CORONERS COURT
OF NEW SOUTH WALES

Inquest:	Into the disappearance and suspected death of Raymond Speechley
File number:	2017/0023809
Hearing dates:	9-12 September 2019
Date of findings:	6 December 2019
Place of findings:	Coroners Court, Lidcombe
Findings of:	Deputy State Coroner E. Truscott
Catchwords:	Coronial Law - Missing Person –Aged Care Secure Unit Admissions and Assessments-Police Search –Survivability
Representation:	**Counsel Assisting** Ms C. Melis Instructed by Ms J. Natoli of Crown Solicitors Office **Mrs Jan Speechley** Mr T. Hammond counsel directly instructed **Illawarra Retirement Trust and staff** Mr M. Windsor SC Instructed by Ms K. Ruschen of Bartier Perry **Commissioner of NSW Police and involved officers** Mr D. Jordan Instructed by Mr S. Robinson of Office of General Counsel, NSW Police Force **RN Ms D. Pell** Ms L Toose Instructed by NSW Nurses and Midwives Association **Southern NSW LHD** Mr S. Barnes Instructed by Mr M. Renwick of McCabe Curwood

Findings	**Identity**	**Raymond Speechley**
	Date of Death	**Between 8-10 July 2016**
	Place of Death	**Bushland west of the highway some distance north of the turnoff to Dalmeny NSW**
	Cause of death	**Hypothermia**
	Manner of death	Ray Speechley became lost in bushland after scaling the fences of the Illawarra Retirement Trust facility in Dalmeny wanting to return home to be with his wife Jan.
Recommendations:	<u>To The Commissioner of NSW Police Force:</u> 1. That consideration be given to the introduction of greater general purpose, air scent and cadaver dog resources in the South Coast of NSW. 2. That consideration be given to discussing and implementing liaison arrangements between police in the A.C.T and police on the South Coast of NSW in times of emergency. 3. That consideration be given to introducing a policy of maintaining all land search operations for missing persons for 3 days beyond the maximum survival period, being identified by a person with extensive search and rescue medical knowledge, for the purpose of attempting to recover the person's remains, and thereafter consulting with the family of the missing person before a decision is made to stop search 4. That the police co-ordinate and carry out recovery searches for Mr Speechley's remains, with the utilisation of a fit-for-purpose cadaver dog, in relation to areas known as Area 1 D West up to 3.2 km and Area 3(2-SA3) -Task Area 3 in furtherance of the search conducted 7 and 8 July 2016 and 6 and 7 August 2016.	

IN THE CORONERS COURT
LIDCOMBE
NSW

Section 81 Coroners Act 2009

REASONS FOR DECISION

Introduction

1. This is an inquest into the disappearance and suspected death of Raymond Speechley who was last seen on 7 July 2016. On 9 January 2017 the police filed a P79B report to the Coroner that Mr Speechley was a person who was suspected to be deceased. A brief of evidence was ordered and further investigations have taken place.

2. The inquest is required under 27(1) (c) of the Coroners Act 2009 ("the Act") as it has not been sufficiently disclosed whether Mr Speechley has died. If possible I am to make findings under s81 of the Act as to whether a person has died, and if so the manner and cause of such death. Under s82 of the Act a coroner is empowered to make recommendations if necessary or desirable in relation to a death.

3. On 4 July 2016 Mr Speechley was admitted into the secure unit called the Mummaga wing at the Illawarra Retirement Trust Retirement Village at Dalmeny ("IRT"). Mr Speechley was three weeks shy of his 77th birthday. Mr Speechley suffered from dementia and though he was physically strong he was suffering significant cognitive impairment. Shortly before nightfall on 7 July 2016 Mr Speechley scaled a courtyard fence and then with the use of a ladder he scaled a taller perimeter fence and ran to the nearby highway which travels north south with adjacent bushland. An immediate search was conducted by IRT Dalmeny staff, Mrs Speechley and later by the police. Despite numerous searches including in very thick bushland Mr Speechley has never been found.

4. A seven volume brief of evidence was tendered in relation to Mr Speechley's diagnosis, time at IRT, the searches and investigation that followed. Witnesses from IRT and the NSW Police Force gave evidence further to their statements during the

inquest held from 9-13 September 2019. Since that time submissions from Counsel Assisting and a number of proposed recommendations have been distributed and responded to by parties.

5. The focus of the inquest has been on the adequacy of the IRT facility in admitting and caring for a patient at high risk of absconding, the response to Mr Speechley's absconding and any changes they have made to prevent such an event recurring. The inquest has also focussed on the subsequent police search and investigation and had the benefit of two expert witnesses: Dr Paul Luckin, a survivability expert and Senior Sergeant James Whitehead, a member of the Queensland Police Force who is a search and rescue expert.

Background

6. Jan and Ray Speechley were married on 27 September 1958. They have two children: Nicole and Michael. Born and raised in Wollongong, Mr Speechley was a boilermaker, welder and later took on professional fishing. He retired from his trade when he was 51 and continued professional fishing. They lived initially in the Illawarra and then moved to Alstonville in Northern NSW; then in September 2015 moved to Dalmeny.

7. In February 2013 Mr Speechley was diagnosed with dementia and he was under the care of Dr Kurle, a specialist geriatrician who attended rooms at Moruya Hospital. Mr Speechley attended Dr Kurle in March 2016 and at that time he was considered quite stable so an appointment 6 months hence was made.

8. Dalmeny is a small coastal village on the far south coast of NSW. It is an half hour drive south of Moruya, 3 hours south east from Canberra and about 3 ½ hours south of Wollongong. Dalmeny is bordered by the ocean to the east and rugged bushland to the west. It lies approximately 10km north of the township of Narooma, which has the nearest police station. The Speechley's home was only 1km from the IRT aged care facility.

9. Mr Speechley socialised with friends and family, played bowls every Monday at the Dalmeny Bowling Club and was a keen gardener. He and Jan kept a beautiful home garden.

10. In February 2015 Mr Speechley was diagnosed as having a blood disorder called myelodysplastic syndrome which can develop into acute myeloid leukaemia. At that point Jan noticed that Mr Speechley would tire easily but was otherwise well. On

16 June 2016 Jan drove Mr Speechley to Canberra Hospital where he underwent a bone biopsy with local anaesthetic.

11. From the time Jan drove him home that day he began exhibiting markedly changed behaviour which caused Jan great concern about his mental health. He became paranoid and fearful and highly changeable and agitated.

12. Jan arranged for Mr Speechley to be taken by ambulance to Moruya Hospital and he was admitted on 20 June 2016. He remained for the following 2 weeks. Dr Kurle examined Mr Speechley on 1 July 2016 and opined that the medical procedure had probably triggered an acute impact on Mr Speechley's dementia.

13. The Moruya Hospital notes give an insight into Mr Speechley's behaviours and state of mind in those two weeks. The notes record that he was "wandering corridors", "confused", required "a great deal of time and attention", there was a need to keep him occupied otherwise he would wander, he was observed to have "displays of "aggression" and was "threatening to walk home", and was "wanting to find the way out of here". Volunteers and Health and Security Assistants ("HASA"s) were required to supervise Mr Speechley by sitting with him and walking with him.

14. The Medical Team at the Moruya hospital consulted with Jan about how to keep Mr Speechley cared for and safe while he was exhibiting these symptoms. It was determined that he should be discharged into a care facility which catered for people with dementia.

15. Jan approached Barbara Nowak the Care Manager of IRT Dalmeny. Ms Nowak had been the Care Manager at IRT Dalmeny for 8 or 9 years as at July 2016. Her role spanned across both the Mummaga and Wagonga wings of the facility. The Mummaga Wing is the secure unit and Wagonga wing is typically for residents who do not require a secure unit.

16. Her role involved managing the facility, rostering and replacing staff, allocating staff to wings, budgets, occasional clinical care and liaising with staff, residents, families, Aged Care Assessment Teams ("ACAT"), doctors, hospitals and specialists. She was also a Registered Nurse ("RN") and worked in that capacity when required.[1]

[1] It would appear that her position involved too many tasks over too many areas and since this incident the role has been refined and a significant number of tasks have been vested in those occupying newly created management positions.

17. Jan attended IRT Dalmeny and met Ms Nowak to discuss Mr Speechley's situation. Ms Nowak agreed to receive Mr Speechley upon his discharge from Moruya Hospital and he would be accommodated in the Mummaga Wing.

18. The Mummaga Wing has a rear courtyard, which is accessible to residents from the dining room, via a set of sliding doors. The courtyard at the time was surrounded by a fence, described as a "swimming pool like" fence with vertical tubular bars and a top and bottom horizontal bar. Each two vertical bars protruded a few centimetres above the top horizontal beam forming curves or arches. The fence sat about half a metre above the ground level on top of a garden retainer wall. The fence had a locked gate which was made of the same material and design which was ground level. It was affixed to the side of a building. The gate had a "swimming pool fence" opening mechanism which, unless locked, when pulled upwards would release and open the gate.

19. Jan would have preferred to have Mr Speechley at home with her but took heed of medical advice about Mr Speechley's condition and Ms Nowak's assurance that the IRT facility could and would provide safe care for Mr Speechley. The plan was that Mr Speechley would be admitted to the IRT facility for a 14 day period of respite during which he would be assessed for possible placement as a longer term resident or if there was a resolution of his acute decline and agitation a consideration whether he was able to return home to be cared for Jan. Jan has had to live with her decision to place her husband and the father of her children into a facility, trusting them to look after him.

<u>3 July 2016 – Mr Speechley absconded from Moruya Hospital</u>

20. On 3 July 2016, Jan visited Mr Speechley at Moruya Hospital but he became upset when she left. Mr Speechley, determined to see her, went outside the hospital, down the road, telling the nurse to leave him alone and that he was going to make his own way home. Two HASA staff members were called and by the time they caught up with Mr Speechley he was already a few hundred metres up the street and walking in the middle of the road. The HASA staff had to restrain Mr Speechley to protect him from an approaching car which had to stop to avoid colliding with him. Mr Speechley struggled with the HASA staff whilst being returned to the hospital, however once he was brought back to his room, he soon settled with talk about fishing.

4 July 2016 – Mr Speechley is transported to Dalmeny IRT

21. On 4 July 2016, in the late afternoon, Mr Speechley was transferred by patient transport to Dalmeny IRT. Usually the RN on shift would receive a new resident, however, Ms Nowak having become aware that Mr Speechley was about to arrive decided to greet him herself. She did not inform RN Tracey Elmer, who was the RN on shift that Mr Speechley had arrived.

22. RN Delia Pell, a Patient Transport Nurse employed by the Southern NSW Local Health District, accompanied Mr Speechley for his transfer from the hospital to IRT. RN Pell says that when she handed Mr Speechley over to Ms Nowak she also handed to Ms Nowak an envelope. The envelope contained a number of relevant hospital records. The documents were significant because they referred to the HASA incident the previous day[2] alerting IRT that Mr Speechley was at high risk of absconding.

23. IRT does not have the envelope and though Ms Nowak received it she does not know what she did with it[3]. She concedes that she did she did not read the contents of the envelope. Her evidence is that she believes that if she received the envelope she would have put it in a tray for RN Elmer to deal with.

24. RN Pell gave evidence that she received the envelope from a nurse at the hospital who told that her Mr Speechley was at high risk of absconding and of the need to keep an eye on him. She said she understood that she was given this information so she and the driver could keep an eye on Mr Speechley and also so she could pass on that information to the nurse at the IRT facility who would be receiving Mr Speechley. RN Pell said that the envelope would usually include the medication chart, inter-hospital transfer document and discharge summary.

25. She said in evidence that she would have looked at the documents contained in the envelope on route to the facility. She also said that, as at July 2016, she had a checklist in a folder and she would always cross-check that all the required paperwork had been included in the envelope.

26. Significantly, the inter-hospital transfer document recorded that Mr Speechley "*wanders quite a lot*" and that he had "*absconded from the hospital and has had 2x HASAs and a male nurse bring him back*."[4]

[2] I note that the Moruya Hospital discharge summary however did not.
[3] T233.30
[4] Exhibit 1, volume 1, tab 27, p. 8.

