STATE CORONER'S COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Yousif Yousif
Hearing dates:	20 – 21 November 2019
Date of findings:	18 December 2019
Place of findings:	NSW State Coroner's Court, Lidcombe NSW
Findings of:	Magistrate Harriet Grahame, Deputy State Coroner
Catchwords:	CORONIAL LAW – search for missing person, abscond from aged care facility, dementia, Missing Persons Registry, Missing Persons Standard Operating Procedures (SOPS)
File numbers:	2016/380289
Representation:	Counsel Assisting Mr Michael Dalla-Pozza, instructed by Mr Andrew Bell, Crown Solicitor's Office Nicholas Regener, Makinson D'Apice for the Commissioner of Police Patrick Rooney instructed by Matthew Renwick, McCabe Curwood, for the South Western Sydney Local Health District

Findings:

The findings I make under section 81(1) of the *Coroners Act 2009* (NSW) are:

Identity
The person who died was Yousif Yousif

Date of death
He died between 15 and 17 December 2016

Place of death
He died in Orphan Creek, Fairfield, NSW

Cause of death
He died from drowning.

Manner of death
Mr Yousif had dementia. He was briefly unsupervised and left an aged care facility alone. He appears to have wandered into Orphan Creek, where he drowned.

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Introduction

1. On 17 December 2016, Mr Yousif was found, deceased, by people walking in their local park. He was floating in Orphan Creek. Mr Yousif had been missing since 15 December 2016. On that day he had attended a Christmas Party at the Fairfield Community Health Aged Day Care Centre (**FCHADC)** at Carramar. Staff noticed that he was missing just after 10.30am that day.

2. Mr Yousif was a well-loved family man. His disappearance and death in these tragic circumstances has caused distress and grief. His son, Marten, described him as "a good man with a pure heart."[1]

The role of the coroner

3. The role of the coroner is to make findings as to the identity of the nominated person and in relation to the date and place of death. The coroner is also to address issues concerning the manner and cause of death.[2] In addition the coroner may make recommendations in relation to matters that have the capacity to improve public health and safety in the future which are connected to the death in question.[3]

4. In this case there is no question as to the identity of Mr Yousif or to the approximate time or place of his death. Rather the inquest focussed on identifying the manner of his death in an attempt to discover whether there are mechanisms which could prevent a similar event occurring. This process involved reviewing changes already made by South Western Sydney Local Health District (SWSLHD) and developments in the procedures and operational structure of the NSW Police Force in relation to missing persons cases.

The evidence

5. The Court took oral evidence over two days. The Court also received extensive documentary material. This included witness statements, medical records, maps and photographs. A further statement of Detective Inspector Fileman was received to supplement his oral evidence.

Background

6. Mr Yousif was born in Iraq on 5 January 1940 and migrated to Australia in 2007. He was married to Salma Israel and they had seven children.

7. Mr Yousif's son, Mr Marten Mikha, represented the family by providing a statement and attending the inquest hearing.

8. Mr Yousif spoke Arabic and Chaldean fluently. He had some English, but it deteriorated in the period leading to his death.

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[1] Statement of Marten Mikha, Exhibit 1, Vol 1, Tab 34 [5]
[2] Section 81 *Coroners Act* 2009 (NSW).
[3] Section 82 *Coroners Act* 2009 (NSW)

9. Mr Yousif was diagnosed with early onset dementia in 2009, which progressively worsened until his death, often resulting in confusion and the inability to perform daily tasks. He depended heavily on his wife and family.

10. As Mr Yousif's condition worsened, his family arranged for him to attend a day care centre "Aimee's Place", which was located in Fairfield East and operated by the South Western Sydney Local Health District **("SWSLHD")**.

11. At the time of his death, Mr Yousif had been at the centre for a number of years. Staff members were aware of his cognitive disability. A care plan had been prepared for him at the centre which specifically noted his risk of wandering. Mr Yousif had attempted to leave the centre on a number of occasions but was prevented from doing so. The premises at Aimee's place were specifically designed for clients with dementia who presented a risk of wandering. The building is secure and fences and doors lock automatically.

The events leading up to Mr Yousif's disappearance

12. On 15 December 2016, FCHADC held a Christmas party for clients of various day care centres in the Fairfield area, including Aimee's place. Mr Yousif was invited, along with almost 40 others. Some of the invitees, like Mr Yousif suffered from dementia or cognitive impairment.

