of Dr Jennings, which in turn was hampered by an inability to access relevant collateral information. Accordingly, it was not unreasonable for Drs Taylor and Singh to arrive at the conclusion to discharge Mr Lowah without any intervention.

62. Upon discharge from the Noarlunga Hospital ED, Mr Lowah spent some time in Noarlunga and then travelled to Goolwa to stay with his father, Shaun Lowah.

63. Mr Lowah was assisted by a family friend (Ms May) to obtain identification, establish Centrelink benefits and organise a bank account. Prior to Ms May becoming involved and contacting Yatala, Mr Lowah's whereabouts were unknown to the community mental health team.

64. A mental health nurse from Southern Fleurieu Community Health Service made contact with Mr Lowah and organised for a prescription to be filled for his next depot injection which was due on 26 October 2018.

65. The day Mr Lowah's payments were established, he immediately left his father's place and travelled back to Noarlunga. Mr Lowah had no particular destination in mind but had formed the intention to either commit suicide or to kill someone. Tragically for Ms Foster, it was the latter plan that he acted on.

66. At the time of Ms Foster's death, Mr Lowah's antipsychotic medication was up to date. However, it was not adequately addressing his symptoms.

Recommendations

245 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.

246 During the course of the Inquest there were unprompted comments from several witnesses about the resourcing of the mental health system, in South Australia and nationally. An interesting perspective was volunteered by DSU Blandford, who been a police officer for 43 years. In the context of managing someone like Mr Lowah in the community with just a CTO in place, he said the following:

> 'And again I'm not a mental health expert, medical, I don't have a medical degree, so it's not my area of expertise. But what I would say after 43 years is that people who are suffering mental health crisis or mental health issues are not thinking rationally and they're not making good decisions. And what we see in our world on the front line is people who don't maintain their medication regimen, who go off the rails and don't recognise that in fact going off the rails until they hit crisis. And 43 years of policing taking people backwards and forwards once upon a time to Glenside where they were actually given asylum and care to now a public hospital or a GP, they are out before my people have finished the paperwork because there are no secure beds, there are not facilities for people who are in crisis who need a moment or a couple of days to actually get back onto a regimen where they recognise that where they thought they were they weren't at all, and that there is in fact a stable life which they can then be maintained and helped to maintain. Now, it seems to me if a person who has been found mentally incompetent for a criminal offence in his past and has continued to demonstrate a mental illness throughout his incarceration is then suddenly released out of a structure with no clear intention of actually wanting to manage their life or do anything better and is left to their own device on the street, I'm not quite sure anybody expects the end result to be.'[369]

[369] Transcript, pages 255-256

247 A/P Sullivan referred to the chronic under resourcing of services nationally, and the '*scandalously limited resources available for prisoners when they were released*' from custody.[370] With a particular focus on accommodation for released prisoners (as was relevant with Mr Lowah) A/P Sullivan opined that accommodation is known to be critical to treatment, stability of mental state and reintegration of people recently released from prison.[371] Dr Furst agreed that accommodation links the community services to provide the wrap around treatment that people like Mr Lowah require.[372]

248 Intertwined with the issue of resources for community-based supports and housing was the issue of the fragmented information sharing capabilities between the various agencies managing mentally unwell individuals in the prison system, health system, mental health system and the community. This was the most concerning issue at play according to Dr Furst. Mr Lowah was able to, at times, mask the more florid symptoms of his illness, leaving the assessing psychiatrists to rely on the incomplete and limited information which was available to them at that time. It must be remembered that when psychiatrists such as Dr Jennings and Dr Singh (and Dr Taylor) assessed Mr Lowah they were doing so in busy treatment settings with limited information and significant time pressures. With the move away from institutionalised care (as referred to by DSU Blandford) to community-based care, the systems supporting the care must speak to each other. This is of course an enormously complex and resource heavy endeavour. In the meantime, consideration of a legislative mechanism enabling a level of supervision upon release (ESO) is a practical safety net for high-risk prisoners being released into the community with no other supervising orders in place.

249 I therefore refer to the evidence of Chief Superintendent Blandford and Chief Inspector Gray (as well as the Commissioners Briefing Paper) and recommend that the Attorney-General consider broadening the definition of '*high risk offender*' for an Extended Supervision Order in the Criminal Law (High Risk Offenders) Act 2015 (SA), with the additional category of public risk and/or public interest for those offenders who have been identified as an unacceptable risk to the community, such as those with a chronic mental health illness who display violent behaviours, like Mr Lowah.

250 I recommend that the Chief Executive of the Department for Correctional Services consider providing to SA Prison Health staff, and visiting prison specialists, read only direct access to the Justice Information System to assist with the mental health/psychiatric assessment of prisoners.

251 In addition, and in light of the above recommendation, I recommend that the referral forms for the visiting psychiatrists, an example of which is seen in the SAPHS clinical records[373] for Mr Lowah and written by Dr L Noakes, have an area designated within the form to make reference to dates and times of specific episodes of concerning mental health behaviour as recorded in the Justice Information System.

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[370] Exhibit C51, paragraph 75
[371] Exhibit C51, paragraph 46
[372] Transcript, page 563
[373] Exhibit C38, page 95

Acknowledgments

252 I acknowledge the valuable assistance of both special counsel, Mr Peter Longson who opened the Inquest and was counsel assisting for 10 days, and Ms Emma Roper who seamlessly assumed conduct of the part-heard and complex Inquest.

253 I acknowledge the comprehensive investigation conducted by Detective Brevet Sergeant Tyson Mobbs, and his attendance and assistance throughout the Inquest proper.

254 I would like to convey my sincere condolences to the family and loved ones of Michelle Foster.

Keywords: *Homicide; Psychiatric/Mental Illness*