27. RN Pell said she would have handed the envelope over to Ms Nowak and that she specifically recalled telling Ms Nowak *"you need to really keep an eye on him because he is a very high risk of absconding."* Ms Nowak did not say anything back to her as far as she can remember.

28. When asked why she specifically remembers telling Ms Nowak that, she replied that she remembered Mr Speechley in particular as she does not often get patients who have wandered off from the hospitals. She also said in her evidence that, to ensure a patient's safety, a risk of absconding is important information to hand over to someone receiving the patient.

29. Ms Nowak disputes that RN Pell told her that Mr Speechley was a high risk of absconding. Rather, she recalls being told, *"Good luck; he wants to go home."* Ms Nowak did not record being told that he was a high risk of absconding when she completed her progress note on 4 July 2016 about receiving Mr Speechley. The note states, "*Ray verbalised that he was going home and was not staying here."*[5]

30. RN Pell gave evidence that she recalled Mr Speechley saying, *"Can you take me home".* He also told Ms Nowak that he would not be staying long, he lived down the road and that is where he wanted to be. He pointed in the direction of his house.[6]

31. I thought RN Pell had an adequate memory and she struck me as someone who realised the seriousness of her job and would have ensured that the appropriate paper work accompanied the patient.

32. The inter-hospital transfer document is a standard document and the usual practice is for it to be handed to the nurse in charge of the receiving facility, in an envelope, by the nurse escorting the patient.[7]

33. In any event, Ms Nowak would not have looked at the contents of the envelope as she said that it was the role of the RN on shift to commence the admission process by inputting information from the documents in the envelope into the computer system. However, it was not put into the computer.

[5] Exhibit 1, volume 2, tab 30, p. 17.
[6] Exhibit 1, volume 1, tab 14, paragraph [9].
[7] Exhibit 1, volume 6, tab 83.

34. I do note that there are two Progress Note entries made on 4 July 2016. The first is written by Ms Nowak at 5.10 p.m. and the second is written by RN Elmer at 6.29 p.m. The latter says "Vital Resident Information (information included here will appear on the Medical Diagnosis/Handover List)" and it then records Jan's name and telephone number. It is not known whether that was due to an administrative time delay or whether the envelope became lost and not brought to the attention of RN Elmer. There is evidence of administrative delay in relation to inputting other matters such as Progress Notes and Care Plan behavioural assessments into the computer system but it would appear that RN Elmer did not receive the envelope from Ms Nowak. Though it may have been placed in a filing cabinet it does not form part of the material contained in Mr Speechley's IRT Dalmeny file.

35. Upon receiving Mr Speechley, he told Ms Nowak he would not be staying at the facility long, that he lived down the road which was where he wanted to be. Ms Nowak took him to the Mummaga Wing and handed him over to Silvana Renehan,[8] an Aged Care Employee ("ACE").

36. Ms Nowak then telephoned Jan Speechley and asked that she not come to see Mr Speechley that afternoon because he was somewhat unsettled and the staff wanted the opportunity to settle him down. Ms Nowak asked Jan to ring the following day before visiting.

Medication

37. The medication on discharge from Moruya Hospital[9] indicates that Mr Speechley's medication was as follows:

    a. Risperidone 1 mg tablet at night and 0.5 mg in the morning - to help manage agitation and abnormal thoughts and behaviour

    b. Melatonin 2 mg tablet at night – for improved sleep

    c. Sodium valproate (Epilim) 200mg tablet twice a day – to help stabilise mood

    d. Aspirin (Cartia) 100 mg once morning – prevents clots forming in the blood vessels to prevent stroke and heart attacks

    e. Donepezil hydrochloride (Aricept) 10 mg tablet once daily – to treat Alzheimer's disease

[8] Exhibit 1, volume 1, tab 14, paragraph [11].
[9] Exhibit 1, volume 1, 27, pp. 116-117

5 July 2016

38. On the morning of 5 July 2016 Ms Nowak enquired with staff about how Mr Speechley was going and was she told that he had had a restless night.[10] He was identified as a "sundowner", a term that refers to a dementia patient who is prone to being active in the afternoons and evenings. Jan rang IRT intending to visit Mr Speechley but she was asked not to as he remained unsettled. A Progress Note of 5 July 2016 sets out that Mr Speechley complained about having a sore right shoulder.[11] The IRT medication chart indicates that Mr Speechley was administered Paracetamol at 11.30 p.m. for pain in his right shoulder.[12]

6 July 2016

39. A Progress Note made at 2.20 a.m, that covers the period from midnight until about 1.45 a.m, indicates that Mr Speechley was now complaining of pain in his left shoulder and that massage and diversion were not very effective. At the time that note was being made Mr Speechley was sitting in a chair near reception.[13]

40. Mr Speechley exhibited behaviours such as intrusive wandering, seeking out exits and having disturbed sleep. He told an ACE he was waiting for a lift to go home.[14] At 3.00 a.m. he activated an exit door alarm whilst looking for a way to the car park. He got caught between the glass door and screen door. Staff assisted him back inside and asked him where he wanted to go. He said he wanted to meet that *"Indian taxi driver who is taking me home".* The Progress Note sets out that an attempt to orientate Mr Speechley to time and place had "zero effect".[15]

41. Further Progress Notes recorded at 5.34 a.m. and 6.10 a.m., respectively, describe Mr Speechley as being awake most of the night, sitting in the foyer area with a plastic bag, wanting to go home and wandering around the hallway.[16]

42. There is no Sleep Chart created for Mr Speechley's first night but there is one for his second night which indicates that Mr Speechley was "active around home or room"

[10] Exhibit 1, volume 1, tab 14, paragraph [14].
[11] Exhibit 1, volume 2, tab 30, p. 15.
[12] Exhibit 1, volume 2, tab 30, p. 4.p15
[13] Exhibit 1, volume 2, tab 30, p. 4.p14
[14] Exhibit 1, volume 2, tab 30, p. 14.
[15] Exhibit 1, volume 2, tab 30, p. 13-14.
[16] Exhibit 1, volume 2, tab 30 p. 13.

from 1.00 a.m.. At 5.00 a.m. he was resting only in an armchair and then at 0600 he was resting only in bed[17].

43. Mr Speechley's treating doctor, Dr Sacoor, visited him at around 7.30 a.m. Dr Sacoor spoke with the nursing staff and observed that Mr Speechley's cognitive reasoning "was significantly impaired, due to a combination of his psychotic event, his medication and his dementia." He assessed Mr Speechley's cognitive level at around 1 or 2 (1 being the most significant effect of dementia, 10 being the least). This means that if asked a simple question Mr Speechley would be unable to answer.

44. Dr Sacoor gave evidence that he saw Mr Speechley sitting in a chair and Mr Speechley did not respond to him at all. He described Mr Speechley as being "very subdued". Dr Sacoor had been Mr Speechley's General Practitioner since the Speechleys moved to Dalmeny in November 2015. Dr Sacoor said that the previous times he had seen Mr Speechley, which he estimated to be about 4-5, Mr Speechley was in the company of Jan and he had thought that on each of those occasions Mr Speechley's dementia was significant.

45. Dr Sacoor said that the nurses brought to his attention that Mr Speechley complained of shoulder pain so he prescribed him with Ordine 5 mg/L 0.5-1ml up to 4 times per day as required (PRN)[18]. He was not told of Mr Speechley's behaviour as set out above. The following day, by way of a telephone order he prescribed Midazolam 5 mg/L up to four times a day PRN.[19] The Midazolam was to treat Mr Speechley's agitation. Dr Sacoor was aware that Mr Speechley had poor hearing and there is evidence that though he had hearing aids Mr Speechley was not wearing them.

46. Dr Sacoor said in his oral evidence that he did not think Mr Speechley would have been able to mentally function in the community. Physically, he was pretty good, but intellectually, he was not. He doubts he would have been able to deal with money, deal with tickets, buy food etc. He said that Mr Speechley was, however, physically robust and would not have had difficulty with physical tasks.

47. Jan visited Mr Speechley on the afternoon of 6 July 2016. Jan says Mr Speechley recognised her without any problems. They had an affectionate embrace and a

[17] Exhibit 1, volume 2, tab 30 p. 20 – this is the only sleep chart as one was not created for his last night
[18] Exhibit 1 volume 2, tab 30, p3, p 12
[19] There is no record that this was ever administered

conversation over a cup of tea. Jan remained with him for about 5 hours.[20] The RN on shift, Ms Stephanie Yap, saw Mr Speechley that afternoon. He had begun pacing the hallway. He seemed unsettled to RN Yap but not agitated. She asked if he had any pain and he said he did. RN Yap administered Ordine to Mr Speechley.[21] The medication chart indicates that he was given 1 ml at about 6.44 p.m.[22]

7 July 2016

48. IRT Medical records indicate that 1.35 a.m. Mr Speechley was administered 5 mg Ordine for the pain to his left shoulder.[23] On 7 July 2016 Ms Jacilyn Stanford, an ACE, commenced her shift at 8.30 a.m. She was rostered to provide recreational activities to residents. She met Mr Speechley when he was standing outside the dining room and he said to her: "*We need the police*". She recognised him as a new patient she had learned had arrived on 4 July 2016. She had not received a verbal handover but as her last shift had been on 3 July 2016, she had logged onto the IRT's computer system called "LeeCare"[24] and received a notification of his arrival. She introduced herself to Mr Speechley and they had a chat.

49. A few minutes later Mr Speechley again called out that they needed to call the police. Ms Stanford asked him why and he said that a settlement for a house in Port Kembla was not going according to plan. He then said he "had to get to the wharf to see the captain of the boat as they should not be going out in this weather". Ms Stanford stayed with Mr Speechley until about 9.45 a.m. during which time he had put Rawleigh's ointment on her nose ring saying that it would make it go away and then he applied the ointment all over her face.[25]

50. Mr Speechley then asked for a cup of tea and while Ms Stanford was making it he went out to the courtyard. Ms Fonceca and Ms McKenna, who were Occupational Therapy university students on placement at the IRT facility, were in a room that overlooked the courtyard.[26] They saw Mr Speechley grabbing at the gate and rattling it. They had seen other residents do the same so were not too worried about it but shortly after this Ms McKenna said to Ms Fonceca: "*Ray is trying to get out*". Ray had his hand on top of the gate and was trying to climb it. Ms McKenna said in

[20] Exhibit 1, volume 1, tab 10A, paragraph [23].
[21] Exhibit 1 volume 1, tab 15, paragraph [8].
[22] Exhibit 1 volume 2, tab 30, p3, p 13
[23] Exhibit 1, volume 2, tab 30, p.3.p12
[24] Also referred to as "Platinum"
[25] He was noted to be carrying around the tin of Rawleigh's ointment
[26] Room 5 then known as the "sensory room"

her evidence that Mr Speechley was starting to "*lift himself up over the gate...pushing himself up over the gate*". They both immediately ran into the courtyard and whilst doing so Ms Fonceca who had seen Ms Stanford alerted her that Mr Speechley was trying to get out. Ms Stanford also went to the courtyard.

51. Mr Speechley had his feet up on the retaining wall logs and his hands on the gate and/or fence. Ms Fonceca gave evidence that by this stage Mr Speechley was partly over the gate. Ms Stanford called "Ray". He looked at her and jumped down and walked with her back inside. Ms Stanford told Mr Speechley that she would take him to see the nurse.

52. Rather than take him to the nurse she took him to the dining room so he could have his cup of tea. Ms Stanford reported to Ms Debbie McDougall, another ACE, that Mr Speechley had been grabbing the gate and it took two people to get him off. Ms McDougall had the role of team leader that day. Ms Stanford says that Ms McDougall asked her if Mr Speechley was alright to which she replied he was and was having a cup of tea.

53. In her oral evidence, Ms McDougall said that she requested Ms Stanford to document the incident however in her statement Ms McDougall made no reference to giving this direction. Regardless neither she nor Ms Stanford made a Progress Note recording this incident on 7 July 2016. In their evidence they both acknowledged that it was a failure to not have ensured such an incident was logged. However, neither was able to provide an explanation as to why it was not.