13. The party was held at FCHADC in Carramar. These premises were not apparently designed or adapted to accommodate clients suffering dementia who were at risk of wandering. There does not appear to have been full consideration given to the suitability of the Carramar premises as a venue for the party. Nor was there any specific risk assessment done in relation to Mr Yousif's particular suitability to attend such a function.

14. On the day of the party, heavy rain was falling. Mr Yousif was collected from his home in the morning by an employee of the SWSLHD and driven to the Carramar premises. Mr Yousif's supervisor for the day was aware that there was a risk of him wandering off. However, she was not given any specific instructions on how to manage these risks or how to take care of Mr Yousif at the party.

15. It appears that Mr Yousif's absence was first noticed around 10.30am. However, there were some discrepancies in the accounts given of the day. Staff members with responsibility for supervising Mr Yousif also had other responsibilities and it appears clear that he was left unattended for a short period of time. Once his absence was noted, SWSLHD staff searched the immediate area in and around the centre. They contacted his wife at 10.50am and police at 11.15.

16. About 12.20pm, two constables attended FCHADC and spoke with the coordinator. Information was disseminated via VKG radio to keep a look out for Mr Yousif. The two police officers commenced a local search.

17. Around 4.30pm, the two constables attended Mr Yousif's home to obtain further information from the family and a formal "missing persons report" appears to have been created.

18. At approximately 9.00pm, a police officer disseminated a New South Wales Statewide Messaging Service **("NEMESIS")** message to all police officers in the South West, North West and Central Metropolitan Regions, which included a photograph and description of Mr Yousif.[4]

19. It is reported that two constables conducted further patrols from 10.30 – 11.00pm but it was very difficult to see beyond the street due to poor street lighting.[5] Late in the evening, enquiries were made as to CCTV footage from the facility which might assist the search, but police were apparently informed that it could not be accessed until the following morning. No CCTV footage was ever obtained, as NSW Police were subsequently informed that the CCTV cameras in the relevant building were not functioning.

20. The Police Media Unit uploaded a picture of Mr Yousif to the NSW Police Facebook site at about midnight.

21. During the afternoon of Friday 16 December, POLAIR conducted a search flight over the local area without result.

22. Mr Yousif's family and friends also continued searching for him.

The discovery of Mr Yousif's body

23. On 17 December 2016 a member of the public noticed what appeared to be a body submerged in Orphan Creek.[6] He had been walking a dog when he noticed something in the water. He telephoned for police assistance and waited until they arrived. Police divers were subsequently called and were able to remove the body from the water. As he was an elderly man wearing a maroon jacket, police were soon able to confirm it was Mr Yousif.

24. Mr Yousif was located less than 700 metres from the venue of the party. His son, Mr Mikha later formally identified his father.

Post mortem examination and cause of death

25. A limited post mortem examination was conducted by Dr Rebecca Irvine. She recorded that post mortem CT scanning found no significant acute findings or injuries. She noted evidence of immersion and recorded a cause of death of drowning. The report did not record any antecedent causes.

26. Dr Irvine recorded, "Drowning is primarily a diagnosis of exclusion of other causes and is substantially based on circumstances. As an internal examination was not performed, no comment can be made regarding internal conditions which may have caused or contributed to death".

[4] Statement of G South, Exhibit 1, Vol. 1, Tab 34 at [6].
[5] Statement of G South, Exhibit 1, Vol. 1, Tab 34 at [7].
[6] Statement of Diego Andres Saez Querol, Exhibit 1, Vol 1, Tab 35 [

Changes made by SWSLHD following its internal investigation

27. After Mr Yousif's death, SWSLHD commissioned an independent investigation into the events, decision making and subsequent management of Mr Yousif while at FCHADC on 15 December 2016. The investigation was carried out by O'Connor Marsden and Associates. The terms of reference included consideration of the actions of all relevant staff involved in decision making and supervision of Mr Yousif. After an extensive investigation involving interviews and interrogation of the relevant policy, a final report was produced. I have had an opportunity to review the report and the recommendations made[7].

