CORONERS COURT

OF NEW SOUTH WALES

Inquest:	Inquest into the death of Carley Metcalfe
Hearing dates:	16 to 18 March 2020, 14 to 15 July 2020 and 22, 24 and 26 March 2021
Date of findings:	**25 February 2022**
Place of findings:	Byron Bay Local Court
Findings of:	**State Coroner, Magistrate Teresa O'Sullivan**
Catchwords:	CORONIAL LAW – cause of death; search for missing person in Mullumbimby; adequacy of police investigation; Missing Persons Standard Operating Procedures; care and treatment at Lismore Base Hospital; mental health diagnosis; discharge planning and procedure
File number:	2017/362424
Representation:	(1) Counsel Assisting Ms Kirsten Edwards of counsel, instructed by Ms Caitlin Healey-Nash of the NSW Crown Solicitor's Office (2) Christine and Maxwell Metcalfe Mr David Evenden, solicitor advocate of Legal Aid NSW (3) NSW Commissioner of Police, Senior Constable Jonathan Cartmill and "Officer A" Mr Ryan Coffey of counsel, instructed by Ms Alaana Wooldridge of the Office of the General Counsel, NSW Police Force (4) Northern NSW Local Health District Mr Patrick Rooney of counsel, instructed by Ms Olga Sclavenitis of McCabe Curwood

	(5) Dr Alexander Pullen Mr Dominic Priestly SC, instructed by Ms Chandrika Darroch and Mr Nick Audet of Meridian Lawyers (6) Dr Patrick Shively Ms Karen Kumar of counsel, instructed by Ms Amy Regan and Ms Joanne Lee of MDA National (7) Dr John Wardell Mr Simeon Beckett of counsel, instructed by Ms Emma Winch of Avant Law (8) Dr Robert Byrne Mr Gary Gregg of counsel, instructed by Ms Lauren Biviano and Mr Christopher Gates of Meridian Lawyers
Protective orders:	Orders made on 16 March 2020 1. Pursuant to s 74(1)(b) of the *Coroners Act 2009*, the Court orders that there shall be no publication of: (a) paragraphs [15]–[25] of the statement of Detective Senior Constable Scott Nowland dated 13 August 2019 at Tab 11 of the brief of evidence; (b) paragraph [3] and the words [redacted] in paragraph [8] of the statement of Detective Senior Constable Scott Nowland dated 13 September 2019 at Tab 12 of the brief of evidence; (c) The name of the person who provided the witness statement dated 22 August 2019 at Tab 34 of the brief of evidence; (d) the name [redacted]; (e) the contents of the letter to the State Coroner from Mr Stephen Heydt, clinical psychologist, dated 11 March 2020; and (f) the contents of the letter to the State Coroner from Mr Heydt dated 13 March 2020. 2. Pursuant to s 65 of the *Coroners Act 2009*, the Court orders that there shall be no access to: (a) the letter to the State Coroner from Mr Stephen Heydt, clinical psychologist, dated 11 March 2020; and (b) the letter to the State Coroner from Mr Heydt dated 13 March 2020.

	3. Pursuant to implied power, the Court orders that: (a) The person who provided the witness statement dated 22 August 2019 at Tab 34 of the brief of evidence be referred to by way of pseudonym, namely "Ms B". (b) The person who provided the CrimeStoppers report be referred to by way of pseudonym, namely "Ms C". (c) [redacted] be referred to by way of pseudonym, namely "Officer A". <u>Orders made on 14 July 2021</u> 4. Pursuant to s. 65 of the *Coroners Act 2009*, the Court orders that a notation be made on the coronial file that the NSW Commissioner of Police be notified of any application for access to the file. 5. The transcript of 16 March 2020 be amended to be consistent with the orders made on 16 March 2020.
Findings:	*Identity* The person who died was Carley Metcalfe. *Date of death* Carley died between 3 November 2017 and 29 November 2017. While I am unable to determine the exact date of death, I find that Carley was alive for a number of weeks after she disappeared on 3 November 2017. *Place of death* Carley died in or around Mullumbimby, NSW. *Cause and manner of death* I am unable to determine the cause or manner of Carley's death.

Recommendations:	*To the Commissioner of Police, NSW Police Force*
	(1) That the Missing Persons Registry ("MPR") consider amending the definition of "missing person" in the Missing Persons Standard Operating Procedures ("MP SOPs") to make it clear that no particular form of words need be used by an informant when reporting a missing person. If it is communicated to police that a person cannot be located and there are concerns for their safety and welfare, that person is a missing person.
	(2) That the MPR consider amending the MP SOPs to:
	(a) Require that police attempt to identify, and obtain and safely store the last known CCTV footage of a missing person as a matter of course within the first 48 hours of a missing persons investigation.
	(b) Make clear that CCTV footage is a valuable resource in a missing persons investigation, even if its forensic significance is not immediately apparent and/or there may not be human resources to view the footage immediately.
	(c) Include "identify any obtain any potentially relevant CCTV footage" in the mandatory maximum investigation timeframes for the Officer in Charge of an investigation, ideally within 48 hours.
	To the Northern NSW Local Health District
	(1) That the Northern NSW Local Health District ("NNSW LHD") ensure that the summary document page on HealtheNet includes information that easily identifies a mental health patient's past admissions, any psychiatric diagnoses, any mental health-related incidents (including incidents of violence, or self-harm/suicide attempts), and any other relevant information that may be significant for an assessing clinician to know when undertaking an assessment within the Emergency Department or elsewhere.
	(2) That the NNSW LHD consider expanding the scanning project within NNSW LHD to cover all hospitals and medical centres in the LHD, so that paper records for mental health patients so that they are available as part of the Electronic Medical Records System.
	(3) That the NNSW LHD:
	(a) formalise, whether by way of a written procedure or similar, the practice of inpatient mental health units and community mental health services obtaining medical records and any assessment reports from the Justice Health and Forensic Mental Health

	Network and where appropriate, from any other available source (including a court or legal practitioner) in circumstances where a consumer/patient has been psychiatrically assessed whilst in custody, and the medical records and assessment reports are likely to be of clinical relevance; and (b) take measures to press for those records to be scanned or otherwise made easily available electronically to clinicians. (4) That the NNSW LHD introduce the use of instant saliva-based testing for the detection of illicit drug use by mental health clinicians within NNSW LHD emergency departments and elsewhere as required. (5) That the NNSW LHD assess and determine the need for a Psychiatric Emergency Care Centre at Lismore Base Hospital.

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Introduction

1. Carley Metcalfe ("Carley") was discovered deceased in the Brunswick River on 29 November 2017. She was just 41 years old. She had two sons, now 26 and 16, and her devoted parents, Maxwell ("Max") and Christine Metcalfe ("Chris"), had been searching for her with increasing concern for several weeks after she disappeared on 3 November 2017.

2. A cause of death was not identified because of the level of decomposition. Pathologist Dr Alan Cala did not identify any physical injuries or signs of trauma but could not rule out foul play due to the advanced level of decomposition. There were no signs suggestive of drowning. No drugs were detected in Carley's post-mortem blood and while alcohol was present, it was at such a low level that it could be explained solely by decompositional processes.

3. On 1 November 2017, three days before her disappearance, Carley had been taken to Lismore Base Hospital in an ambulance in a confused and disoriented state after sleeping outside Lismore Courthouse for a number of days. She was seen by doctors and psychiatrists, provided with anti-psychotic medication and cleared for discharge. The next day, 2 November 2017, Carley attended Lismore Mental Health Unit 7 at around 1.00pm, saying she was hearing voices and asking for admission. Carley left when a nurse left the room to collect more information.

4. Carley was last definitively seen on 3 November 2017 by ex-partner Turhan Dervish. Carley arrived at his house on 2 November 2017 incoherent and laughing hysterically. She stayed the night and Mr Dervish dropped her at the bus station in Lismore at 8.09am on 3 November 2017 where Carley boarded a bus to Mullumbimby. On 4 November 2017 Carley's handbag and personal items (including her bank card, her identification and money) were discovered at Apex Park in Mullumbimby. Carley's parents reported her disappearance to the NSW Police Force ("NSWPF") at Byron Bay Police Station on 5 November 2017 and at Lismore Police Station on 8 November 2017. There were possible sightings of Carley in Mullumbimby on or around 20–25 November 2017. However, no one has come forward to say they spent any time with Carley after 3 November 2017, despite public calls for information from NSWPF and Coroner Stafford in December 2019.