54. Two Progress Notes relating to 6 a.m and 7 a.m. were written at 1.29 p.m. and 2.36 p.m. on 7 July 2016, respectively. The first related to Mr Speechley agreeing to have a shower and then changed his mind saying it was too cold and he dressed into the clothes he was wearing the previous day. The second was that he was trying to get to inappropriate places and he was in the dining room for breakfast and was very restless and continued to touch everything in the kitchen. He was very disorientated and thought he was at work. He kept telling the ACE to slow down that she was working too hard. He eventually settled down and ate all his breakfast.[27]

55. The Progress Note about the 10.00 a.m. courtyard incident was not made by Ms Stanford until 3.31p.m. on 8 July 2016.[28] It was obvious from that incident that Mr Speechley was trying to leave the facility and it was likely that it was only due to his

[27] Exhibit 1, volume 2, tab 30, p.11
[28] Exhibit 1, volume 2, tab 30, p.9

compliance with a command that he did. That incident should have been brought to the attention of at least the RN on duty and probably the Care Manager. At the absolute minimum a Progress Note should have been made and it should have been brought to the attention of the RN on the next shift. This turned out to be a major contributing factor giving rise to a decision by another employee to take Mr Speechley into the courtyard later that day.

56. Shortly after the incident Jan visited Mr Speechley and she thought he was a bit agitated. Nobody advised her that Mr Speechley had attempted to jump over the courtyard gate. Ms Stanford had seen Jan but she said that there is policy that ACE workers are not authorised to inform family members of incidents, such task being left to the managers.

57. Jan left Mr Speechley around 12 p.m. whilst he was having lunch. She returned at about 1.35 p.m. Mr Speechley was still sitting at the table where she had left him. At about 2.30 p.m. Mr Speechley joined in sing-a-long activity that Ms Stanford was facilitating. Jan left shortly after, she said Mr Speechley was singing and was in good spirits.[29]

58. Ms Stanford stayed with Mr Speechley until after the sing-a-long which finished at 3.20 p.m. by which time Ms McDougall had left as she had finished her shift at about 3 p.m. Ms Stanford left work at about 3.30 p.m. before her scheduled finish time of 4 p.m. as she was required to attend an appointment elsewhere. Though she would usually complete a Progress Note before leaving her shift, she did not do so due to the need to keep her appointment.

59. Mr Speechley returned to the Mummaga wing at about 3.30 p.m. Chris Murtagh, an ACE who commenced her shift at 3 p.m. was in the dining room and heard a noise at the rear door near the laundry. She went to investigate and saw Mr Speechley kicking the door. He had a wooden dowel stick which he had taken out of the slide of a window and was using it to prise the door open. The dowel broke. Ms Murtagh said: "*Are you alright*?" and Mr Speechley replied *"I'm trying to get out of this place".* Mr Speechley raised the broken stick above his head and threw it to the ground in an aggressive gesture.[30]

60. Ms Murtagh picked up the dowel and went to the reception area. She asked RN Yap to assist. They both returned to Mr Speechley who was still at the door. The

[29] Exhibit 1, volume 1, tab 10, paragraphs [6]-[8].
[30] Exhibit 1, volume 1, tab 16, paragraph [9].

other piece of the dowel was stuck in the hinges of the door and they tried to remove it. Mr Speechley gripped RN Yap's arm and said: *"There must be a way to get out of here".* RN Yap said in her evidence that he was aggressive and she felt frightened. RN Yap asked if he would like a cup of tea. Mr Speechley walked down the hallway with them to the dining room but he did not want to sit down.

61. On their way they passed Ms Nowak and Ms Murtagh showed her the broken dowel and explained what had happened. Ms Nowak says in her statement that this was at about 3.45 p.m.

62. Mr Speechley was agitated and did not want to sit down in the dining room to have a cup of tea. Ms Murtagh says she sought to divert Mr Speechley by taking him into the courtyard from which unbeknown to her, he had earlier tried to scale the fence. However, RN Yap says that when they had taken the stick off Mr Speechley he was angry and when they got to the dining room Mr Speechley opened the screen door and walked into the courtyard. Neither Ms Murtagh or RN Yap were aware of the 10 a.m. incident and it may be that had they known they would not have taken Mr Speechley to the dining room or if they had, they would have ensured that he did not go out there. It became quickly apparent that Mr Speechley's agitation was not reducing.

63. RN Yap said Mr Speechley began to pace back and forth alongside the fence. It was approaching 4 p.m. and starting to get dark. It had also started to rain. RN Yap and Ms Murtagh tried to call Mr Speechley to come back inside.

64. RN Yap says that she and Ms Murtagh tried to get Mr Speechley to come inside for 5 minutes but he did not respond and he did not acknowledge them. She wasn't even sure if Mr Speechley heard them.[31] I note that Mr Speechley was not wearing his hearing aids (nor had he been wearing them in the morning when he responded to Ms Stanford). He must have been in a far more agitated state than the morning when he was compliant with requests to get off the retaining wall gate and return inside.

65. Whilst RN Yap and Ms Murtagh were calling for him to come inside Mr Speechley climbed onto the retainer wall logs at the base of the fence (as he had done in the morning) and he grabbed hold of the top of the fence. He had one leg on top of the gate and his right hand on the vertical edge of the fence. Both Ms Murtagh and RN Yap were trying to grab hold of him but he kicked out.

[31] Exhibit 1, volume 1, tab 15, paragraph [17].

66. Ms Murtagh left to fetch Barbara Nowak. RN Yap tried to stop Mr Speechley by grabbing his ankle but he kicked out and she backed away. Mr Speechley had one leg on either side of the fence and said *"I have to go; I have to get out of here".* After about 3 attempts he jumped to the other side, landed on both feet in a crouching position and quickly walked away from the courtyard.

67. RN Yap ran inside and ran out of the building via the rear door (where Mr Speechley had been earlier trying to exit). RN Yap says that she caught up with Mr Speechley near the self-care units. She said Mr Speechley was walking fast. Though she had caught up to him and said "*Let's go back*", she did not grab him because she was concerned for her safety due to his earlier aggression. She continued to ask Mr Speechley to come back to the Mummaga Wing with her; however he just looked at her, "with a fierce face".[32]

68. There was a ladder leaning against a wall of one of the independent living units. That was unit 116 which is close to the 185 cm high colourbond perimeter fence. Mr Speechley saw the ladder, picked it up and placed it against the colourbond perimeter fence. He climbed the ladder and jumped over. RN Yap climbed the ladder and she saw Mr Speechley get up from his crouched landing position and walk quickly towards the Princes Highway. She did not follow him for legitimate reasons- she did not believe she could jump down without hurting herself, she had no means of communicating with other staff without running and telling them that Mr Speechley had left and she could not leave the facility because as a RN she is required to remain on the premises.

69. I note that the IRT records do not include a record or Progress Note indicating the making of a telephone or facsimile request to Dr Sacoor requesting a prescription for Midazolam. Dr Sacoor's records indicate a prescription of Midazolam 5 mg/1mL injection 5 mg up to 4 times per day PRN. He records the reason for the prescription as "agitation".[33] It is unknown if it was this incident or an earlier incident which precipitated the request for that medication. It does not appear on the medication chart which indicates it was never administered to Mr Speechley. All that can be said is that Dr Sacoor must have received the request within business hours for it to appear in his records for that day.

<u>The Immediate Search for Mr Speechley</u>

[32] Exhibit 1, volume 1, tab 15, paragraph [21].
[33] Exhibit 1, volume 1, tab 26, p.5

70. It was dark, cold and raining the evening Mr Speechley scaled the fence. Sunset was at 4.57 p.m. with last light at approximately 5.30 p.m. Mr Speechley would have been exposed to temperatures in the 10 to 14 degrees Celsius range during the evening and night.

71. When Mr Speechley went missing he was wearing jeans, a dark grey jacket and a pyjama top underneath.[34] He was wearing brown lace up shoes. He had no head covering and no waterproof clothing, his clothing offering little protection against the rain or cold.

72. He had a black leather wallet with about $15, an expired Dalmeny Bowls Club card, a NSW Bowls membership and possibly his Medicare card. He had a handkerchief and a jar of Rawleigh's ointment. He also had a jar of humbugs.

73. Jan describes Mr Speechley as fit and capable of walking long distances. It appears that he can cover a reasonable area fairly quickly. His ability to jump the gate and scale the fence with apparent ease is consistent with this observation.

74. Mr Speechley was deaf. He was not wearing his hearing aids when he was admitted to IRT Dalmeny because he did not have them when admitted to Moruya Hospital on the advice of staff. The consequence is that if anyone was calling out to him, be it in the courtyard or in the search he may not have heard.

75. Ms Murtagh said that she had fetched Ms Nowak. Ms Nowak said that as she approached the courtyard she saw RN Yap running out the exit door. Mr Speechley was not in the courtyard and Ms Murtagh said she heard RN Yap calling from a short distance off. RN Yap said that as she ran from the courtyard down to the exit door she saw Ms Nowak just behind her, she thought she was following her, as she told her that he had jumped the gate.

76. Ms Nowak did not follow but went to the office, collected her raincoat and anticipating that Mr Speechley would make his way to the back carpark, she went there but she did not see him or any staff. Ms Nowak returned to her office and was met by RN Yap who told her that Mr Speechley had scaled the fence and walked towards the highway.

77. Ms Nowak instructed RN Yap to contact Jan, which she did. Ms Nowak and another employee Wendy Machin went to the back car park entered Ms Nowak's car and drove north on the highway for about 1 km turning around just before the sawmill at

[34] Mr Hammond point out that Mrs Speechley was aware that the clothing comprised 4 layers: a white t-shirt, a long sleeved chequered button-up shirt, a long sleeve pyjama top and a corduroy zip-up jacket.

a location which was probably Lawlers Creek Road. They did not see Mr Speechley so they drove to his home but he was not there either. Ms Nowak rang her manager who advised her to call the police. At about 4.28 p.m. Ms Nowak called the Narooma police station and spoke with Senior Constable Warner who said that the police would attend.

78. Helen Clarke, an Aged Care Funding Instrument ("ACFI") specialist and RN, was also a staff member who participated in a vehicle search for Mr Speechley. She was a passenger in a vehicle the driver of which she could not recall. She says she searched with the driver after 4 p.m. and up to about 4.30 p.m. They drove out of the facility in a northerly direction on the Princes Highway. They drove just short of the Boral Sawmill and turned around. Again, it is difficult to say where the vehicle turned around. Ms Clarke said they drove for about 10-15 minutes and at a speed of approximately 60km per hour. Mr Speechley was not seen.

79. Jan was in Narooma when she received the call from RN Yap at around 4.10 p.m. She drove to the facility where she arrived by 4.30 p.m. She spoke with Ms Nowak. Ms Nowak informed her that she had notified the police. Jan then drove home and searched outside to see if Mr Speechley was there. He was not.

80. At around 4.45 p.m., Jan drove north along the Princes Highway to check whether Mr Speechley had made his way to the Boral Sawmill, as Mr Speechley considered it a landmark. The sawmill is about 2 km from the Dalmeny turn-off. As Jan was driving north on the highway, about halfway to the sawmill, on a bend in the road, she noticed a red car stopped on the western side of the highway facing northbound. She says that she saw skid marks (indicating the car had stopped suddenly). The car's left indicator was on and the front passenger door was open.

81. Jan saw that a person was leaning in the open door. Jan continued driving and after she passed the bend she turned her car around and returned to where the car was. She got out of her car and standing at her door she saw the car pull back onto the road and continue driving. She says that both the driver and passenger waved to her. She could not tell whether the passenger was Mr Speechley.[35]

82. Remarkably, a southbound vehicle drove past whilst this occurred. The driver of that vehicle provided to police Dash Cam footage capturing that moment. It shows Jan standing at the driver's door of her vehicle and the red car pulling out onto the

[35] Exhibit 1, volume 1, tab 10, paragraph [13]-[17].

road. Unfortunately, the vehicle has not been identified and its relevance, if any, in relation to whether Mr Speechley was the passenger has never been determined.