28. As a result of the investigation commissioned by SWSLHD, I am satisfied that individual failings of staff members were identified. Adverse findings were recorded against a staff member for allowing Mr Yousif to attend the party without adequate consideration of his behavioural issues or with effective risk management strategies implemented. Another staff member was identified as having failed to make proactive inquiries in relation to the management of clients of Aimee's Place if they were to attend the party. In light of this comprehensive process and its outcome, it is unnecessary for me to conduct a duplicate review of these decisions and actions.

29. However, it was appropriate for the Court to hear from the SWSLHD in relation to any structural improvements made to reduce the risk of the re-occurrence of a similar tragedy.

30. Ms Rosemary Fraser, Senior Service Manager of Aged Care and Rehabilitation in the SWSLHD provided a statement and gave oral evidence before me. Her responsibilities include the operational management of a number of aged care centres within the LHD.

31. Ms Fraser outlined a number of aspects of the position at the time of Mr Yousif's death, and the changes which have occurred since. They were:

- That as at December 2016, there was no policy or procedure in place relating to absconding patients with the SWSLHD that was specific to Aged Care and Rehabilitation: [5];
- That within the SWSLHD, there were hospital-specific policies relating to absconding patients but no policy or procedure in place for a client within the Aged Care and Rehabilitation services who had absconded;[8] that is, whilst there were paragraphs or sections which would have applied to absconding patients, they were not compiled in a unified policy; However
- In September 2017, the Guideline *Aged Care & Rehabilitation Assessment and Care Management of Clients who are at Risk of Wandering and Absconding* was published by the LHD. That policy was in evidence;[9]
- Celebrations, including Christmas parties, now only occur at the site at which the client usually attends. The merging of patients for one-off events no longer occurs. In oral evidence,

32. In relation to the discontinuation of consolidated Christmas parties, Ms Fraser explained in her oral evidence (T2 6.3—13):

[7] The O'Connor Marsden Report, Exhibit 1, Volume 2, Tab 36
[8] Statement of Rosemary Fraser, 29 February 2019, [6]
[9] Statement of Rosemary Fraser, 29 February 2019, Annexure A

> "historically, the Christmas party has been a huge thing and part of that was because we have different sites and within those sites operates smaller groups of different languages, and in the past there has been an opportunity for these people to come together […] and there's no doubt that the staff enjoyed the fact that they had a big group of people […] but I think the gravity of the situation and the terrible outcome that people are still terribly upset about, they understand that it is worth it from that perspective."

33. Aside from the publication of the new guideline *Aged Care & Rehabilitation Assessment and Care Management of Clients who are at Risk of Wandering and Absconding*, Ms Fraser gave evidence to improvements in clinical practice in SWSLHD, including the completion of a risk assessment for intra-facility outings.

34. The policy *Guideline Aged Care and Rehabilitation (AC&R) Safety in the Community* was in evidence. It requires a Transport/Escort Daily Risk Assessment to be undertaken "on every occasion a client is taken out of their usual environment, whether to hospital appointments, day centres or on approved outing".[10]

35. Ms Fraser also described a revised process of the handover process in her oral evidence (T2 7—8):

> "Well the usual practice is that every afternoon once the clients have been taken home, staff gather and debrief about the day and any concerns that staff have noticed during the day, any change in behaviour any increase in needs, other [matters] along those lines are discussed at that meeting, so that if further action is needed by the co-ordinator to follow up with the family then she would do that. Now following this incident there's a morning handover as well and the purpose of that really is to ensure that every staff member and there is quite a few staff members on each side, every staff member knows who is coming for the day they know their particular - the particular risk associated with that client, particular concerns or things that are important about each client so that every staff member knows that they are responsible for every client who attends on that day. I think in reviewing some of the earlier information there did appear to be some confusion amongst staff about who was responsible for what."

36. Ms Fraser also described a process by which client information can be easily communicated to police to assist their investigation, as it is collated in a "client folder" (T2 9.35—39).

37. It was also Ms Fraser's evidence that the CCTV cameras are now on the premises are now in working order (T2 9.16—21).

38. Ms Fraser gave comprehensive and detailed evidence. I am satisfied that SWSLHD have undertaken a genuine and fulsome review of their policies and procedures to ensure that no similar tragedy takes place in the future. I note that there has been no like incident since the death of Mr Yousif in 2016.

[10] At page 14.