5. The principle issue explored during the inquest was the manner and cause of death. In particular, if it could be determined whether Carley killed herself, died from misadventure, or if she was killed. The inquest also examined two discrete systemic issues; namely, the treatment of Carley at Lismore Base Hospital on 1–2 November 2017, and the adequacy of the NSWPF search, particularly in the days after Carley's parents attended Byron Bay Police Station on 5 November 2017.

6. Because Carley, Chris and Max all share the same last name, and to avoid any confusion that might be caused by referring to them as Ms, Mrs or Mr Metcalfe, these findings will generally refer to them by their first names with their permission and without intending any disrespect.

The role of the Coroner

7. The role of a Coroner, as set out in s. 81 of the *Coroners Act 2009* (NSW) ("the Act"), is to make findings as to the:

   (a) identity of the deceased;

   (b) date and place of the person's death;

   (c) physical or medical cause of death; and

   (d) manner of death, in other words, the circumstances surrounding the death.

8. Pursuant to s. 27 of the Act, an inquest is required when the manner and cause of a person's death have not been sufficiently disclosed. In this case, neither the exact cause nor the circumstances of Carley's death could be readily ascertained. Therefore, there has been a need to consider whether Carley's death was the result of misadventure or foul play, or whether it may have been intentionally self-inflicted. It is important to note that suicide can never be presumed in this jurisdiction. It is generally accepted that such a finding will not be made without cogent evidence and the coroner must turn his or her mind to all possibilities.

9. In addition to the above matters, pursuant to s. 82 of the Act, a Coroner may make recommendations in relation to matters in relation to the death which have the capacity to improve public health and safety in the future.

Procedural background

10. The inquest into Carley's death was held at Ballina and Byron Bay Local Courts in March and July 2020, with further days of hearing at Lismore and Byron Bay Local Courts in March 2021.

11. The hearing of the inquest was severely disrupted due to the COVID-19 pandemic and the resultant public health orders in 2020 and 2021. This resulted in the unexpected adjournment of the initial hearing in March 2020 after three days, and the need to hear the inquest in three separate tranches over a period of 12 months. Regrettably it also precluded the inquest from being finalised in a timelier manner.

12. These unforeseen disruptions and further delay can only have exacerbated the distress experienced by Carley's family; in particular, for Chris and Max who attended each of the tranches of the hearing in person. Despite these challenges, Carley's parents have demonstrated extraordinary resolve, patience and dignity.

13. I also acknowledge that it is likely that this delay has caused additional stress and anxiety for all of the interested parties involved in these proceedings, and their understanding and cooperation over this period is greatly appreciated by the Court.

The focus of the inquest

14. Pursuant to s. 81 of the Act, the inquest examined the following issues.

    1) Determination of the statutory findings required under s. 81 of the Act, including as to manner and cause of death, specifically:

        a) What was the cause of Carley's death, in particular, is the cause of death able to be ascertained as homicide, self-harm, accident or misadventure?

        b) What was the date or approximate date of Carley's death?

    2) Was the response by the NSWPF to concerns raised by Carley's parents on 5 and 8 November 2017 timely, appropriate, and adequate, including in relation to:

        a) compliance with the NSW Police missing persons protocol;

        b) the risk assessment process and documentation of the outcomes of risk assessments;

        c) seeking relevant CCTV footage from locations and businesses in Mullumbimby and Byron Bay;

        d) liaising with Carley's family; and

        e) seeking out and interviewing known associates of Carley.

    3) Were NSWPF procedures, processes, and common practices relating to obtaining CCTV footage effective and appropriate? Should any recommendations be made in this regard?

    4) Was the medical care received by Carley at Lismore Base Hospital on 1–2 November 2017 adequate and appropriate, with a particular focus on:

        a) the assessment and diagnosis of Carley's condition and the potential interaction between her mental health condition and any substance abuse or withdrawal from methadone;

        b) communication between the Emergency Department and Mental Health Services about Carley and documentation of that communication;

        c) whether voluntary admission was appropriate and if it was considered as a treatment option;

        d) the decision to discharge Carley and the adequacy and appropriateness discharge plan; and

        e) whether Carley's parents should have been contacted in relation to her planned discharge.

The Facts

Personal Circumstances

15. Carley René Metcalfe was born on 7 December 1976 in Manly, NSW. Carley was the daughter of Chris and Max Metcalfe. She was the middle of three children with an older brother, Jason, and a younger sister, Amber. Carley's sister Amber was born deaf which had a profound impact on her early childhood.

16. Carley was raised on the Northern Beaches of Sydney. Chris described Carley as "a beautiful, intelligent and creative child", who excelled in her primary school years at Dee Why and Cromer Primary Schools. However, Carley started to struggle in high school, which was marked by a decline in performance and truancy.

17. It was later discovered that Carley had endured regular childhood sexual abuse from a family member and had been raped by another man when she was 12 years old. As a young adult she also endured rape and violence. Michael Burgess, a caring and very diligent drug and alcohol counsellor who saw Carley from February 2017 onwards, said that trauma was key to understanding why Carley's life had taken the trajectory it did.

18. Some time in her late teens, Carley started engaging in self-harm, binge drinking and taking drugs. In 2016, she told a psychologist that drug use helped manage her traumatic memories. She ultimately developed an addiction to heroin.

19. Carley's first son Matthew was born in early 1995, when Carley was aged 18. Carley spent time in rehabilitation facilities and had periods during which she was free from drugs, but she also had a number of relapses. Carley's devoted parents helped her with addiction treatment and caring for Matthew. Rachael Thomas, Carley's Legal Aid lawyer, who also impressed me as compassionate and highly diligent, gave evidence that Chris and Max supported Carley and offered up everything that they possibly could for her.

20. In 2004, Carley began a relationship with Aaron Williams and while that relationship had difficulties, she was able to come off heroin. In October 2005, Carley's youngest son Cael was born. While Carley struggled with her mental health and drug addiction, she adored her boys and was always devoted to them. Carley's family described her as a "kind natured loving person".

21. At some point around 2012, Carley started a relationship with Turhan Dervish. Carley complained on a number of occasions about violence in the relationship. It is difficult to know if these claims were true as Mr Dervish strongly denied them and Carley had previously made obviously false reports while delusional that Mr Dervish had poisoned her and had murdered her whole family. On 21 December 2015, Carley presented at Lismore Base Hospital complaining of violence at the hands of Mr Dervish and asking for admission. It is likely that she was experiencing an acute psychotic episode at this time. Carley left Lismore Base Hospital after a couple of hours and later that evening Mr Dervish was admitted to the same hospital with stab wounds.

22. Carley was charged with the stabbing and spent several months in custody on remand at Grafton Correctional Centre, Long Bay Hospital, and Silverwater Correctional Centre. In March 2017, Carley received a suspended sentence of 18 months, which included

conditions that she refrain from illicit substances and submit to drug and alcohol testing.

23. Ms Thomas gave evidence that Carley was very unwell during much of this period in custody. On 21 January 2016, Carley was scheduled under s. 55 of the *Mental Health (Forensic Provisions) Act 1990* ("*Mental Health Act*") after she was noted to be incontinent, acting in a bizarre manner, refusing antipsychotic treatment and complaining of hearing voices. On 2 February 2016, Carley was admitted to Long Bay Hospital (within the Long Bay Correctional Centre) and commenced on fortnightly Clopixol depot injections, a medication used for the treatment of schizophrenia.

24. In May 2016, Carley was assessed by forensic psychiatrist Dr Kerri Eagle, who diagnosed her with schizophrenia, stating that she exhibited signs of "acute psychosis including delusions, disorganised behaviour and disorganised thoughts". On 16 August 2016, Carley was granted bail to attend the Miruma residential rehabilitation facility ("Miruma"), which is an intensive residential rehabilitation facility for women in Cessnock. Carley spent about three months at Miruma, during which she was committed to addressing her addiction and her mental health. Carley responded well to the Clopixol depot injections which she continued taking for a time after her release.