Police Attendance

83. Senior Constable Scott Wharfe is the officer in charge of this investigation. He was on duty at the single-officer police station at Narooma. He commenced his shift at 5 p.m. and when he arrived he was told by Senior Constable Warner that IRT Dalmeny had called about Mr Speechley having absconded. Senior Constable Warner then left the station. Apparently he had not attended IRT because there is only one police car and if he had taken it Senior Constable Wharfe had no means of travelling to IRT Dalmeny.

84. Senior Constable Wharfe was at the police station when he received a call from Ms Nowak at about 5.15 p.m. asking when the police were coming. He told her he was on his way. He left the police station and called Bermagui police station requesting an officer to attend IRT Dalmeny with him.[36] It is only a ten minute drive and he arrived a little bit after 5.30 p.m.[37]

85. Upon his arrival, he spoke with Ms Nowak and Jan and then walked to where the ladder was against the fence. He described it as a 6 foot ladder (185 cm) and some 30-60 cm from the top of the fence.[38] He then contacted Chief Inspector Gregory Flood who was based in Bateman's Bay. The Batemans Bay police called for volunteers from the local State Emergency Service ("SES") and Volunteer Rescue Association ("VRA") teams to perform a search of the immediate area. In the meantime Senior Constable Wharfe and Officer Jorey from Bermagui performed a quick torch search around the area where Mr Speechley had left the fence line.

86. By about 6.30 p.m. about 10 volunteers had arrived, the police searched the bushland area from the point Mr Speechley scaled the fence to the highway proceeding 1 km north. Senior Constable Wharfe describes the bushland as heavy, with large trees and areas of thick undergrowth. The search was made more difficult as it was raining, dark and the area was subject to road works. The search covered about 80m south of the ladder position and proceeded 800 m north. Senior Constable Wharfe described it as heavy going due to the presence of roadworks,

[36] T 12.35
[37] T10.50
[38] T 11.15

concrete drains and mud. The search was concluded at about 7.45 p.m. with no sign of Mr Speechley.[39]

87. Chief Inspector Flood issued a VKG broadcast so that any police vehicles on the road were made aware of Mr Speechley's disappearance and to keep a look out for him but as Chief Inspector Flood said in his evidence, there are limited police vehicles in the region with one at Narooma police station, two in Bega and two at Moruya. There were also highway vehicles, although Chief Inspector Flood was not sure how many were working that night.[40]

88. Chief Inspector Flood says he did not give consideration to calling out the Dog Unit on the evening of 7 July 2016. At that time the nearest General Purpose Dog was 3 hours away[41] and the closest air scent dog was in Sydney.[42] Even if consideration had been given to making a request for such resources, the heavy rain that evening and the need to carry out an immediate on-foot-search would have been factors militating against the effectiveness of a dog.

<u>Mr Speechley Crossed the Highway and travelled northwards</u>

89. By about 9.30 p.m. police had been contacted by a member of the public[43] who had witnessed Mr Speechley run across the highway at about the time he had jumped over the fence. Ms Deanne Owens, a RN and midwife, had been driving south from Moruya to attend a 4 p.m. appointment at a home in Dalmeny. She said that when she was about 500m north of the Mort Avenue turnoff she saw a man described as "*elderly, balding, Caucasian, average height"* who looked *"dishevelled, or as though he was unhappy about something"* run across the road (east to west) and then run north. She describes that there was a car in front of her and that the man hand signalled to the car as you would to slow it down. She said this occurred about 50m from her vehicle which would place Mr Speechley crossing the road about 450m north of the Dalmeny turn-off.[44] Later calculations suggest that it was at a point a little less than 200m from the Dalmeny turnoff.

[39] T15
[40] T374.30-375.10
[41] Exhibit 1, volume 1, tab 8, paragraph [7].
[42] T341.
[43] Exhibit 1, volume 2, tab 34;
[44] Exhibit 1, volume 1, tab 25.

90. On 8 July 2016 Chris Warton reported to the police[45] that he had been driving north on the Princes Highway. He saw a man walking along the western side of the highway in front of him, heading in a northerly direction. The man was about 500 metres north of Mort Avenue. The man was between an excavator and roller parked on the side of the road. This was later walked by police with an odometer which measure 420m from the turnoff. [46] As Mr Warton got closer, the man turned and looked at him. Mr Warton describes the man as "*a little older…wearing jacket and jeans…about 5 feet 8 inches tall….he looked as though he was anxious."* Mr Warton placed the time as being between 4.10 and 4.30 p.m. [47]

91. On 9 July 2016 Patricia Byrne also reported to the police[48] about a man she had seen about this time and place. She said it was about 4 p.m. she was driving south and at about 300 m north of the Dalmeny turn-off (Mort St) she saw a man who was *"about 70 plus years old, grey hair, short, medium build, wearing a dark top"* walking on the western side of the highway.[49]

92. Senior Constable Wharfe plotted the sighting locations together on a photograph.[50] He said that the point at which Mr Speechley crossed the road if travelling in a direct line from the fence was about 182 metres north of the Dalmeny turn off. He said that is consistent with the position that Ms Owens located on the map when she was showing him the point she saw Mr Speechley crossing the road. Unfortunately, he didn't ask her to put a marking on the map and attach it to her statement because that is inconsistent with her seeing Mr Speechley 50 metres in front of her when she saw him cross the road when she was 500m from the intersection. In any event, Ms Byrne's estimates that the point at which she saw Mr Speechley he was about 300m from the intersection. This indicates that Ms Owen was closer to the turnoff than she thought when she saw Ms Speechley cross the road.

93. Senior Constable Wharfe says that at the spot he believes that Mr Speechley was seen by Mr Warton, he was only about 200m north of the location of where Ms Owen saw him. He estimates that Ms Owen saw Mr Speechley at 3.55p.m and Mr Warton saw him at 4.10.[51] Given the speed at which Mr Speechley walked away

[45] Exhibit 1, volume 2, tab 34.
[46] T327
[47] Exhibit 1, volume 1, tab 24;
[48] Exhibit 1, volume 2, tab 34.
[49] Exhibit 1, volume 1, tab 23;
[50] Exhibit 1, volume 1, tab 2 Annex.2
[51] T20-21

from RN Yap and given that Ms Owen describes him as running north, it seems likely that Mr Speechley would have travelled further than 200m in 15 minutes. The only explanation is that if Ms Owen arrived at her appointment on time Mr Warton left work earlier than he thought and Mr Speechley would have covered twice that distance in half the time. It is more likely that Ms Owen and Mr Warton were within less than 5 minutes of each other.

94. Deanne Owen's appointment in Dalmeny was for about 30 minutes and as she drove back north on the highway, at about 1 km from the Dalmeny turnoff she saw a dark red car stopped on the side of the road with its hazard lights on[52]. This no doubt this was the same dark red car that Jan Speechley saw. Ms Owens says she saw two people standing next it. She could not say whether either of the people was the elderly man she had seen earlier. She noted it was further north from the location she had seen him cross the road.[53]

95. Senior Constable Wharfe has plotted the red car location on the photograph as well. He estimates that point to be a linear 900m north of the location Ms Owen saw Mr Speechley cross the road. He estimates the time that the car was there at about 4.40 p.m. which is consistent with the Dash Cam time stamp of *"16:41:36".*[54] The car was at the location for at least a few minutes given the time it took for Jan to pass it and find a location to turn her vehicle around and return to it.

96. Ms Nowak and her passenger and Ms Clarke and her driver travelled from IRT Dalmeny to a little north of where the red car was later sighted. At the time they were driving along the highway, Ms Owens and Mr Warton had already seen Mr Speechley. The IRT staff were actively looking for Mr Speechley and I have no doubt that if he was on the roadway at that time they would have seen him. Mr Warton remarked in his statement that when he drove past the area, there were no vehicles on the road. On her way back to IRT Dalmeny, Ms Nowak rang the police and that time is noted to be 4.28 p.m. It was unlikely that the red car was at that stage stopped on the roadside. If it had been it is likely that one of the IRT people would have seen it.

97. I think it likely that if Mr Speechley remained on the highway walking north that it would have taken him no more than 15-20 minutes to arrive at the location of where

[52] T340 An odometer measurement from the turnoff was 1.1 km
[53] Exhibit 1, volume 1, tab 25
[54] Exhibit 1, volume 1, tab 2.

the car was later sighted. If he had remained on the highway he would have been seen by the IRT staff members who were on that part of the road looking for him at that time. The fact that they didn't see him indicates that he has left the highway prior to reaching that point. I think it highly unlikely that he would have returned to the highway 20 minutes later and entered the red car.

98. There have been no reported sightings of Mr Speechley after that of Mr Warton's. Senior Constable Wharfe opines that he likely left the highway shortly after that, entering bushland before the point that the red car was located. The terrain at that point however had a ridgeline which may have made entering difficult. Whether he crossed back over the road after Mr Warton saw him and has entered more accessible bushland is also possible.

Extensive Search and Media Campaign to obtain information to find Mr Speechley

99. All hospitals in the area and north to Wollongong were contacted without result. Bus companies that operate in the local area were contacted and it was confirmed that Mr Speechley had not booked any tickets. A media campaign was launched on 8 July 2016 involving police media, local radio stations and Facebook. Family and friends of the Speechleys were canvassed without success.

100. Steps to conduct a co-ordinated land and aerial searches were commenced shortly after Senior Constable Wharfe had arrived at IRT Dalmeny on 7 July 2016. He had contacted Chief Inspector Flood and briefed him on the situation, who in turn contacted the Co-ordinator of the Rescue and Bomb Disposal Unit (R&BDU). Chief Inspector Flood then requested resources through the SES, VRA and Rural Fire Service (RFS).[55]

Search and Rescue 8 and 9 July 2016

101. A co-ordinated land and aerial search was conducted on 8 and 9 July 2016. The search co-ordinator for the first day was Sergeant Clinton Simpson who had over a decade of experience. In 2009 he had been a member of the R&BDU and he had completed the State Land search rescue course in May 2010, and in August 2011 he was selected to go down to the Australian Federal Police College where he had completed the two-week ANZAR national search coordination course. By 2016 his

[55] T373.50;329.10

experience included being the co-ordinator or assistant co-ordinator in some 30-40 search operations.[56]

102. The previous day Sergeant Simpson had been contacted by Chief Inspector Flood about co-ordinating the search. Chief Inspector Flood had sent out bulletins for volunteers and resources for the search. On 8 July 2016 Sergeant Simpson was rostered on duty 6 a.m. – 6 p.m. and travelled to Dalmeny. At 8.30 a.m., Sergeant Simpson completed a Search Urgency Assessment.[57] The assessment measures certain known factors about a missing person, including age, medical condition, clothing, experience of the person, and environmental and weather factors to produce a total score indicative of the level of response required. The assessment produced a score of 12 requiring an emergency response.[58]

103. Sergeant Simpson set up his command post at the IRT Dalmeny facility[59]. Sergeant Simpson's resources included 4 police officers and 22 volunteers which included 6 SES and 4 VRA, 6 RFS personnel plus a Westpac rescue helicopter and pilot.[60] The search on 8 July 2016 focussed on 11 search areas to the east and west of the Princes Highway and canvasses were conducted of the residential area surrounding the IRT Dalmeny facility.

104. The first of the volunteers arrived at the facility around 8.40 a.m. Obviously an earlier start would have been better but it appears that there had been no request for an earlier time for volunteers to arrive. Senior Sergeant Whitehead was not critical of the start time noting the need to maximise the potential to have volunteer searchers attend and that it was good to have daylight.[61]

105. The first taskings involved a line search of the bushland from the perimeter fence of the facility to the highway – the same area that was searched the night before (task 1A) – and a search of the grounds of the facility (task 1B).

106. Sergeant Simpson considered that these areas needed to be searched again for a number of reasons: the previous search had its limitations due to being performed at

[56] T319-329
[57] Exhibit 6.
[58] A score of 9-17 constitutes an emergency response.
[59] T338.20
[60] T343.25 and T329.35
[61] T390.30

night and in the rain, they needed to be checked for any clues as they encompassed the last known position of Mr Speechley and it also needed to be ascertained whether Mr Speechley had returned to those areas. He might also have returned home which was the next search location-area 1C[62].