Evidence relating to NSW Police

39. The court has also undertaken a review of the adequacy of the police search, with a view to considering whether recommendations are appropriate. In this respect I was assisted by three statements and oral evidence provided by Detective Superintendent Martin Fileman, who is the current Acting Director of Crime Operations, State Crime Command. His role includes oversighting the newly formed NSW Police Force Missing Persons Registry ("**MPR**") which replaced the Missing Persons Unit ("**MPU**") on 1 July 2019 (Supplementary Statement, at [3]).

40. Superintendent Fileman did not give evidence as a witness of fact, but as a senior officer with detailed knowledge of missing persons procedures, and the development of the MPR from the previous model of the MPU. Accordingly, his evidence can be distilled into two themes:

    (a) An assessment of the adequacy of the police response in relation to Mr Yousif; and

    (b) Developments in police processes which might assist in identifying appropriate recommendations.

Adequacy of the search for Mr Yousif

41. The first statement of Detective Superintendent Fileman identified the following weaknesses in the search for Mr Yousif:

    (a) There was no written Risk Assessment either in the COPS system or the VIEW Imagery Management System (another information management system) (T1 19.50—20.2).
    (b) Police should have contacted the Media Unit earlier in the 12 hour period after the initial response of police, "as a priority, due to the positive impact that social media can have" (at [20]);
    (c) Importantly, there should have been contact with the MPU, which "would have assisted investigating police to undertake a more thorough investigation into the disappearance" (at [29]);
    (d) A land based search should have been performed (at [22]) which includes the nomination of a "land search coordinator" (at [21]) which is required when a decision is made to conduct a land search operation (at [23]) and should have occurred "in the first instance" as Mr Yousif was a vulnerable person (at [27]). That person would "undertake the actual search operation planning and coordination function" (at [23]);
    (e) That land based search could, and usually would, have involved the assistance of other emergency service organisations and community volunteers (at [24]);

42. Regarding the delayed contact with the Media Unit, Detective Superintended Fileman deposed (in his first statement at [13]):

    "With respect to contact with Media Unit, some 12 hours after the initial missing persons report, I believe that this specific task should have occurred soon after police spoke with [the next of kin]. This would have allowed the Media Unit to circulate the

description and photograph on NSW Police Force social media sites. In doing so, members of the public may (though not necessarily would) have assisted by alerting Police to the identification and subsequent location of [Mr Yousif] earlier."

43. And importantly, in relation to the completion of the risk matrix contained in the Standard Operating Procedures for Missing Persons ("**SOPS**") (above at (a)):

> "the SOPS provide two checklists (Initial Response Checklist and LAC MP Checklist) and a Missing Person Risk Assessment. Under the head 'Conduct Risk Assessment' in 5.2 of the SOPs, it states, 'Risk Assessment is a critical process for all MP matters and it should directly inform the level of response from NSWPF. Remembering that going missing itself is not a crime, the NSWPF response should match the level of identified risk for the person who is missing; the higher the risk to the person, the greater the response. In this instance, by not accessing the Missing Person SOPs, the Missing Peron Risk Assessment was not conducted, and the level of response not adhered to. **Completing the risk assessment would have provided the correct level of response under the heading of 'Risk Mitigation Action,' which is contained in the Risk Assessment [Template].** These levels are 'Low,' Medium,' High' and 'Very High.' All levels state, 'Refer to SOPs."

44. The oral evidence of Detective Superintended Fileman clarified the nature and existence of a number of the deficiencies in the search for Mr Yousif, as follows:

(a) Whilst Detective Superintendent Fileman's first statement indicated that the time between Mr Yousif being reported missing to police and the generation of the NEMESIS message was reasonable in the circumstances (at [13]), his oral evidence was that, with the benefit of hindsight, a nemesis message should have been generated earlier (T1 20.25). That evidence was subject to the possibility that other issues arose which might have delayed the sending of the message, of which the Court was not aware (T1 20.31).

(b) Detective Superintendent Fileman also clarified that it would have been preferable to contact Mr Yousif's next of kin earlier, noting that family members can often provide information as to the likely places to which people with dementia would recurrently wander (T1 20.45—50).

(c) Importantly, his evidence was that completion of a documented risk matrix may have avoided a number of the deficiencies in the police search (T1 16.24—30).