25. After Carley left Miruma in November 2016 she ultimately went to live with her parents in Myocum. In the months before her death in November 2017 Carley was making excellent progress. She took methadone daily and completed regular drugs tests without any incident. She began engaging with the Drug and Alcohol Service at the Byron Central Hospital, where she met Mr Burgess, who conducted a drug and alcohol assessment as well as a mental health assessment on 28 February 2017. Mr Burgess referred Carley to psychiatrist Dr Helen Donaghy for a formal Mental Health Review, which was carried out on 2 March 2017. Dr Donaghy noted that Carley did not appear to be experiencing any psychotic symptoms and recommended that she switch her anti-psychotic medication from Clopixol depot injections to oral olanzapine at 10mg per day. Carley started attending a support group, co-facilitated by Mr Burgess, to support relapse prevention and maintain wellbeing.

26. Mr Burgess's counselling notes reflect Carley becoming more outgoing and more interested in others – expressing a desire to help her mother around the house and do more to contribute to her parents' lives and the community. She tried to give up smoking, started yoga and explored her interest in art. Both Mr Burgess and Ms Thomas expressed that they were struck by Carley's commitment to staying drug free and improving her life.

27. However, the court order requiring regular drug and alcohol testing lapsed in around October 2017. Shortly after the order lapsed Carley admitted to her mother that she had taken some cannabis.

Psychiatric history and addiction treatment

28. Forensic psychiatrist Dr Andrew Ellis provided a retrospective diagnosis of Carley and commented on the care and treatment that she received at Lismore Base Hospital prior to her death. I accept Dr Ellis's opinion that:

(a) Carley had a long-term psychotic disorder since around 2011 or 2012, probably schizophrenia or the related condition schizoaffective disorder; and

(b) Some of Carley's behaviour over the years had been ascribed to substance induced psychosis when she was actually experiencing manifestations of an underlying psychotic illness.

29. Carley had periodically presented to hospitals and mental health institutions from about 2011 with symptoms consistent with psychotic episodes including auditory hallucinations. She sometimes reported experiencing violence, but it is not clear if this was an accurate history or a delusion. At times Carley would leave hospital before she could be properly assessed or treated. On some occasions she reported using illicit drugs and her behaviour was attributed to drug induced psychosis. Dr Donaghy, who assessed Carley on 2 March 2017, recorded that Carley had been psychotic in the past when withdrawing from methadone. As explained by Dr Ellis, methadone has mild antipsychotic properties so the symptoms were not so much opioid withdrawal as the emergence of otherwise suppressed psychotic symptoms.

30. Dr Ellis has described Carley as presenting "diagnostic and management challenges" to any practitioner treating her because of her traumatic personal history, the impact of that trauma on her personality development, and the interaction between her use of substances to self-medicate and her vulnerability to developing an acute and long-term psychotic illness. She was also an unreliable historian and displayed intermittent compliance with her medication and appointments.

31. Dr Ellis singled out for praise Carley's methadone prescriber and general practitioner, Dr Bronwyn Hudson, and her drug and alcohol counsellor, Mr Burgess. They both started caring for Carley in February 2017. Their care was diligent, thorough and compassionate. They were also Carley's most regular health providers, and both have been affected profoundly by Carley's death. Their evidence at the inquest was invaluable.

Events leading to Carley's disappearance

32. On 10 October 2017, Carley failed to attend her scheduled appointment with Mr Burgess.

33. On 24 October 2017, Chris contacted Mr Burgess as she was concerned that Carley was starting to deteriorate. As noted above at [22], Carley's court ordered supervision had ceased and Carley had admitted using cannabis on one occasion. Chris believed that drug use was affecting Carley's mental health. In particular, Carley was showing signs of paranoia about her sons and was complaining of auditory hallucinations. Additionally, Carley had disclosed to Chris that she had not been complying with her medication regime and that she had only been pretending to take olanzapine for the previous eight months.

34. On 26 October 2017, Mr Burgess and Dr Donaghy reviewed Carley. Carley reported that she had smoked marijuana, but denied methylamphetamine use. She said her paranoia about her sons had settled down, but she complained of a lack of motivation. She had stopped her yoga and art and said she spent every second day wandering

around Byron Bay. Carley also admitted that she had ceased taking her prescribed olanzapine but said she had resumed it over the last few days.

35. On 27 October 2017, Carley presented to Dr Hudson. This was Carley's last presentation to Dr Hudson prior to her disappearance. Dr Hudson noted that Carley was stable on her dose of methadone and that her mood was stable, with "nil suicidal ideation" and "nil behavioural issues".

36. On 27 October 2017, Carley attended LiveLife Pharmacy in Byron Bay for her daily dosing of methadone. This was Carley's last witnessed dose of methadone. During that attendance, she was also dispensed with weekend "takeaway" doses of methadone for 28 and 29 October 2017.

37. On 28 October 2017, Chris noticed that Carley was again very paranoid and fixated on the idea that some harm had come to her sons. Carley was calling both her sons obsessively and could not be reasoned with or reassured that they were safe. She spoke of hearing voices and admitted that she had used marijuana the day before.

38. Carley left her parents' home on the evening of 29 October 2017. This was also the date of her last "takeaway" dose of methadone that she had collected two days earlier. Carley took a cab to Lismore driven by Geoff Morrow. She took with her a blue Ikea bag, an Indian embroidered handbag and a number of Aldi plastic bags with clothes and hygiene products. Mr Morrow was concerned about Carley's mental health, and described her as "acting strange" and "confused". Mr Morrow drove Carley to a friend's house on Cromer Street in Lismore and then on to the Winsome Hotel in Lismore.

39. It is not entirely clear what Carley did between 29 and 31 October 2017. On or around 30 October 2017, Carley called Chris to say that she was at Lismore Courthouse. According to Chris, Carley did not sound drug affected and was able to hold a "proper conversation".

31 October 2017

40. On 31 October 2017, Ms Thomas saw Carley outside Lismore Courthouse and recognised her as a former client. (Ms Thomas had appeared for Carley in 2016 and 2017.) Carley was sitting on a blanket with her personal belongings scattered around her. Ms Thomas and Carley engaged in an initial conversation. Ms Thomas thought Carley looked unwell, compared to when Ms Thomas had last seen her in March 2017. Carley agreed to speak again with Ms Thomas when she finished at Court.

41. While in the Courthouse, Ms Thomas spoke to Cherie Vella, a Registered Nurse ("RN") from the Justice Health and Forensic Mental Health Network ("Justice Health"), about Carley. At around 12.15pm, RN Vella contacted RN Victoria Childs at Byron Central Hospital and Community Health to advise that Carley had been living on the porch of the Courthouse for the past three days and was not taking any medication except methadone. RN Childs suggested that RN Vella contact Lismore Acute Care Mental Health Service. RN Vella also spoke with Mr Burgess, and advised that Carley was planning to stay with a friend called "Bev" in Mullumbimby.

42. After Court, Ms Thomas found Carley in the same spot at the Courthouse. Carley had trouble engaging in conversation with Ms Thomas; she took a long time to respond to questions or stare blankly. Carley told Ms Thomas that she had stopped taking her

medications, but had not consumed drugs. Ms Thomas took Carley back to the Lismore Legal Aid office and helped Carley to call her mother. Carley indicated to Ms Thomas that once she left the Legal Aid office, she would collect her belongings from Lismore Courthouse and go back to Mullumbimby where she may be able to stay with a female friend. Ms Thomas urged Carley not to see Mr Dervish because it would breach her court orders.

43. Later that day, Ms Thomas spoke to Mr Burgess and expressed her concern about Carley's wellbeing. Mr Burgess noted that Carley had failed to attend an appointment with him that morning, and shared his concern about Carley's mental health and the possibility that she had relapsed. Mr Burgess told Ms Thomas that Carley had been asked to leave her mother's house for using cannabis. He indicated that he was happy to see Carley anytime.