107. I accept that it was necessary and reasonable to re-search these areas but given that by then the police knew that Mr Speechley had likely entered bushland on the western side of the highway, a deployment of a first team of searchers should have been tasked to attend to area 1D west very quickly while the other search was being conducted. As Sergeant Whitehead pointed out, this area when compared to the others, was more life threatening.

108. Personnel attended the timber mill and canvassed workers at that location.[63] The timber mill is about 2 km north of Mort Avenue. Nearby is a bridge on the highway. Sergeant Simpson did not consider that Mr Speechley had gone as far as the bridge.[64] In any event he said that he did not have the resources to go beyond the Lawlers Creek and sawmill area.[65]

109. Area 1D was the next search area. On the western side of highway the search area was bushland. On the eastern side the search area involved a residential area. I distinguish those areas as west and east. Area 1D west encompasses the area that Sergeant Simpson believed to be the most likely area where Mr Speechley would have entered when walking off the highway.

110. The search of the 1D west was conducted by the 6 members of RFS spaced about 5 metres apart performing a line search along a 4WD driving track south of Lawlers Creek Road. The line search included parts of some dry creeks beds. Sergeant Simpson thought that the search extended only about 30 metres into the bush. He explained that the reason it did not extend further was due to the limited resources on the day. [66] Given that this is the "most likely located" area, a 30 metre extension into the bush was unfortunately likely inadequate.

[62] T324-325
[63] T325
[64] T330
[65] T340
[66] T329

111. The Westpac helicopter was tasked with searching bushland west of IRT Dalmeny, the southern side of Mort Avenue between Princes Highway and Killara. It searched for about 1 ¾ hours before heading back to Moruya at 9.40 a.m.[67]

112. Sergeant Simpson gave evidence that in his opinion Mr Speechley had entered the bushland to the west of Princes Highway somewhere between Lawlers Creek Road and Mort Avenue (the turnoff to Dalmeny) and that he has succumbed to the elements and has likely died in that area, in a 3 km radius.[68] The search did not locate anything in relation to Mr Speechley.

113. Sergeant Simpson completed his duty by handing over the next day's search to Sergeant Richard Walsh, by briefing him over the telephone and emailing him the scanned search log and maps which indicated the areas which had been searched.[69]

114. On 9 July 2016 the search was expanded to cover a 20 km radius from the facility. Chief Inspector Flood organised resources for this day's search as well. Sergeant Walsh works in the Police Rescue Unit based in Illawarra Police Station which is a 3 hour drive to Dalmeny. He arrived at 9.30 a.m. Sergeant Walsh had half as many volunteers to cover a greater area – 10 personnel comprised of a group of four from the VRA and two groups of three from the SES and a General Duties police constable. There was also the Westpac helicopter[70] but if Mr Speechley was within the bushland canopy he would not have been seen by a helicopter.

115. Sergeant Walsh said that searching the tracks and side of tracks was all he could undertake with the resources he had. He would have liked to do creek lines and re-entrants but couldn't with the limited volunteers he had.[71] He had also considered that Mr Speechley though suffering dementia was quite fit. He noted that the areas searched the previous day were based on an assumption that Mr Speechley was not very fit; he took a different view[72]. The difficulty of locating Mr Speechley was compounded by his deafness and not having his hearing aids.

116. He said: *"The instruction to the search crew was to follow the tracks, 15 metres either side, looking for entry points where he might have gone down into a ditch,*

[67] T334
[68] T331
[69] T331
[70] T345
[71] T346
[72] T369.45

sought shelter under some leaf litter, a log or something like that. Because it was so cold over those few days, I didn't think he would be moving much more than that, but still in my mind, based on the conversations I'd had, he was still fairly fit for his age."[73]

117. In any event, like the previous day no signs or clues of where Mr Speechley might be or had been were discovered on 9 July 2016. The search was stopped as darkness drew near. It was determined not to continue the land and air search the next day. Had the search been suspended, approval to do so from the Bomb and Rescue co-ordinator was required.

118. However, police were considering that in light of not having located Mr Speechley, he may have left the area in the red car. Sergeant Walsh explained this decision in his evidence:

"Stopping is you stop putting the resources out at the time to complete the investigation side of things, if there was something, a bit of information. In the case of the red car, because it was a high probability that he's got into the car and then left the area, we needed to investigate that a bit more thoroughly before we invested more resources. Unfortunately, because of the location, we are on the Far South Coast, Sergeant Simpson had a fairly good crew, but unfortunately, the volunteers had work commitments and things like that, so we only had a fairly small crew the next day….. A suspension for us is that that is the end of the search phase until it's been ruled that we don't need to search any more. At the time I still believed we needed to search".

119. Chief Inspector Flood referred to the stopping of the search as a "suspension" and said that he relied on the advice of the search co-ordinators to pursue the possibility that Mr Speechley "*may have gone north*".[74] He said he did not seek the advice of a survivability expert but relied on the co-ordinators.

120. Sergeant Walsh did not seek advice from a survivability expert either. He said that at the time when he discussed with Chief Inspector Flood whether to continue or not with the land and rescue search he was of the view that, had Mr Speechley entered and remained in the bush, he was no longer alive.[75]

[73] T347, 369.45, 345.45
[74] T377.10
[75] T357

121. Sergeant Walsh said he agreed with Chief Inspector Flood's decision to not seek search and rescue resources for the next day *"because the red car needed to be explored further. Based on the fact we found no clothing clues of Mr Speechley, it was something what we really did need – the possibility that he got in the car was looking very high".*[76] I do not think that, at that stage, there was any real basis to elevate the significance of the red car, especially given that the futility of the land search seemed impacted upon the lack of search and rescue resources.

122. Sergeant Whitehead, whilst not critical of the view that investigations into the red car were pursued, suggested that those investigations could have been conducted whilst carrying at the land search.[77] I agree. Particularly because at that stage, the police had little information about the car to undertake meaningful investigations in any event. By the time Sergeant Walsh's team had completed the second day's land search, the areas that they had expected Mr Speechley would have been found had been searched. He had not been found nor had any clues been found.

123. Given that there were only 10 volunteers there were limits on the thoroughness of the search. Even on the first day when there were 22 volunteers, Sergeant Simpsons' team only went 30 metres in the bush. The 2 day search was as good as it could have been given the circumstances of limited search and rescue resources that were available. It must have been massively disappointing to the Speechley family that the police did not search beyond the 45 minutes[78] on the night of 7 July 2016 and that they didn't commence the daylight searching earlier or perform night time searches.

124. Sergeant Whitehead explained that night time foot land searches are dangerous. I accept that and I think they would have been particularly treacherous in the terrain in which Mr Speechley ventured. However, alternatives to foot searching could have included a vehicle moving slowly up the tracks as suggested by Sergeant Whitehead but that was not considered by the search co-ordinators.

[76] T358.5
[77] T396.30
[78] Mr Jordan submits that the 10 pm finish is more likely but the evidence is that the search of the bushland between the highway and IRT fence was conducted on 7 July was no more than an hour, commenced at 7 and finished at 7.45 pm. T15.30

125. The survivalist expert, Dr Luckin, opined that Mr Speechley likely did not survive past the evening of 9 July 2016. Sergeant Whitehead concurred. Any land search after that time would likely have been a recovery effort.

126. Sergeant Walsh was asked to assume that if at the time he had had an expert opinion that Mr Speechley could survive up to four days whether that would have changed his approach (in regards to investing more search and rescue resources after 9 July) he said that he didn't think so because he disagreed with that opinion.[79] Dr Luckin considers it probable that Mr Speechley did not survive as long as 48 hours. His expectation is that he most probably died by the afternoon of 8 July 2016 or during the night of 8 to 9 July 2016 from exposure. [80]

127. Dr Luckin identified the factors affecting Mr Speechley's ability to survive:[81] Mr Speechley's condition; his dementia, deafness, likely fatigue and probable dehydration, being dressed in light non-waterproof clothing which would have been wet and cold given that it was the middle of winter.

128. Jan's sense is that Mr Speechley survived beyond the 48 hours and that had the search continued into 10 July 2016 he would likely have been rescued. She was aware of her husband's bush skills, strength, fitness and that his clothing whilst not waterproof was reasonably warmer than what has been suggested. If that is so, Mr Speechley's survival would have been within the upper end of Dr Luckin's range. If Mr Speechley had survived by the end of Sergeant Walsh's search on 9 July 2016 I think it is extremely unlikely he would have survived into the next morning. Dr Luckin opined that Mr Speechley's dementia was such that any previous bush skills would not have been available to Mr Speechley in these dire circumstances.[82]

129. I think that there had probably been an under-estimation of Mr Speechley's fitness by Sergeant Simpson and if Mr Speechley had entered "1D west" he was likely to have travelled significantly further than 30 metres into that area. Given the resource limitations of the land search, particularly the limited search of the egress into the bushland at area 1D west on 8 July 2016 and confines of the search to trails and

[79] T358.30
[80] Exhibit 1, volume 5, tab 74, lines 67-69 and p 7. Senior Sergeant Whitehead put Mr Speechley's survivability, in the right circumstances, as a possible 4 days, using the Wet Chill Hypothermia graph He acknowledged in oral evidence however that he is not an expert on survivability and did not have the benefit of Dr Luckin's report when preparing his report. He would defer to the expertise of Dr Luckin.
[81] Exhibit 1, volume 5, tab 74, lines 57-65.
[82] T207-208

tracks without covering creek lines and beds on 9 July 2016,[83] both days being limited to day light searching, there should have been an extension of time to search on 10 July 2016 even if it involved even less volunteers.

130. Mr Jordan adopts the position of Chief Inspector Flood that the NSW Police Force conducted a 3 day search and rescue operation for Mr Speechley. Whilst it is correct that searches were made on 7 July 2016, I don't think the period of time involved from the time Mr Speechley was reported missing by Ms Nowak at 4.28 p.m., it being responded to between 5.30 p.m. and 7.45 p.m., is of such length to warrant it being called a 3 day search. Though a search was conducted over the course of 3 days they were not daybreak to night fall searches.

Delays

131. The Speechley family were anxious about the time it took for the police to start the searches on each of the 3 days, and would have thought that they would have been conducted at least from daybreak to nightfall. It is unfortunate that Sergeant Walsh had a 3 hour journey on the morning of 9 July 2016. I understand that to be due to the rostered police shifts however, such roster compliance tends to not conform to an expectation that an emergency search protocol would require non-rostered timetabling.

132. There was no doubt that on 7 July 2016 when Mr Speechley absconded from IRT Dalmeny time was of the essence in locating him. Preferably that night. IRT staff had immediately and appropriately responded by driving on the highway. How far and for how long has never been adequately determined. Ms Clarke could not recall the car or the driver but did recall that it was between 4 p.m. and 4.30 p.m., it was raining and they drove north to the sawmill. She returned to the IRT reception and Mrs Speechley had just returned to IRT after having been to her home to see if Mr Speechley had gone there. Ms Clarke estimated the duration of that trip was 10-15 minutes. She said that Ms Nowak arrived at about 4.50 p.m. but she did not know where she had arrived from. She was unable to identify any other staff she was aware of who searched the road in a vehicle. [84]

133. The IRT guidelines require staff to search the immediate vicinity and other staff searched the fence area. Ms Nowak estimates that she and Ms Machin drove north

[83] T369.34
[84] T129-132

up the highway for about 1 km at about 4.10 p.m.[85] turning around perhaps at Lawlers Creek Road but certainly before the sawmill.[86] She estimates she had returned to IRT by 4.20 p.m. when she then rang her management and then the police at 4.28 p.m.[87] Mr Speechley was either off the highway soon after being sighted by Mr Warton or if he was on the highway he might have been secreted by roadwork vehicles or equipment or perhaps concrete drains. Whatever occurred or wherever he was, it was as if he vanished.