(d) It was clarified in oral evidence that, in a case such as Mr Yousif's the maximum available resources should be deployed, which would involve the engagement of the community or volunteer rescue services such as the State Emergency Services (T1 23.41—47).

45. In my view there were clear inadequacies in the planning and implementation of the search for Mr Yousif. There was a failure to consult the relevant **SOPS** and to contact the MPU for advice. Had the relevant police sought advice from a trained Land Search Coordinator, a more comprehensive search could have occurred. By identifying Mr Yousif as "high risk", further resources for an immediate local search may have been provided. There needed to

be a coordinated effort to get more people out looking for Mr Yousif as soon as his disappearance had been confirmed.There are clear lessons to be learnt from this tragedy.

Evidence as to developments in police processes

46. This inquest was heard after the abolition of the MPU, but before the full operation of the new MPR and prior to the approval of new standard operating procedures. In light of that, Detective Superintended Fileman provided the Court with a supplementary statement which clarified the role of the new MPR in the following respects:

    (a) The MPR is a unit within State Crime Command which coordinates NSWPF response to missing persons investigations;

    (b) The MPR Manager reports to the Director of Crime Operations, State Crime Command;

    (c) As with the MPU, the MPR does not assume investigative responsibilities;

    (d) The MPR is responsible for maintaining and monitoring adherence to the SOPs, collating data regarding missing persons, coordinating and cross referencing missing persons against unidentified remains and bodies databases and cases; and

    (e) The MPR has further related functions.

47. The supplementary statement deposes that it is planned, when the new SOPs are finalised, to engage a widespread education campaign within the NSW Police Force to promote the role and functions of the MPR (at [5]). That is to include mandatory online training, education packages, training programs, presentations and conferences (at [5]).

48. In oral evidence, Detective Superintendent Fileman expressed the view that having detectives administer the MPR would affect a major shift from the abolished model of the MPU (T1 11.13–17). In contrast to the MPU, the Registry will be predominantly composed of uniformed staff, headed by a Detective Inspector with a background in homicide investigation, and the five staff members working for that Detective Inspector are all detectives (T1 9.6—10) including analysts, a detective sergeant and a detective senior sergeant.

49. In oral evidence, Detective Superintendent Fileman expressed an understanding of two further developments:

    (a) It is anticipated that each command will have a dedicated missing persons liaison officer, a role assumed by existing officers, who will assist each officer in the command with missing persons cases and the procedure to be followed.

    (b) Officers will, under the new system, be unable to generate a COPS event unless the risk matrix is completed. This was understood to constitute a significant departure from the present system whereby the risk assessment is compulsory but the use of a particular form is not. Unfortunately there is no time frame for this improvement.

50. The third statement of Detective Superintendent Fileman, prepared after the conclusion of his oral evidence but before oral submissions, clarified that the yet-to-be released Missing Person Standard Operating Procedures dealt with Dementia in the following way:

(a) On page 6, dementia is a specific "risk factor" (i.e. a factor associated with a person being high risk);

(b) On p. 32, the fact of dementia will place a person in the "High Risk Category" therefore requiring the attendance of a land search coordinator; and

(c) In connection with the Safely Home Program (p. 44, which was in the previous versions of the SOPs which were in evidence). The essence of that program, as described by paragraph [4] of the statement, is to provide a stainless steel bracelet which is to be worn by a registered person, which features a toll-free telephone number and personal identification.

51. From the above, an inference seemed available that there was no discrete section of the SOPs, identifiable from the index, which related to dementia or similar degenerative mental illnesses. From the bar table, Mr Regener confirmed (as noted, without those SOPs in evidence), that there was no such separate section (T2, 18.44).

52. In relation to social media, the third statement clarified that releasing information via social media is coordinated by the Public Affairs Unit of the NSW Police Force. The approach appeared somewhat more qualified than the oral evidence given by Detective Superintendent Fileman. The approach is apparently described in Chapter 19 of the new SOPs. It reads:

> "While social media is an important and valuable tool, it needs to be carefully monitored and can be human resource intensive … the posts need to be monitored carefully to ensure that comments do not contain information that may be defamatory or prejudicial to any future court matters or prejudicial to the investigation. Further, Police always need to get permission from next of kind before releasing identifying information about missing persons."