44. Following her telephone conversation with Mr Burgess, Ms Thomas spoke with a sheriff officer at Lismore Courthouse, who confirmed that Carley was still out the front of the Courthouse. The sheriff officer took down Mr Burgess's details and said he would convey to Carley that she could contact Mr Burgess at any time.

1 November 2017

45. On 1 November 2017, Ms Thomas discovered that Carley was still at Lismore Courthouse. Ms Thomas saw Carley's belongings strewn along the gutter. Carley also still had a blank affect and was slow to answer. Ms Thomas spoke to Kay, a security guard at Lismore Courthouse, who was concerned about Carley. Kay had seen Carley wandering the streets of Lismore in the very early hours of the morning. Kay helped Carley to call Mr Burgess later that morning, at around 11.50am. Mr Burgess described Carley as sounding "confused, thought disordered and very flat in tone" on the phone. Kay also described Carley to Mr Burgess as "almost catatonic".

46. I pause here to note and commend the level of care and concern displayed by Ms Thomas and the staff at Lismore Courthouse, including RN Vella and Kay, towards Carley.

47. Mr Burgess and Kay arranged for Carley to be transferred to Lismore Base Hospital. At 12.25pm, Mr Burgess prepared a note in Carley's electronic medical record outlining the recent events and recommending that Carley receive a mental health review from the acute care service. He also provided contact numbers for himself and Dr Hudson. I find that the notes prepared by Mr Burgess on this day are critical documents. They were prepared by a person with a clinical rapport with Carley and who had great insight into her condition and history. In particular, they outlined Carley's history of psychosis and noted that Carley had most likely not consumed methadone or any antipsychotic medication for several days. Mr Burgess also noted that Carley's psychotic symptoms had re-emerged in the past when she had ceased her methadone.

48. Carley was ultimately taken from Lismore Courthouse to Lismore Base Hospital Emergency Department by ambulance arriving at 12.56pm.

Attendance at Lismore Base Hospital: 1–2 November 2017

Assessment in Emergency Department

49. Upon her arrival at Lismore Base Hospital, Carley was triaged promptly by a registered nurse in the Emergency Department. The triage note recorded at 12.56pm set out the following:

> "BIBA [brought in by ambulance] from near court house. Today states feeling unwell. Admits to having bad thoughts but denies suicidal ideation or harm to self or others. Feels flat.
> Known schizophrenia and bipolar."

50. A subsequent nursing progress note recorded at 1.57pm by RN Jane Abbott set out that, on admission, Carley was "looking vacant" and "answering questions slowly and without affect". RN Abbott also recorded:

> "History of Drug induced psychosis on medication
> ? has not hae (sic) regular meds for a few days, setting off deterioration in mental health
> For medical review and Mental Health review"

51. At around 2.36pm, Dr Patrick Shively, Emergency Medicine registrar, saw Carley for a medical assessment. Dr Shively recorded a medical history, which included the following:

> "pt recently released from jail
> recently re-started smoking marijuana
> long hx of drug abuse/dependence
> note from D+A stating likely she's been off her regular meds (antipsychotics and methadone)
> encouraged to present to LBH due to low mood
> pt has lapse of memory
> - recalls sleeping outside police station, unsure why
> - poor historian
> - unclear where she is or what happened
> admits to smoking marijuana recently, denies other illicit"

52. Dr Shively recorded that there was no evidence of recent intravenous drug use. He assessed Carley as medically well, pending her blood results.

53. I note that Dr Shively's reference to the "note from D+A" indicates that Dr Shively was aware of the note from Mr Burgess (referred to at [47] above) that Carley had been off her olanzapine and methadone.

Assessment by Dr Robert Byrne

54. The nursing progress notes indicate that during the afternoon of 1 November 2017, Carley remained in the Emergency Department and was quiet, if vacant, and compliant. At around 5.15pm, Carley urinated on the floor and needed to be directed to a toilet.

55. Carley was then assessed by the on-call psychiatric registrar Dr Robert Byrne in the Emergency Department. Dr Byrne estimated that he assessed Carley at around 6.00pm. (There is no contemporaneous record of the time of his assessment and he

did not record his clinical notes until about 8.39pm. Dr Byrne accepted that his failure to record the time of consultation was a deficiency in his notetaking.)

56. Dr Byrne spent about 10 to 15 minutes with Carley in total. He agreed that he was unable to do a proper mental health assessment – a progress that when done thoroughly and completely would take between one and two hours – because he was having difficulty engaging with Carley.

57. Dr Byrne reviewed Carley's notes and tried to take a history, which he found difficult as Carley was confused and disoriented. Carley did not know where she was, what month it was, or how she got to hospital. She had trouble answering questions and seemed exhausted.

58. Dr Byrne gave evidence that, due to her presentation and history, he believed that Carley was affected by cannabis or methamphetamine and/or suffering symptoms of withdrawal from methadone and also olanzapine potentially. At the time Dr Byrne reviewed Carley, he had read the triage notes and Dr Shively's review, which recorded that Carley had denied taking drugs other than cannabis. Dr Byrne could not recall asking Carley whether she had taken cannabis or methamphetamine.

59. At some point, Dr Byrne spoke with the following persons about Carley's presentation:

    (a) Carley's mother, Chris;

    (b) The drug and alcohol consultant, Dr Krell; and

    (c) The on-call psychiatry consultant, Dr John Wardell.

60. The exact timing and order of these conversations was not clear from the records. However, the evidence of Dr Byrne was that the conversations took place after he had tried to assess Carley and before he recorded his clinical notes at 8.39pm.

61. In relation to his telephone conversation with Chris, Dr Byrne thought this conversation occurred at around 7.30pm but accepted that it could have been as late as 8.30pm. In her recollection of the conversation, Chris stated that Dr Byrne took a very thorough history, and informed her that Carley was quite unwell and was not talking to him. Chris understood that Carley as to be admitted overnight and she and Max decided to travel to Lismore the next morning to collect Carley.

62. Dr Byrne's notes record that Chris reported that ice was Carley's "substance of choice in Lismore". As will be discussed further below at [264], Chris denies that she said this to Dr Byrne.

63. In relation to the conversation between Dr Byrne and Dr Wardell, Dr Wardell accepted that Dr Byrne called him at around 8.00pm or 9.00pm. Dr Byrne conveyed his opinion that Carley was likely under the effect of drugs and did not present "with positive psychotic symptoms". He also told Dr Wardell that he had trouble getting information from Carley as she was confused, disorganised and hard to engage. Dr Wardell (who was off-site and had no access to records, including Mr Burgess's notes) initially agreed with Dr Byrne's plan to conduct another mental health assessment when Carley was less confused, but recommended that the Emergency Department be consulted.

64. At some point, Dr Byrne also discussed Carley's methadone dosing with Dr Krell.

65. After speaking with Chris, Dr Wardell and Dr Krell, Dr Byrne recorded his clinical notes at 8.39pm. The Immediate Action Plan recorded by Dr Byrne, and approved by Dr Wardell, set out that Carley:

> "Currently does not require admission to mental health as acute intoxication/withdrawal is most likely diagnosis presently
> If remains in ED, Mental health would be happy to review again in the morning, if not she will be followed up in the Community"

66. Dr Byrne also requested a urine drug screen, charted 10mg of olanzapine and asked Carley be dosed with methadone in the morning (as no methadone was on site at night).

Consultation with Emergency Department

67. At around 9.00pm, Dr Byrne spoke to Emergency Department consultant, Dr Alexander Pullen, in the Emergency Department. The details of this conversation are set out below at [281]–[289]. In summary, Dr Byrne informed Dr Pullen of his opinion that Carley was likely confused due to acute intoxication and did not display psychotic symptoms. Dr Byrne also said that he thought a more thorough mental health review should take place after a urine screening test and when Carley was better able to engage.

68. I note here that the urine screening test was never conducted. I will return to this point later when I consider the question of whether any recommendations are necessary or desirable in this matter.

69. Dr Pullen disagreed with the plan proposed by Dr Byrne. Dr Pullen expressed the view that Carley should either be admitted to the mental health unit or, if there were no concerns for Carley's mental health, she should be discharged from the Emergency Department as there were no apparent medical issues to keep her.