134. Though Ms Nowak rang police at 4.28 p.m. it was an hour later that Senior Constable Wharfe arrived – that was due to a changeover of shift and the availability of one police vehicle at the Narooma police station. The commencement of the line search at 7 p.m. indicates that the local volunteers responded very quickly to the call-out initiated an hour or so earlier.

135. Senior Sergeant Whitehead agreed that it is dangerous to search at night; he said it is a balance between that consideration and the vulnerability of the missing person. He said it would be prudent to search for part of the night or at the very least, passive night searching in a vehicle should have been done. Especially given that the police had information from Ms Owens at 9.30 p.m. that night that she had seen a person matching Mr Speechley as having crossed the highway and walking north.

The Red Car

136. On 12 July 2016, police obtained the Dash Cam footage of the red car. Honda provided police with a list of 1400 vehicles that had been produced and sold in Australia with the same make and year as the red Honda seen on the relevant day. The registration plate was not able to be ascertained.

137. With the assistance of the RTA, police ascertained which cars had been written off or stolen and which were still operating. Narooma police asked the surrounding Local Area Commands ("LAC") being Monaro, The Hume and Shoalhaven to speak with the registered owners of nominated vehicles within their LACs and make inquiries to ascertain if the registered owners of their vehicles were in that area on 7 July 2016 at about 4 p.m. travelling north.[88] There were 150 vehicles registered in those three LACs. Accordingly, 150 files were sent out. General duties staff at each

[85] T256-260
[86] Ms Nowak's statement says that she turned around at Brou Lake Rd but that is north and to the east of the saw mill, in her evidence she said she definitely did not drive as far as the saw mill.
[87] T259
[88] See Exhibit 1, volume 2, tab 32 for an example of the letter.

of the three LACs were tasked to speak with each of the owners. Only 150 of the 1400 cars have been checked.

138. The decision to send out the 150 files to only the three neighbouring LACs was made by Detective Sergeant Robertson. The Detective Sergeant was asked by Senior Constable Wharfe for some direction on how to handle this part of the investigation. The direction he received was that the 150 files would be sent out to the neighbouring LACs only. For some inexplicable reason it was not thought that those inquiries should be made for vehicles located in the Wollongong LAC even though Mr Speechley was known to have some association with that area. It is somewhat unclear about how systematic the searches for the driver of the red car have been. Though each inquiry has been completed, it is not known at what stage the investigation had achieved that result.

139. Despite that investigation and the media circulation of the footage as part of a national media campaign nobody has identified themselves as being in that car at that location at that time. On the whole the inquiries and media circulation has been reasonable and there seems that little would now be achieved by pursuing any wider inquiry about the car especially when it seems unlikely on any analysis that Mr Speechley had an association with the vehicle.

140. On 24 July 2016, Senior Constable Wharfe and others re-searched the area to the west of the Princes Highway, where the red car had been seen. The reason for conducting this search was the possibility that the red car did not stop to pick-up Mr Speechley but rather to assist him and that he may have subsequently entered bushland at that location. A line search was conducted for over two hours, however nothing was located. Senior Constable Wharfe states that the terrain was so dense that pockets of bush could not be accessed at all and he ultimately called the search off as it was too hazardous.

141. I think it is unlikely that Mr Speechley entered the bush at that location because of the existence of an embankment and ridgeline that commenced 80 metres south[89] of the red car location. The description of the difficulty and height of ridgeline would be an unlikely entry point. I do not think that Mr Speechley was in the red car because Jan was standing in clear view of both the driver and passenger of the car. Despite his dementia Mr Speechley was quite aware of whom Jan was, she calmed

[89] T416.30[89] See Exhibit 1, volume 2, tab 32 for an example of the letter.
[89] T416.30

him and he wanted to go home so I do think he would have said something to be reunited with her.

Recovery Search for Speechley

142. On the weekend of 6 and 7 August 2016, a large scale recovery search was co-ordinated which involved helicopter, trail bikes, mounted police, the dog squad, the VRA, the SES and the NSW Police rescue squad. No signs of Mr Speechley were discovered. The search for Mr Speechley has been described as one of the largest conducted by police in the southern region. The evidence I have heard demonstrates that the terrain is extremely challenging.

143. Despite the large scale nature of the recovery search, all police witnesses involved believe that Mr Speechley was likely within 3 km of the last known sighting which is 420m north of the Dalmeny turnoff from the Princes Highway. It is without controversy that Mr Speechley has died and that the likely location is in area 1D West.

144. Statistically at the time of Mr Speechley's disappearance, missing persons with dementia were located within 1.6km in 80% of search incidents. This distance is based on the information obtained through the Australian Lost Person Database and has recently been increased to 2.5km for elderly missing persons and 3.2km for younger or walker type missing persons.[90] Senior Sergeant Whitehead opined that Mr Speechley was capable of considerable physical activities given his age; the climbing of the pool style fence and the ladder and rear boundary fence attest to this. His ability to walk would put him into the younger/walker category of missing person but his dementia, leukaemia and associated tiredness would have been limiting factors.[91]

145. Senior Sergeant Whitehead says that with the last known position of Mr Speechley being the western side of the Princes Highway, a circle with a radius of 1.6km could be drawn, reaching Lawler Creek to the North and Duesbury Road to the south. Statistically, this is the area Mr Speechley was most likely to be in.[92] Sergeant Simpson and Walsh gave the likely radius as 3 km and the area that Senior Sergeant Whitehead circled on the map to show where he believed Mr Speechley

[90] Exhibit 1, volume 5, tab 75, paragraph [8].
[91] Ibid, paragraph [10].
[92] Ibid, paragraph [12].

may be, is greater than a radius of 1.6km[93] and extends beyond the area that was searched by police (area 1D).

146. Senior Sergeant Whitehead comments that it is more likely that Mr Speechley walked off the western side of the Princes Highway into the bush and undergrowth at one of the lower sections before the Lawlor Creek Bridge. The reasoning behind this is the dearth of sightings of any person on the highway after 4.30pm on the day and that most persons with dementia tend to take the path of least resistance; the path of easiest walking.[94] Senior Constable Wharfe described the terrain, in general, west of the highway, as dense with steep drop-offs and rotting trees. He said that there are, however, very rough tracks and fire trails. Sergeant Simpson said that the information coming back from the search teams was that there were *very dense areas unable to be penetrated.*[95]

147. Dr Luckin also said in evidence that if Mr Speechley crossed the highway to the western side and then started walking along the highway, it is quite possible he continued to walk along the road, but at any point where he saw a downhill gully or path, it is quite possible he would have turned and walked off the road downhill.

148. Dr Luckin said that if Mr Speechley stayed on the highway it is quite possible that he could have walked some distance, possibly as far as the sawmill but probably not any further. He thought that if Mr Speechley had reached the sawmill, he would likely have stopped there. If that is correct, then the evidence indicates that Mr Speechley did not walk as far as the sawmill. Dr Luckin thought it possible that Mr Speechley crossed back over to the eastern side and found himself in a body of water, a situation he would not have survived.

Maximum period of survivability

149. Counsel Assisting submits that the Search and Rescue Coordinator ought to have sought advice from a person with extensive search and rescue medical knowledge to ascertain the maximum period of survival, at least by the second day of the search on 9 July 2016. As Senior Sergeant Whitehead said, timeframe for survival is relevant. The lower the chance of survival over the shortest period of time would necessitate a large and intense search from the outset. If a person,

[93] Exhibit 9.
[94], Exhibit 1, volume 5, tab 75, paragraph [15].
[95] T339.15

such as Mr Speechley was, has a shorter timeframe for survival then the search needs to be significant and intense from the outset. Given the wet and cold conditions it is uncontroversial that the most likely cause of death, absent a sudden and fatal injury, would be hypothermia.

150. Sergeant Whitehead suggested that a search coordinator should conduct his/her own assessment of survivability at the start of Day one. He advised obtaining survivability advice at the latest by the end of Day two.

151. Sergeant Whitehead takes the position that even when a search co-ordinator believes that the time of survivability has passed, the rescue search should continue as a recovery search for several days beyond to attempt to locate any remains. He takes this position because he understands, as does the Queensland Police Service by their policy supporting this practice[96], that the police service has coronial matters to consider and additionally the recovery of remains is a highly significant value held by our society and in particular the family of the missing person.

Was the Police Response Sufficient in both Timeliness and Resources?

152. I think that both Sergeants Simpson and Walsh were cognisant of the need to find Mr Speechley as soon as possible but their ability to conduct a longer or more extensive search was limited by the resources available to them. That lack of police capacity appears to have been the accepted plight of Far South Coast policing.

153. Mr Jordan refers to as much in his submissions pointing out Chief Inspector Flood's evidence:

a. at the time, the Far South Coast Command of the NSWPF had 112 staff;[97]

b. the Command stretched from Durras (north of Batemans Bay) to the Victoria border[98] (a distance of about 260km);

c. a number of stations were staffed at night by only two officers with one car[99].

[96] 3 days beyond the expected survival date provided by an expert
[97] T387.50
[98] T388.02
[99] T380.25 (on 7 July 2016, there was only one police car at Narooma)

154. The police capacity to search was limited by the number of volunteers that could make themselves available on short notice. Ten volunteers readily arrived within an hour of the Chief Inspector's request. Though a reasonable response was achieved the next day; that number halved on the second day.

155. Given that Senior Constable Wharfe had limited search and rescue training and only had the use of torches to carry out the line search it was fairly evident that if an overnight search and rescue operation was to be mounted that decision would have had to be made by the co-ordinator of the Rescue and Bomb Disposal Unit and Chief Inspector Flood.

156. Chief Inspector Flood did not request a particular starting time for any search and it seems that there was no consideration to commencing that task earlier than what the search co-ordinator was rostered to commence work on each day. The urgency of the search did not prevail over the police service roster which is difficult to understand even though resources were thin.

157. On 7 July 2016 the gravity of the situation must have been evident to Chief Inspector Flood and the Co-ordinator of the Rescue and Bomb Disposal Unit. It would not be expected to be the task of Senior Constable Wharfe to co-ordinate a search and rescue operation. A properly trained co-ordinator was not tasked that night to commence. The urgency and gravity of the situation was not matched by an urgent deployment of resources. One reason is that a night time search is dangerous so would not be anticipated. The other is that a request for a particular start time was not made by Chief Inspector Flood. I think it was reasonable to leave that to the Co-ordinator of the Rescue and Bomb Disposal Unit who is aware of the resources.

158. I note that there is an initiative being undertaken in Queensland called *"The Getting Home Safely project".* It is being undertaken by the Queensland University of Technology and is looking at ways to better improve the initial response to a missing person with dementia. It is focusing on care facilities and police to create a better reporting system and a faster response. A grant has been received from the Dementia Australia Research Foundation to progress this project.[100] Senior Sergeant Whitehead said that this project is designed to get one Australian standard so that the country can have a standardised approach.

[100] Exhibit 1, volume 5, tab 75, paragraph [34].

Should the Search Have Continued on 10 July 2016?

159. The decision to stop the search was made by Chief Inspector Flood in consultation with Sergeant Walsh. Sergeant Walsh says that if the search was suspended it would have required the approval of the Co-ordinator of the Rescue and Bomb Disposal Unit. He says that was not required because the investigation was continuing. I do not accept that distinction and the circumstances were such that an approval from the Co-ordinator should have been obtained. Though Sergeant Walsh does not describe himself as a survivability expert, I think his experience is such that he would have a fairly good grasp on that aspect and there is no suggestion that his analysis of Mr Speechley's survivability was unreasonable. Accordingly, I do not think that the Co-ordinator would have declined approval to suspend or stop the land search.

160. However, I note the position taken by Senior Sergeant Whitehead: Search and Rescue Coordinators have an obligation to maintain a search effort up to the maximum period of survival as identified by a person with extensive search and rescue medical knowledge unless conclusive evidence is found that the target person is no longer in need of assistance. Adopting that position, Chief Inspector Flood should have sought the advice from such an expert, who may have been the co-ordinator of the Rescue and Bomb Unit.