Scope for recommendations

53. At the conclusion of the inquest, three draft recommendations were raised for consideration. Those were:

54. **Recommendation 1:** "That consideration is given to building a procedure, *as a matter of priority*, into the COPS system whereby an officer is obliged to undertake a risk assessment matrix upon creating a COPS Event, in relation to a missing person."

55. It is possible that some of the deficiencies in the search for Mr Yousif could have been avoided if there had been a documented risk assessment undertaken. Mandating the completion of a risk matrix would greatly assist in ensuring that there is an appropriate level of response in high risk cases. This recommendation is framed as "*as a matter of priority*" for two reasons: firstly, it is clearly feasible as the Commissioner has indicated an intention to

implement it *at some point*; and secondly, it appears to present significant utility. The court asks that consideration is given to raising the priority of this improvement.

56. For context, once sufficient information is obtained in relation to a missing person, an "event" is created on the NSWPF Computerised Operating System ("COPS").[11] This generates a unique reference number and is used to record and manage investigative actions and records relating to the missing person. Completion of a risk assessment at this time is likely to direct the investigation in an appropriate direction.

57. **Recommendation 2:** "That consideration is given to conducting a strategic review as to the use of social and other media in the case of vulnerable missing persons such as those suffering dementia and cognitive impairment."

58. It was acknowledged by the Commissioner that social media is an important tool in missing persons operations. It appears that, especially where the Missing Persons Registry will be clarifying its role and accordingly the way it directs the use of social media, it would be useful for the Commissioner to review how social media can be best used to assist police in the location of missing persons with dementia or similar disabilities.

59. The Court heard that the number of people with dementia living in the community is ever increasing. The inclination to wander is well known in many of this cohort. Immediate land search is usually the most effective way to achieve a positive result in these investigations. Time is of the essence. Mobilising volunteers and encouraging "more eyes on the area" can sometimes be achieved by careful and strategic use of social and other media.

60. **Recommendation 3:** "That consideration is given to amending the Missing Person Standard Operating Procedures (**SOPS**) to include a specific section for those suffering dementia, as is the case for children."

61. The value of a discrete section, identifiable from the index of the missing person SOPs, would be to ensure that even a brief consideration of the SOPs would lead to an officer to categorise a person with dementia as a "high risk" missing person. The prevalence of a degenerative disease which increases risk might be seen to warrant such a concern. Whilst the Commissioner is concerned that the SOPs should be concise, and that unnecessary complexity might reduce their clarity or efficacy, this seems to be an amendment which could be made without threatening the readability of the document.

62. In light of its response following the death of Mr Yousif, it is not necessary to direct recommendations to the SWSLHD.

Findings

63. The findings I make under section 81(1) of the *Coroners Act 2009* (NSW) are:

Identity

The person who died was Yousif Yousif

[11] Statement of Detective Senior Sergeant Tucker, at [9]

Date of death

He died between 15 and 17 December 2016

Place of death

He died in Orphan Creek, Fairfield, NSW

Cause of death

He died from drowning

Manner of death

Mr Yousif had dementia. He was briefly unsupervised and left an aged care facility alone. He appears to have wandered into Orphan Creek, where he drowned.

Recommendations

64. For reasons already stated I make the following recommendations arising from the evidence pursuant to section 82 of the *Coroners Act 2009* (NSW).

To the NSW Commissioner of Police

That consideration is given to building a procedure, *as a matter of priority*, into the COPS system whereby an officer is obliged to undertake a risk assessment matrix upon creating a COPS Event, in relation to a missing person.

That consideration is given to conducting a strategic review as to the use of social and other media in the case of vulnerable missing persons such as those suffering dementia and cognitive impairment.

That consideration is given to amending the Missing Person Standard Operating Procedures (SOPS) to include a specific section for those suffering dementia, as is the case for children.

Conclusion

65. Finally, I once again express my sincere condolences to Mr Yousif's wife and his family.

66. I thank Mr Yousif's son, Marten, for his attendance at this Court and for his participation in this inquest.

67. I thank Counsel assisting Mr Michael Dalla-Pozza and his solicitor, Mr Andrew Bell, for their assistance in the preparation of this inquest.

68. I close this inquest.

Magistrate Harriet Grahame
Deputy State Coroner,
NSW State Coroner's Court
18 December 2019