70. Following his conversation with Dr Byrne, and between 9.00pm and 9.26pm, Dr Pullen reviewed Carley in person. Dr Pullen thought that Carley seemed tired, but considered that she didn't seem grossly affected by drugs or alcohol. Carley knew who she was and that she was in hospital but not the month. He observed no delirium.

71. Dr Pullen recorded a note which included:

> "Patient reviewed. Has been at home and caught a taxi today to come and see a friend. Was not able to see her friend. Strongly denies having taken any street drugs tonight."

72. As will be discussed further below, this is an account of Carley's day on 29 October 2017, not 1 November 2017, because Carley had been brought to Lismore Base Hospital after sleeping for a few days at Lismore Courthouse.

73. After Dr Pullen reviewed Carley he telephoned Dr Wardell. Dr Pullen's written record of the conversation stated:

> "Discussed with Dr Wardell psychiatry consultant. Nil mental health issues apparent though he feels the patient may be intoxicated. Can be discharged tonight. If any further issues, then the mental health team would be happy to discuss."

I discuss the details of this conversation further at [290]–[301] below.

74. Dr Pullen's note also recorded that Carley's family could not collect her but she was to call a friend. Dr Pullen informed his night team that Carley was not to be detained under the *Mental Health Act* and was free to leave with a friend or family. Dr Pullen gave evidence that he was reluctant for Carley to be allowed to leave on her own, however Carley refused to give him any information about the friend she said was going to collect her.

Discharge referral

75. At 9:23pm on 1 November 2017, Dr Shively prepared a discharge referral for Carley. Dr Shively's note stated that Carley had been medically cleared and reviewed by mental health. He made reference to the discussion between Dr Pullen and Dr Wardell in which they agreed that Carley "could be admitted if mental health had concerns or otherwise discharged". The note also stated that Carley said a friend was collecting her and she was happy to be discharged.

76. At 9.31pm, RN Rebecca Tickle completed an ED to Ward Nursing Safe Transfer Form for Carley. It recorded, relevantly, that a patient escort was not required and that no risk assessments had been completed.

77. At around 9.30pm, Dr Byrne's shift concluded and he left the Emergency Department, having had no further involvement in Carley's care since earlier that evening.

78. Despite the apparent discharge, Carley spent the night in the Emergency Department. At 9.57pm on 1 November 2017 and 1.42am on 2 November 2017, nursing staff checked if Carley's father was coming to collect her and she said, incorrectly, that he was. Staff also continued to check Carley's vital signs throughout the night.

79. The last observations of Carley at Lismore Base Hospital were recorded at 6.19am on 2 November 2017. The nursing progress note recorded that Carley "states feeling okay" and "will attempt to call father in AM". Carley left the Emergency Department undetected by staff some time shortly afterwards.

80. Chris and Max called Lismore Base Hospital on the morning of 2 November 2017 to check on Carley but were told that Carley had been released because her treatment had concluded.

Carley leaves Lismore Base Hospital

81. At around 6.30am on 2 November 2017, Carley attended Lismore Police Station and spoke with Detective Senior Constable ("DSC") Tegan Smith about some lost property which was held by police. DSC Smith described Carley as "dishevelled and unkept, however timid and shy". DSC Smith told Carley that her property was located at Byron Bay Police Station and could be collected there. About 30 minutes later, DSC Smith spoke with Chris, who had called out of concern for Carley, and advised that Carley seemed forgetful. DSC Smith told Chris that she would keep an eye out for Carley. DSC Smith then notified car crews to keep a lookout for Carley, but did not submit a formal record.

82. At around 1.00pm on 2 November 2017, Carley attended the Lismore Mental Health Unit and spoke to RN Liz Joblin about being admitted. Carley said she was paranoid and hearing voices. However, she was vague and disoriented, and couldn't give a

coherent account. The clinical note recorded by RN Joblin stated that Carley was smoking THC and possibly ice. However, RN Joblin later said that Carley was vague about any illicit drug use and that the source for this information may have been Chris.

83. RN Joblin left the room to call Chris and find out about bed availability. When she returned, Carley had left. Sadly, after hearing from RN Joblin, Chris and Max attended the Lismore Mental Health Unit hoping to see Carley. They immediately started searching for her in the Lismore area.

84. Meanwhile, in Byron Bay, Dr Hudson and Mr Burgess held case conferences with the Drug and Alcohol Team and Byron Bay Acute Care Team. Carley's clinical notes indicated that she was still at the Emergency Department at Lismore Base Hospital. However, Dr Hudson discovered that Carley had been discharged when she called the Emergency Department at around 10.00am with the specific intention of making sure that Carley was not discharged. Mr Burgess was alarmed as he had assumed from Dr Byrne's notes that Carley was going to be admitted at least overnight. He prepared a clinical note stating:

> "If Carley presents to a health facility please be aware that there has been a rapid deterioration in her mental health and she needs to be treated as an inpatient".

85. Later on 2 November 2017, Carley attended Mr Dervish's house in Lismore. Mr Dervish thought that Carley arrived at about midday; however, it is not clear if this was before or after Carley had left the Lismore Mental Health Unit.

86. Carley told Mr Dervish she had been in hospital and asked if she could come in and have a shower. Mr Dervish had not seen Carley since she stabbed him two years earlier. When Mr Dervish asked Carley if she remembered what she had done to him, she began laughing hysterically. Mr Dervish gave evidence that Carley appeared to be in the same psychotic state as the day on which she had stabbed him. He said that Carley was "talking funny" and "spinning out, she wasn't there in the head".

87. Mr Dervish gave evidence that he let Carley have a shower, washed her clothes and took her to Lismore Police Station and Lismore Base Hospital that afternoon to help her find her bags, which she picked up from the main entrance at Lismore Base Hospital. Mr Dervish and Carley returned to his house, where Carley sat in a chair and watched TV before sleeping overnight in the spare bedroom.

88. The next morning, 3 November 2017, Mr Dervish drove Carley to a bus stop in Lismore to catch the bus to Mullumbimby. Carley told Mr Dervish that she was going to ask to stay with a friend in Mullumbimby, as she did not want to stay with her parents. Chris later gave evidence that Mr Dervish told her that Carley planned to see a friend called "Babs", believed to be Barbara Doyle, who lived near Apex Park in Mullumbimby. Mr Dervish said he didn't hear from Carley at all after he dropped her off at the bus station. He gave evidence that he went looking for Carley in Mullumbimby once he heard she was missing and that this this included visiting Ms Doyle's house, who told him that Carley had been there but she had refused to let her stay.

89. Ms Doyle gave evidence at the inquest that Carley was her close friend and had visited her in 2017, but had never asked to stay overnight. She stated that the last time she saw Carley, she seemed happy and was going to Lismore. Ms Doyle estimated that this

was in September 2017. She denied having had any contact with Carley after this occasion. Ms Doyle gave evidence that after she found out that Carley was missing, she asked around to try to find out if anyone had seen Carley. Ms Doyle stated that everyone in Mullumbimby was keeping an eye out for Carley, but Ms Doyle did not find anyone who had seen her.

90. On or around 4 and 5 November 2017, a local resident informed Chris and Max that she had found Carley's handbags at Apex Park in Mullumbimby with a pillow and quilt. Max then found Carley's Ikea bag containing her shoes and other items nearby at the disused Mullumbimby Railway Station. Max was told by a security guard near the Railway Station that he had seen a blonde lady sleeping on the platform. The security guard was unable to be located to give evidence at the inquest.

91. Chris and Max found Carley's identification, bank cards, Medicare card, pension card and a small amount of money in her bags. They also located a bus ticket from Lismore to Mullumbimby time stamped 8.13am on 3 November 2017 and a receipt for a drink from Mullumbimby IGA stamped 1.59pm on 3 November 2017.