161. In the event that the maximum survival time has been reached, the search if it continued would change from a search and rescue to a search for recovery operation. Sergeant Whitehead says that such a search should continue until the entire search area has been covered to a satisfactory Probability of Detection (POD) standard. Only then could it be argued that the search efforts have been conclusive and provided the best chance of the missing person being located or their remains found.[101] An 80% POD is an acceptable level for a land search. The accepted most likely area where Mr Speechley entered and has succumbed is in Area 1D west which is calculated as being 54-55% for the searching conducted in that area across the search days 8-9 July and 6-7 August. The area that was searched was only that within a 1.6 km radius of Mr Speechley's last

[101] Exhibit 1, volume 5, tab 75, paragraph [23].

known position. I agree with Senior Sergeant Whitehead's opinion that there is definitely further searching that can be done in that area but extended to 3.2 km.

162. Sergeant Whitehead suggests that police have obligations to assist the Coroner with respect to potentially deceased persons under the Coroners Act. Carrying out a recovery search on the back of a search and rescue search as suggested by Sergeant Whitehead may have given the best chance of recovering Mr Speechley's remains. Queensland enjoys a 99.2% success rate for recovering bodies – whether it is due to those 3 extra days I don't know.

Police Dogs

163. The issue of dogs and the variety of category from general purpose, air scent, and cadaver was the subject of examination and due to the issue of police methodology I need not traverse the subject but to note the following. Senior Sergeant Whitehead observes that the area to the west of the Princes Highway could have been suitable for a general-purpose police dog initially and may have provided an indication as to whether Mr Speechley followed the highway northwards or veered into the bushland to the west.[102]

164. Neither Chief Inspector Flood nor Senior Constable Wharfe gave the acquisition of a police dog any consideration on 7 July 2016. Chief Inspector Wharfe did not specifically ask for one for the 8 and 9 July 2016 leaving the deployment of resources to the Co-ordinator. I agree with Senior Sergeant Whitehead's view that the search coordinator should consider seeking advice from the dog unit in this situation.

165. Though a cadaver dog was deployed for the August search it had limitations in a bushland setting so really was not entirely fit for purpose.

166. Chief Inspector Flood's lack of consideration of the utility of a dog in being engaged to search for Mr Speechley seems to have been the result of the earlier observed plight of being at the distance end of the arm of the law on the Far South Coast. There seems to be good cause to reduce the isolation or dearth of resources by establishing some liaison with ACT and Canberra police forces as well as consideration of establishing a dog unit south of the Illawarra Police Station.

[102] Exhibit 1, volume 5, tab 75, paragraph [25].

167. A decision to search on 10 July 2016, as the family had sought, would have for them gone some way to make up for the time and resource deficiencies of the searches. The tension between the police sense of futility and the family sense of hope has caused the Speechley family to feel aggrieved with the decision to end the search.

168. Evidence taken in the inquest indicates that a likely location of Mr Speechley is in area 1D west which is now calculated as extending twice as far as originally conducted.

169. The family are seeking that area is properly searched with the use of a well-equipped cadaver dog. They also seek a recommendation that the police search an area known as Area 3(2-SA3) -Task Area 3 which is directly west of Mr Speechley's Last Known Position on the Princes Highway. Sergeant Walsh identified that area as also a likely location of Mr Speechley.

Illawarra Retirement Trust – Review of Residential facility Dalmeny

170. The IRT conducted an immediate review into the circumstances of Mr Speechley's admission and absconding from the IRT Dalmeny facility. They were provided a Report prepared by the Quality and Systems Review Manager (QSRM).

171. The report identifies numerous shortcomings[103]and numerous inadequacies relating to the admissions processes, shift handover procedures, training of carers (to recognise that a patient with dementia who is at risk of absconding is a person who presents with a life threatening risk), communications with family and documentation in clinical care, while Mr Speechley was resident between 4 and 7 July 2016. In addition to the QSRM Report, the Trust developed a working group to review both the respite and permanent admission processes resulting in an overhaul and uniformity of procedures so that the processes no longer distinguish between whether the admission is for a permanent or temporary placement.[104]

172. Those deficiencies meant that Mr Speechley's risk of absconding from the IRT Dalmeny was **never** recognised either at his admission or more importantly

[103] Exhibit 1, volume 3, tab 57, 9.59-64.
[104] Exhibit 1, tab 92 para 1-2

during his stay despite significant and numerous events indicating an escalation of risk **but** even if it had been recognized and documented, there was no process in place for that to be communicated to anyone charged with his care **and** even if that had been done it is likely that **no-one** would have recognized that the fence or gate surrounding the Mummaga Wing courtyard was easily breached because it was assumed that residents of the wing were either physically or mentally incapable of doing so.

173. On the morning of 7 July 2016 Mr Speechley clearly indicated that he was considering jumping the gate and but for his compliance with a command issued by Ms Stanford he would have likely done so. That was evident to the students who sought Ms Stanford's assistance and Ms Stanford herself. Ms Stanford did not record a Progress Note and neither she nor her team leader informed the RN on duty.

174. However, even if the incident had been recorded as is conceded it should have been, there were no procedures in place whereby a verbal handover from the morning to the afternoon shift would communicate about a patient or any incident. RN Yap who had commenced duty at 2 p.m. gave evidence that due to her responsibilities for all residents that it would be most likely that it would not be until about 6 p.m. that she would be in a position to read any Progress Notes in any event.

175. Mr Speechley was apparently the first resident to breach the courtyard fence though it was fairly common for patients to attend the gate and rattle it as if testing to see whether it was able to be opened.

176. Within a short period of time IRT replaced the fence with a border that cannot be scaled. Additionally they have installed a duress alarm in the courtyard.

177. Other physical works have been undertaken at the Mummaga Wing and include:

- Murals to unobtrusively disguise risk and exit points and enhance the overall ambience of the courtyard area.
- Update to the Nurse's Station to improve lines of sight.
- Creation of a Namaste room.

The Admission Process

178. In July 2016 there was no formal pre-admission process at the IRT Dalmeny facility. Accordingly, there was no formal risk assessment process. When Mrs Speechley spoke with Ms Nowak about Mr Speechley for the first time she told her the bone marrow biopsy had accelerated his dementia and he was currently in hospital. She also told her of the incident at home when Mr Speechley had taken hold of a knife and held it in his hand. This behaviour was totally out of character which caused Mrs Speechley significant concern about his mental health. This information informed Ms Nowak that there was behaviour of concern.

179. Ms Nowak met with Jan on a couple of further occasions, to discuss Mr Speechley's admission and his care needs, including the episode with the knife, how he was in hospital, the possibility that he may go home after his stay with the IRT Dalmeny facility, whether he could walk or shower himself and other general information like that.

180. Ms Nowak did not complete any paperwork prior to Mr Speechley's admission on 4 July 2016. IRT has a computer system called Platinum (also known as Lee Care) whereby the records and Care Plan for each resident is kept electronically. Nowhere on Platinum are there notes about the conversations with Jan. No risk assessment was conducted based on information around Mr Speechley's psychological state.

181. An Aged Care Assessment Team ("ACAT") Report was prepared whilst Mr Speechley was in Moruya Hospital. It was forwarded to IRT Dalmeny but it is unclear whether Ms Nowak read the assessment prior to admitting Mr Speechley.

182. Ms Nowak said that whilst she did not recollect reading the ACAT report, she approved Mr Speechley for respite admission and it follows that she read the report. She accepted on that basis that she would have read and understood the matters outlined in the report, including Mr Speechley's wandering behaviours. She agreed it was vital pre-admission information. Yet, clinical information emanating from that document has not made its way into the assessment documents and Care Plan.

183. The QSRM concluded that Mr Speechley was admitted based on incomplete information. The inter-hospital transfer document, as it turns out, was a vital admission document yet was not read by anyone nor did it occur to anyone that it

was missing from Mr Speechley's file. On admission, minimal information was entered into Platinum. No relevant care or behavioural management information was entered. There is no evidence of the development of a care plan based on known information around Mr Speechley's psychological state.

184. It is without contest that the admission process was inadequate resulting in a significant failure by the facility even before Mr Speechley was received into the care of the staff.

185. Mr Speechley ought to have been recognized as an absconding risk prior to 7 July 2016. There was ample evidence to form this opinion. However, a number of systemic failures within the facility prevented this. The failures included no process in relation to the receipt of a resident via an Inter-hospital transfer, no completion of Behaviour and Risk Assessment Documents and inadequate Progress Notes and no process involving Handovers resulting in poor communication which led to adverse outcomes involving continuity of care.

Lack of Risk Assessment from Admission and Inter-hospital transfer documents to Escalating Behaviours neither Documented nor Discussed

186. The first opportunity to identify Mr Speechley as an absconding risk was the inter-hospital transfer form.[105]

187. Had the inter-hospital transfer document been read and appreciated, it would have, according to Ms Nowak's evidence, been brought to the staff's attention, recorded in Platinum which populates other fields including behavioural assessments and the Care Plan.

188. At no time was Mr Speechley assessed as a resident who was at specific risk of absconding other than being identified as a person with dementia significant enough to be needing to be contained in the secure unit. It did not appear to be within anyone's thinking that a Mummaga Unit patient would be physically fit enough or capable enough, let alone mentally capable, to traverse the courtyard pool fencing.

[105] Possibly also if the ACAT report had been read.

189. The courtyard fencing aside, because there had been no absconding risk assessment undertaken at or during Mr Speechley's admission, no consideration was given to any type of intervention to manage Mr Speechley's wandering or absconding behaviour.

190. Ms Nowak said that wandering behaviours relevant to Mr Speechley were never brought to her attention that would necessitate consideration of a meditrack device. It is unclear what management strategies would have been put in place, but a "sight chart" could have been commenced and a direction that Mr Speechley be denied access to the courtyard may have been entertained.

Behaviour and Risk Assessment Documents

191. There is a paucity of any completed assessment document. It was not until after Mr Speechley absconded that Ms Nowak asked Ms Clarke to *"tidy up"* the assessment documents.

192. The Platinum document for "Admission: Hygiene/Mobility/Transfers/Falls/Safety" field asks: "*Is the resident's own safety at risk due to lack of insight into their own safety? e.g. Wandering, potential for burns…*" The field for the answer has "*No*" entered. However, another field asks the question: "*Is the resident's own safety at risk due to altered behaviour patterns*?" The answer to that question was recorded as *"Yes"*. Though there is a field for strategies to address the issue that field is occupied with a description as to why the answer is "yes": *"wanting to leave and go home, becomes agitated*."[106]

193. It is not possible to ascertain when a particular document was created nor by whom. Any change to a document will result in the last person's name appearing with the relevant date and time. Ms Clarke cannot recall which of the assessment documents she created for the first time on 8 July 2016 and which of those documents already existed and were tidied up by her and saved on 8 July 2016.[107]

[106] Exhibit 1, volume 2, tab 30, p. 39.
[107] Exhibit 1, volume 6, tab 90, paragraph 6.

194. The IRT facility produced a document (Exhibit 10) which identifies each staff member who accessed Mr Speechley's electronic file 4-8 July 2016. It however does not identity the authorship or the date upon which an entry is made.

195. It was evident that some staff members were not confident with their skills in using Platinum and some were not aware of which parts of the document would be cross-populated such as a Progress Note populating a Behavioural Assessment. In any event, the information in the Platinum Care Plan was deficient.

Procedural lapses in completing Progress Notes and Conducting Shift Change Handovers

196. There was no requirement or procedure in place requiring staff to read the notes on Platinum at the start of each shift. Ms McDougall said that it was the policy for workers to familiarize themselves with notes before starting a shift but it was not her practice to do so. Ms Stanford's practice was to look at Platinum. She did so on the morning of 7 July 2016 as she had not been at work since 3 July 2016.

197. Though she was alerted to the arrival of Mr Speechley as a new resident the notification did not include any reference to Mr Speechley being at risk of absconding despite the fact that very morning Mr Speechley had attempted to leave via the laundry exit door, activating the alarm door and had been displaying agitated and exit-seeking behavior.

198. Ms McDougall knew nothing about Mr Speechley either from reading his electronic file or from others in an oral handover. Ms Murtagh was told on shift handover on 5 July 2016 that Mr Speechley could become aggressive and to be aware of this.[108] Significantly, however, when she started her shift on 7 July 2016 at 3 p.m. she did not know that Mr Speechley had tried to climb over the gate of the courtyard fence in an attempt to abscond. Nor did she know about the incident earlier in the morning in relation to the door. It was the same door where she was required to intervene later that day.

199. No one told the RN on the morning shift or RN Yap who was on the afternoon shift. Consistent with training in behavioural management,[109] RN Yap had an

[108] Exhibit 1, volume 1, tab 16, paragraph [5].
[109] Exhibit 1, volume 3, tab 48, p. 8.

expectation that reports of increasing anxiety, restlessness and pacing, trying to get out doors or gates, would be reported to her.

200. Both Ms Murtagh and RN Yap said that had they known about the earlier incident they would not have allowed Mr Speechley to go into the courtyard after his attempt to prise open the exit door with a piece of dowel. RN Yap said she would have locked the screen door leading out into the courtyard if she had known.

201. Ms Nowak said that had she known of Mr Speechley's earlier attempt to leave through the exit door in the early hours of 6 July, together with his attempt to prise open the same door on 7 July 2016, she would have called a case conference with staff to see if triggers could be identified and put management strategies in place.

202. Had there been a verbal handover between the morning and afternoon nurses, information about the 10 a.m. courtyard incident would not have been conveyed to RN Yap because neither Ms Stanford nor Ms McDougall spoke about the incident with the morning RN. Accordingly, handovers needed to have involved both ACE staff and nursing staff.

203. There appears to have been a general lack of diligence to communicating and recording relevant incidents. A couple of days after Mr Speechley absconded Ms Nowak learned that a staff member had found a pillow case that Mr Speechley had stuffed with his clothes to use as a suitcase which is apparently an act showing an intention to leave which people with dementia are known to do. Ms Nowak was unable to say where and when and by whom the pillowcase was found.

204. Ms Nowak did not know about the 10 a.m. courtyard incident until the night Mr Speechley absconded. Ms Stanford saw the social media broadcast that Mr Speechley had absconded. She immediately sent a text message to Ms Nowak's mobile phone to say that Mr Speechley had tried to jump the fence earlier that day.

205. Ms Nowak directed Ms Stanford to make a note of the incident on 8 July 2016 and despite starting work at 8.30 a.m. that note was not made until just before end of shift.

Training

206. Ms Stanford had been with the IRT facility for 6 years as at July 2016. She said in evidence that she received training in behavioural management of dementia patients, but could not recall how recently she had received that training as at July 2016.

207. Ms McDougall had been with the IRT for 10 years as at July 2016 and stated she had received training called *"Defense in Dementia"* prior to July 2016 to keep the staff and residents safe. She had also received annual training in behavioural management of dementia patients.

208. Ms Murtagh also said she was familiar with the IRT facility's policy on Behavioural Management[110] and had been given training around that policy, including training in defensive dementia.

209. RN Yap had been with the IRT for two years as at July 2016 and said she received training in behavioural management of dementia patients after Mr Speechley went missing; she was unable to recall whether she had received training prior to that. She said that she only became aware that wandering behavior can be life threatening after the disappearance of Mr Speechley, indicating that perhaps she did not receive any training.

210. Ms Nowak told the Court that prior to this time, there had been training on behavioural management that may have included wandering and absconding but it was only after Mr Speechley's disappearance that there was specific training in wandering and absconding on 19 August 2016.[111]

211. Since Mr Speechley's disappearance and the implementation of changes arising from the QSRM report, staff participate in monthly online modules and toolbox talks. Toolbox talks are approximately 10 minute information sessions with an educator or the in-charge nurse. There are different toolbox talks, not all of them involve behavioural management. They are on different subjects that arise in the Aged Care industry.

[110] Exhibit 1, volume 1, tab 13B.
[111] Exhibit 1, volume 6, tab 77, p. 8.

Changes Made by IRT

212. The improvements are described in the statement of Mr Malone and were elaborated upon in his oral evidence. Briefly, the improvements address the suggestions contained in the QSRM Report include:

- New admission procedures and associated staff training on Platinum.
- If a resident is coming from hospital, the RN will meet the resident in hospital. If that is not possible the nurse will have a telephone conversation with the Nursing Unit Manager (of the hospital, for example, about the resident's acuity, care needs, behaviours, then all of that information goes to the Care Manager to determine whether the facility can meet their care needs.
- Implementation of a pre-qualification and pre-admission risk assessment.
- Monthly safety net reviews using Platinum record keeping system to generate reports which help to identify gaps in record keeping and escalation processes.
- A technology solution for resident tracking for at risk residents will be rolled out in March 2020.
- Mobile phones and pagers are used by RN. They also have access to walkie talkies if necessary.
- Duress alarm in the courtyard.
- Toolbox talks and training on absconding and wandering behaviours.
- A Progress Note Direction that requires new admissions to have progress notes recorded at least daily for 14 days. The Care Manager retains the discretion to set the time for progress notes to be more frequent, based on individual resident requirements.
- Now as part of the progress note one can check a box which puts it into the handover for the next shift. One can also check a box to turn the progress note into an alert and to send it to a particular person.
- Handover is supported by the Platinum system such that at handover there is a document on the screen (or in hard copy) which shows all incidents for the residents, e.g. a fall or a particular behaviour, or a change in acuity.

- A handover now includes all staff on outgoing shift and all staff on incoming shift.
- There is a team meeting that involves the RN, the Aged Care Employees, any allied health, GP and the family, to review how the resident is adapting to the facility and to determine what assessments need to be undertaken within 21 days.
- There is now a review of a resident after 4 months, then there is a 12 month review, and there is also a review if there is an incident (e.g. a fall, a hospital admission, something that would trigger a change in acuity). This is all systematised, so that the staff get a printout with the names of all residents who are due for a review.
- There has been an increase in the number of staff at the busiest times (breakfast and dinner time). Between 7am and 10am and between 4.30pm and 6.30pm or 5pm and 7pm. Additional lifestyle staff have been recruited and additional clinical nurse educator hours at the facility have been extended.

213. A new IRT document called "Guide to Completing Assessments" was created without a mention of the risk of absconding or even wandering behaviours. Since that evidence, IRT has again improved the Guide by including same. That document is now Exhibit 7. As a result of that change Counsel Assisting's recommendation that it be made is now redundant. It is evident that IRT are committed to addressing deficiencies so that the service the Trust's charter requires are of an improved standard.

214. The following recommendations were proposed to be made:

To the NSW Commissioner of Police:

1. That consideration be given to the introduction of greater general purpose, air scent and cadaver dog resources in the South Coast of NSW.

2. That consideration be given to discussing and implementing liaison arrangements between police in the ACT and police on the South Coast of NSW in times of emergency.

3. That consideration be given to introducing a policy of maintaining all land search operations for missing persons for 3 days beyond the maximum survival period, being identified by a person with extensive search and rescue medical knowledge, for the purpose of attempting to recover the person's remains, and thereafter consulting with the family of the missing person before a decision is made to stop search.

4. That the police carry out recovery searches, with the utilisation of a fit for purpose cadaver dog in relation to Area 1 D West up to 3.2 km and Area 3(2-SA3) -Task Area 3.[112]

215. Mr Jordan, on behalf of the Commissioner of NSW Police Force resists each of these recommendations:

216. In relation to carrying out a further search with a cadaver dog he says there is no evidence that a cadaver dog would locate remains of this age, there is no evidence that there is a fit for purpose dog, there is no evidence identifying it would be reasonable to conduct another search of the same area where a search has already been conducted.

217. With respect, given that the search of the two most likely areas did not use such a dog effectively and the search produced a POD well below the standard and the fact that the evidence is that it is most likely Mr Speechley is in either of those two areas, the only issue is whether or not there is a fit for purpose dog. If there is, then the search should be conducted.

218. In relation to recommendation 1, Mr Jordan submits that the issue of resources should be left to the consideration of the Commissioner. I agree and that is why the recommendation is in such terms. The evidence that that resource was not considered even though it may well have proved useful was because of the distance of travel and the urgency of the requirement. Should there be the availability of a nearby resource then it would likely to improve an outcome involving the life and death of someone the police have been asked to locate.

[112] This is a summary of I have encapsulated. The recommendation made by Counsel Assisting was "That NSW Police coordinate a further search for Mr Speechley's remains in the bush to the west of the Princes Highway, encompassing the area identified by Senior Sergeant Whitehead in Exhibit 9." Later, Nicole Smith asked that the Coroner also make a recommendation: "That the NSW Police also coordinate another search for my father Raymond Speechley in Area **3(2-SA3) -Task Area 3** directly West of Dads Last Known Position on the Princes Highway" which was supported by Counsel Assisting. Any recovery search will require the assistance of a fit for purpose cadaver dog.

219. Likewise in relation to the request for liaison arrangements between police in the ACT and police on the South Coast of NSW in times of emergency. There should be when a matter, such as this case presented, a mechanism whereby other nearby police resources can be co-operatively deployed. Though a search such as this may rely on volunteer rather than police personnel perhaps other police resources could be made available. Mr Jordan pointed out police forces throughout Australia assist each other. That is so and the fact that a poorly resourced Far South Coast police officer did not consider calling for support is a matter which should be addressed. An improvement in liaison would see an improvement in requests.

220. Finally, in response to the proposed recommendation 3, Mr Jordan is concerned that this recommendation would cause an oversight to the fact that a recovery search did take place on 6-8 August 2016 and that an immediate search may not receive the careful planning and allocation resources that a belated search would receive. I am confident that the NSW Police Force could plan and allocate resources 3 days post-survivability. It is reasonable that an expert be retained so that the police can properly assess an individual's survivability. It is also reasonable that a search duration of 3 days post that expected date be considered both in terms of prospects of rescue (some people have better survival rates than expected) and in terms of recovery.

221. The Speechley family adopt Counsel Assisting's Recommendations and I am of the view that they are necessary and reasonable recommendations to make arising out of this matter and I make them.

222. At the conclusion of evidence of the inquest Mr Renfrew spoke of his cousin Ray Speechley thus: *Ray loved his sports, rugby league, he was a winner in premiership 5 Illawarra competition. He also loved and enjoyed fishing, the bush and the wildlife, the animals, birds and nature. He enjoyed his garden, especially his pet dogs, over the years. To be with Ray and see and feel his quiet manner in guiding with compassion, understanding, and his love for his family, a lifetime of memories for everyone who knew Ray. His greatest love, his wife Jan, children, Michael, Nicole and family.*

223. Mr Hammond on behalf of Mrs Speechley read to the court these words inscribed on a framed hand drawing of Ray: *"When Ray Speechley clasped her hand on the way home from the dance, Jan knew they would walk through life*

together. Every evening like the first, Ray would kiss Jan goodnight. He would spend mornings drinking in nature, sipping his tea and crumbling biscuits for the birds, prancing comfortably around his feet. It was dawn when Jan was unexpectedly awoken, "Look, love", Ray said, pointing to the small galah perched on his hat. That wild bird, like Jan, made Ray family and remained that way for years. Ray and Jan shared 57 years nine months and ten days of marriage, had two kids, five grandkids and a couple of great grandchildren, not to mention and endless number of cows, pigs, birds, and of course, dogs as pets. When Ray wandered away from the monitored care facility into wildlife filled bushland Jan knew he was trying to find her, but his hand remains out of reach. Help find Ray Speechley".

224. Mr Renfrew said that Ray was a man of great heart and soul and he had an enduring bond with his family. I offer my condolences now that I enter my findings:

Ray Speechley has died.
The date of Ray Speechley's death is date between 8 and 10 July 2016.
The place of Ray Speechley's his death is bushland, west of the highway, some distance north from the Dalmeny turn-off, NSW.
Ray Speechley died of hypothermia after he became lost in bushland after scaling the fences of the Illawarra Trust aged care facility in Dalmeny wanting to return home to be with his wife Jan.

This Inquest is now closed.

Magistrate E. Truscott
Deputy State Coroner
6 December 2019