NSWPF Missing Persons Investigation

92. At around 10.45am on 3 November 2017, a 'Keep a Look Out' Computer Aided Dispatch ("CAD") message was generated by Richmond Police District ("PD") Manager Kelly Everson. The CAD message provided a physical description of Carley, referenced that she had mental health issues, was off medication and that her mother was concerned for her safety as her whereabouts were unknown. The officer in charge of the coronial investigation, DSC Scott Nowland, gave evidence that his understanding was that Chris would have contacted Lismore Police Station on 3 November 2017 and reported the information that appeared in the CAD message. The CAD message was broadcast over the VKG at 11.02am that morning, and remained on the CAD system until around 11.00pm on 4 November 2017.

93. On 4 November 2017, a further 'Keep a Look Out' CAD message was generated by Senior Constable ("SC") Ian Gordon and broadcast on the VKG at 10.49pm. The CAD message noted that Carley had not been seen or heard from for a few days and that Chris believed Carley may have been sleeping in a park in the Mullumbimby area. The CAD requested a patrol of parks in the Mullumbimby area. Again, it is likely that the CAD message was generated after Chris made contact with police.

94. A note was added to the CAD message by SC Michael Chaffey at 11.53pm on 4 November 2017. SC Chaffey stated that he had:

> "Contacted informant [Chris] to obtain more details and to ask her to report the matter as a missing person if required. At this stage police will make patrols of the area but this is not considered a missing person incident – please process"

95. At 3.36am on 5 November 2017, SC Chaffey added a further note to the CAD message. He stated that patrols had been made of the area, but that police were unable to locate Carley. SC Chaffey also outlined that he had left a message for Chris asking that a missing person report be made to police if genuine concerns were held. He considered that there was no further police action required at that stage.

First visit to police: 5 November 2017

96. On the afternoon of 5 November 2017, Chris and Max attended Byron Bay Police Station and spoke to SC Jonathan Cartmill. They told SC Cartmill that they could not locate or contact Carley. They also explained Carley's history of drug addiction, her current homelessness, her lack of access to money and their serious concerns for her untreated mental health issues.

97. What exactly was said when this initial report was made to the police was the subject of differing evidence at the inquest. Chris and Max stated that they wanted to report Carley missing and made that very clear.

98. SC Cartmill said that the conversation lasted approximately 15 to 20 minutes, and was focused only on Carley's mental health and concerns about her welfare. SC Cartmill interpreted the visit as a concern for welfare report and a request to have Carley scheduled. SC Cartmill created a COPS event for a Mental Health Incident, which *inter alia* stated:

> "The mother is concerned for her daughters mental health and has been unable to get into contact with the POI. The POI is homeless and has been frequenting Apex Park, in Mullumbimby. The informant and her husband have been patrolling for the POI in Apex Park and Byron Bay.
>
> In the last Month, the POI has come under notice of both mental health and NSW ambulance service. Each time, she has been released without schedule. It was explained to the informant that police have limited scheduling powers and that often the assessment of the Doctor or psychologist releases the patient back into the community."

99. SC Cartmill gave evidence that he also took the following steps:

    (a) generated a CAD message for police to 'keep a look out' for Carley. The CAD message instructed police to contact Chris if they located Carley;

    (b) obtained photographs of Carley, and placed these in the supervisor's handover folder for Byron Bay and the sector's pigeon hole to be circulated to Bangalow, Mullumbimby and Brunswick Heads Police Stations; and

    (c) explained the matters to Chris and gave her a customer care card.

100. SC Cartmill denied that Chris and Max specifically asked him to take a missing person report. By contrast, Chris said that SC Cartmill gave her a COPS event number and told her that he would not take a missing person report because "if we did a missing person report on that information half of Byron Bay would be locked up". SC Cartmill's memory was that he may have said "if we scheduled every person on that information half of Byron Bay would be locked up". SC Cartmill apologised to the family at the inquest for this comment and conceded that any such statement would have been insensitive.

101. There was no documented evidence of follow-up by police with the family after their attendance at Byron Bay Police Station on 5 November 2017. I was provided with evidence by the Commissioner of a note made on a CAD message by Sergeant Paul Thierjung at 7.16am on 7 November 2017. The entry stated "Phone number tried. Unable to be contacted". It is not clear on the face of this record whether or not Sergeant Thierjung left a message.

Second visit to police: 8 November 2017

102. Three days later, on 8 November 2017, Chris attended Lismore Police Station to follow up on what was happening with Carley's case. This time, SC Fiona Stewart took a formal missing person report from the family. At the inquest, the family praised SC Stewart's thoroughness and sensitivity during this process. SC Stewart also generated another CAD message for police in the local area to keep a look out for Carley. SC Stewart informed her supervisor, Sergeant Robert Marr, of the report as SC Stewart did not usually work at Lismore and needed another officer to follow the matter up. SC Stewart was advised that another officer, SC Stirling, would be allocated the matter.

103. On 9 November 2017, Sergeant Marr contacted Lismore Base Hospital and confirmed that Carley was not an inpatient in any North Coast hospitals or other mental health facilities. Sergeant Marr has since been medically retired from NSWPF and did not give evidence at the inquest. It was therefore not possible to ascertain whether he undertook any other investigative steps in the four days between 9 and 13 November 2017. The records indicate only that he accessed Carley's records and, in particular, her photograph on 8 November 2017.

104. Meanwhile, Carley's parents searched for her on the streets, parks and riverbanks of Mullumbimby. They were desperately concerned for Carley's mental health and her ability to support herself without money or her personal cards. Chris and Max used their own money to create a flyer with a photo of Carley and distributed it around the Mullumbimby area.

Third visit to police: 13 November 2017

105. On 13 November 2017, Max and Chris again attended Lismore Police Station to express their increasing concern about Carley's welfare. Max and Chris spoke to SC Stirling about Carley's case. They provided police with a more recent photo of Carley and authority to publish the photograph, as well as a timeline of Carley's movements for the assistance of police. Their attendance was recorded but it does not appear any other action was taken to advance the investigation that day.

106. I find that Chris and Max's third visit to police not only indicated their high level of concern for their daughter but provided a significant amount of information as to Carley's movements and contacts that could have formed the basis for a number of further enquiries.

Allocation to Officer A: 14 November 2017

107. On 14 November 2017, Carley's case was allocated to an officer of the Tweed Byron PD, who I will refer to as "Officer A". Officer A was unable to appear at the inquest due to serious illness and the comments made about his investigation must be understood in the context that he was unable to respond to the criticism as a witness.

108. On 14 November 2017, Officer A and Constable Rick Hayes searched Apex Park and the disused Mullumbimby Railway Station located adjacent, and conducted patrols of Mullumbimby CBD. They also made enquiries at the Mullumbimby Community Centre and spoke to local homeless people to determine if they had seen Carley. Officer A

attended the recorded address of Carley's ex-partner Mr Williams, but the address was vacant.

109. From 15 to 21 November 2017, police recorded further patrols of the Mullumbimby Railway Station, Mullumbimby CBD, Federation Bridge area, Mullumbimby Community Garden and Mullumbimby Civic Centre. Officer A also attended the recorded address of Carley's next of kin to obtain further information. No one was home, and police left a calling card for the next of kin to contact police.

110. On 17 November 2017, Officer A submitted a request with St George Bank for Carley's bank account records.

111. On 21 November 2017, Officer A spoke to Chris in relation to the status of police enquiries. Chris gave Officer A the names of two friends of Carley's, Bella and Ms Doyle, who may have further information about her movements, and advised that Ms Thomas had sighted Carley prior to her being reported missing. Police spoke to Ms Doyle that day, but she reported that she had not seen Carley for three to four weeks. Officer A also attended the St George branch at Byron Bay and was informed that no withdrawals had been made from Carley's account since 3 November 2017.

112. Further patrols of the area were conducted on the days following, and a number of homeless people and other local residents were spoken to in relation to the investigation.

113. On 27 November 2017, Officer A updated Chris on the status of the investigation. Later that day, Officer A spoke to Kym Hensen at the Craig Watson Soul Patterson Pharmacy in Mullumbimby ("the Pharmacy"), who conveyed that she had sighted Carley in the past week (see below at [121]–[124]). Officer A proceeded to inform Chris of the possible positive sighting later that afternoon.

114. On 28 November 2017, Officer A supplied posters of Carley to Mullumbimby Woolworths and to a local pub for display.

Carley is found dead in the Brunswick River

115. On 29 November 2017, Ben Menzcer located Carley's body in the Brunswick River while he was collecting rubbish in a dinghy with his young son. Carley's body was floating face up in the river. She was wearing a jumper, colourful necklace, bra and underpants. A skirt similar to the one seen on Carley in CCTV footage later obtained from Lismore bus station was located on the shore nearby.

116. Mr Menzcer saw no signs of trauma and no signs of recent occupation on the nearby riverbank. He also saw nothing in the river such as a current, rocks or snags that would cause a good swimmer to come to grief.

117. Mr Menzcer dropped a location "pin" with his phone and contacted NSWPF. DSC Kurt Edmonds attended with a number of police officers and SES volunteers to assist with the recovery of Carley's body.

118. On 5 December 2017, forensic pathologist Dr Allan Cala conducted the autopsy.

119. On 10 January 2018, DNA evidence identified the body as that of Carley Metcalfe.

Possible sightings

120. Several witnesses provided evidence of possible sightings of Carley after 3 November 2017.

Kym Hensen

121. Kym Hensen, a retail manager at the Pharmacy, knew Carley as she used to collect her methadone from the Pharmacy.

122. Ms Hensen gave evidence that she firmly believes she saw Carley walking alone on Argyle Street in Mullumbimby at around 8.00-8.30am on a day around 20–22 November 2017 as she was driving to work with her daughter. Ms Hensen's daughter was driving at about 50-60km/ph towards Mullumbimby and Carley was walking on the opposite side of the road, in the same direction. Ms Hensen noticed that the person had a large handbag, was dressed in the long flowing clothes that Carley often wore and had a distinctive loping walk like Carley. Ms Hensen said she remembered the event because she had seen a post on Facebook that Carley was missing the weekend prior and she presumed that Carley had just "turned up".

123. Ms Hensen also gave evidence of another sighting of Carley at around 6.50am on 24 November 2017. Ms Hensen saw a woman wearing a long skirt crossing the road at Dalley Street near the RSL. Ms Hensen is less certain about this sighting.

124. As noted above, Ms Hensen had seen Carley reported as missing on a Facebook post around 18 November 2017. She did not contact police immediately but told Officer A about the two possible sightings when he came to the Pharmacy on 27 November 2017 while he was making enquiries about Carley.

Sally Bell

125. Sally Bell, the owner of Mullumbimby Pet Store, also gave evidence that she was certain she saw Carley during the week commencing 20 November 2017. Ms Bell estimated that it was the Thursday after the Mullumbimby Music Festival, i.e. 23 November 2017.

126. Ms Bell said Carley was sitting on a bench outside the IGA supermarket in Mullumbimby. There were other people on the bench, but Carley didn't seem to be with them. Ms Bell walked by Carley twice on her way in and out of the bank. Ms Bell didn't stop to speak to Carley but noted that Carley seemed to be subdued and was looking at the ground. On her way out of the bank, Ms Bell overheard Carley having an exchange with a woman about liking her colourful skirt.

127. Ms Bell said she found out shortly after that sighting that Carley was missing when she saw a poster with Carley's picture on it at Rotary Park. After seeing the poster, Ms Bell told Max that she had seen Carley, when Max came into her store asking about Carley. Police did not contact Ms Bell to ask about Carley or if Ms Bell had seen her.

Other sightings

128. Billy Jack Lever, who had known Carley for a number of years, stated that he thought he saw Carley on Melbourne Cup Day (which was 7 November 2017). Mr Lever saw Carley sitting near the IGA supermarket in Mullumbimby with two other persons.

129. SC Jason Haywood gave evidence that he encountered a female in the carpark of Mullumbimby Woolworths. After seeing a photo of Carley at the morning changeover, he recognised Carley as being very similar in appearance to the woman he encountered the previous day.

130. Finally, Trent and Jane Morgan came forward to assist after a plea for information was made by Coroner Stafford at Byron Bay in December 2019. Mr and Mrs Morgan knew Carley through having children at the same pre-school in around 2009–2010. They thought they saw Carley sitting on a bench outside the IGA supermarket in Mullumbimby in early November 2017. They stated that Carley seemed really happy and gave Mrs Morgan a hug. Carley didn't seem affected by drugs or alcohol. Mrs Morgan later saw Carley had been reported missing on Facebook and heard she died not long after.

What was the cause of Carley Metcalfe's death?

131. Sadly, the evidence does not enable me to make a finding as to the manner and cause of Carley's death. The level of decomposition of Carley's body means that no cause of death can be reliably ascertained.

132. However, I consider there to be sufficient evidence to make a finding, on the balance of probabilities, that Carley was not intoxicated by alcohol or drugs at the time of her death. In making this finding I note the following evidence:

   (a) Carley's post-mortem toxicology report showed that her blood was free of illicit drugs. Dr Cala said he would expect that Carley had not consumed substances for 72 to 96 hours prior to her death.

   (b) The toxicology report also recorded Carley's blood alcohol level as 0.069g/100mL. Dr Cala's evidence was that this finding could be entirely due to decomposition.

   (c) Dr Cala also stated that if Carley had consumed drugs or alcohol at a level that would affect her ability to swim, he would expect her blood alcohol level to be much higher, even after a prolonged period.

Did Carley die by misadventure?

133. Dr Cala found no physical evidence of drowning. However, Dr Cala could not exclude this as a possible cause of death as he would not expect to see any of the signs of drowning given the level of decomposition of Carley's body and her time in the river.

134. The evidence also suggests that Carley's psychological state had declined prior to her death, and that she was likely to be unwell, irrational and suffering from delusions. The report of Dr Eagle dated 25 May 2016 and evidence from Ms Thomas demonstrates how profoundly unwell Carley became when her schizophrenia was not treated (see at [23]–[24] above).

135. Dr Ellis considered misadventure as a possible cause of death. He stated that "fearful disorganisation as a result of untreated psychosis" may explain the circumstances of Carley's death, "wandering without adequate food/clothing in countryside to avoid perceived persecution".

136. For these reasons, I find that there is a real possibility, and one cannot put it any higher, that Carley fell or ran into the river and drowned while in the grip of a persecutory delusion.

Did Carley meet with foul play?

137. There has been no reliable evidence that enables me to make a finding that Carley was intentionally killed by a person or persons known or unknown. However, homicide cannot be excluded as a possibility.

138. No physical signs of homicide were identified on Carley's body, such as stab wounds, gunshot wounds, large bruising and lacerations, skull fracture or signs of strangulation.

139. When found by Mr Menzcer, Carley's shirt was raised and her skirt was missing. Dr Cala was of the view that the tide in the river could be responsible for clothes being dislodged or missing. A very similar skirt to one Carley was wearing on CCTV was found on the riverbank close by. Carley's underwear remained on and there were no physical signs of sexual assault.

140. There is no evidence of a person with a motive to kill Carley. As part of the police investigation, a number of witnesses alleged that Mr Dervish confessed to his involvement in Carley's death. I do not place any weight on that evidence for the following reasons:

    (a) DSC Nowland identified a number of significant reliability issues with these witnesses' accounts;

    (b) the account of one witness is internally inconsistent and not supported by witnesses whom she claimed were present when various statements were made;

    (c) some of the accounts suggested that Carley had consumed large amounts of ice prior to her death. This evidence is inconsistent with the toxicology results and the evidence of Dr Cala; and

    (d) Mr Dervish cooperated with the coronial investigation and inquest, voluntarily gave interviews and evidence when he had the right to decline and had no apparent motive to do Carley any harm.

141. Further, Mr Dervish's account of dropping Carley at the bus stop was supported by CCTV footage obtained after her body was found. There is no evidence from telephone towers which suggests that his phone was in the area at the relevant time (albeit that evidence is not conclusive). Finally, I must note that while Carley said their relationship was violent, and that may be true, or at least genuinely believed by Carley, there is no independent evidence that Mr Dervish was violent towards Carley and Carley had previously made false reports of Mr Dervish being violent towards her.

Did Carley die by suicide?

142. There is no evidence to suggest that Carley was suicidal. Mr Burgess gave evidence that Carley had engaged in self-harm around her teenage years, but that, to his knowledge, she did not engage in any self-harm while in treatment with him or give

any indication of suicidal ideation or past suicide attempts. Dr Hudson records noted that Carley exhibited "nil suicidal ideation" during their last appointment on 27 October 2017. Further, self-harm was not noted as a concern when Carley presented to Lismore Base Hospital on 1 November 2017

143. Dr Ellis also did not consider that Carley died by suicide. He noted that while Carley had one overdose in 2012, there was no recent suicidal behaviour or expression of suicidal ideation in any form noted in the evidence before the Court. Suicidal behaviour was not Carley's typical response to stress.

144. For these reasons I consider it unlikely that Carley died by suicide; however, I cannot altogether exclude the possibility.

What was the date or approximate date of Carley's death?

145. The last confirmed sighting of Carley was on 3 November 2017, when she was dropped off by Mr Dervish at the Lismore bus station. Carley was then found deceased by Mr Menzcer on 29 November 2017. This left a potential period of 26 days.

146. It is not clear how long Carley was alive after 3 November 2017. There was no activity in her bank accounts after 3 November 2017, no collection of her daily methadone after 27 October 2017 (with two takeaway doses) and no CCTV footage has been located depicting her after 3 November 2017.

147. However, I consider there to be sufficient evidence to make a finding, on the balance of probabilities, that Carley was alive for some weeks after she disappeared. This finding is primarily based on the evidence regarding the level of decomposition and the sightings of Carley in mid to late November 2017. All of the witnesses who came forward to police to report sightings of Carley, including Ms Henson and Ms Bell who gave evidence at the inquest, were confident in their sightings. They appeared to be helpful and credible witnesses with no apparent motive to lie.

Level of decomposition

148. During the autopsy on 5 December 2017, Dr Cala found "advanced decomposition" of Carley's body. He considered that the fact that Carley's body was found in a saltwater river and spent some time in that water were factors that would tend to accelerate decomposition. Dr Cala was of the view that the level of decomposition and amount of tissue loss suggested that Carley had been deceased for about 7 to 10 days before the autopsy. This would give an approximate date of death of between 22–29 November 2017.

149. Dr Cala considered that a longer post-mortem interval (i.e. that Carley had been deceased for longer than 7–10 days) was unlikely, as he would have expected more tissue loss, but the longer time frame could not be excluded. Dr Cala made it clear that he could not give a precise date of death, but thought it unlikely that Carley died on or around 3 November 2017, i.e. shortly after she disappeared.

Possible sightings

150. Ms Hensen and Ms Bell both thought they saw Carley in the week of 20 November 2017. Both women knew Carley quite well from her regular visits to their respective

stores. Further, Ms Hensen knew Carley was missing at the time she saw Carley, which made the sighting stand out to her.

151. While I am aware of research that certainty in identification has no correlation with accuracy, and accordingly make no assumption that they are correlated, both Ms Hensen and Ms Bell were certain they had seen Carley. I have placed most weight on Ms Bell's account of her sighting. Ms Bell states that she saw Carley close up on two occasions and heard her speak. Ms Hensen was also certain that she saw Carley but her opportunity to see Carley's face was quite limited given that she was travelling in a car at about 50-60kmph and Carley was walking in the same direction as the car on the opposite side of the road. Ms Hensen also relied on Carley's clothing, handbag and walk which could be potentially misleading.

152. The evidence about the dates of these sightings is less clear. Ms Hensen recalled seeing Carley after she had viewed a Facebook post about Carley while sitting in her lounge room during the day. As Ms Hensen would normally be at work during the week, she considered that she saw the Facebook post on a weekend. She estimated that it was the weekend of 18 or 19 November 2017 because it was about a week before she gave her statement to police.

153. Ms Bell believes that she saw Carley on Thursday, 23 November 2017 when she was on her way to the bank. Ms Bell did not believe that it would have been on another day that week as she did not go to the bank earlier in the week (as she usually had plenty of change in her shop) and the bank was not open on Wednesdays. It is possible that both saw Carley earlier. However, Ms Hensen knew Carley was missing at the time of her sighting, so must have seen Carley after Facebook posts and posters stating that Carley was missing were published.

154. I have also considered the evidence of Mr and Mrs Morgan. They estimate that they saw Carley in "early November 2017". While they were unable to be precise about the date they saw Carley, they knew Carley well and spoke to her and Mrs Morgan embraced her.

155. I consider there to be enough evidence to make a finding that all of the witnesses' accounts of their sighting of Carley support each other. Mr and Mrs Morgan saw Carley outside the IGA in Mullumbimby, which is the same location as the sightings by Ms Bell and Mr Lever. It is possible that all of the sightings occurred in the same week.

156. Curiously, Ms Bell and the Morgans recall Carley seeming happy. In particular, both Mr and Mrs Morgan stated that Carley seemed "really happy", and Mr Morgan thought that Carley was probably happier than he had ever seen her. Ms Bell thought Carley was distant, but she was well enough to compliment a woman on her skirt. This evidence is inconsistent with Ms Thomas's account of Carley's demeanour outside the courthouse on 31 October 2017 and may cause some doubt about the sightings. However, I accept that rapid and/or unexpected changes in mood can be a part of many mental illnesses.

157. I also note that the Mullumbimby Music Festival was on during this time. It is possible that the sightings were of an outsider in the area, who had a similar style to Carley.

158. If Carley was alive during the week of 20–25 November 2017, there was potential for police to locate her in Mullumbimby. It is notable that there are two possible sightings of Carley in a similar area of Mullumbimby during the same week, and where Officer A's COPs records suggest he was actively patrolling Mullumbimby during this week looking for Carley and asking about her.

159. There was also a potential for Carley's presence outside the Mullumbimby IGA to be detected by CCTV footage if police had requested the footage earlier. As it was, CCTV footage from the IGA was not requested until 30 November 2017, by which time the footage had been wiped. This fact raises the questions as to the adequacy of the police investigation, which I discuss further below.

160. I also note the evidence of Ms Hensen and Ms Bell about their knowledge that Carley was missing at the time of their sighting. Both women gave evidence that Carley being missing was not a matter of discussion in the small community of Mullumbimby. As discussed at [122] above, Ms Hensen believes that she saw a Facebook post around 18 November 2017. During the first tranche of the inquest hearings, the Commissioner produced evidence of a Northern Star newspaper article published online at 3.15pm on 17 November 2017, which appealed to the public for information about Carley. Ms Hensen couldn't recall if the Facebook post she saw was a post of the newspaper article shared by the Northern Star on its Facebook page.

161. In any event, Ms Hensen and Ms Bell gave evidence that they had not seen posters around the local area about Carley and that they were not aware of any police investigation into her disappearance. Ms Hensen had had no prior discussion with police when Officer A came into the pharmacy on 27 November 2017.

The police investigation into Carley's disappearance

Assessment of Carley's risk

162. The adequacy and appropriateness of the investigation into Carley's disappearance was evaluated against the standard of the NSWPF Missing Persons Standard Operating Procedures ("MP SOPs") in place at the time.

163. The MP SOPs establish the minimum standards for NSWPF officers in their day-to-day management of missing persons investigations. The MP SOPs are designed, as they themselves emphasise, "to maximise the chance that the [missing person] is found safe and well". To that end, they provide a useful guide for the procedures to be taken by officers during each stage of a missing persons investigation, including conducting a risk assessment and suggested responses depending on the outcome of that assessment.

164. I also had before me the revised MP SOPs published on 1 January 2020 ("2020 MP SOPs".

165. I set out my findings in relation to the investigation's compliance with the objectives of the MP SOPs below at [172] onwards. However, at the outset, I consider it important to address a foundational submission made by counsel assisting; namely, that risk informs the nature and the regularity of investigative steps taken by police. I agree with and accept this submission.

166. The fact that no risk assessment was conducted by NSWPF in relation to Carley's disappearance meant that she was not assigned a level of risk at the time of her disappearance. I received, prior to the second tranche of the hearing, a statement from Detective Sergeant ("DS") Bernadette Ingram, Investigations Manager of the Richmond PD. As at October 2017, DS Ingram's duties included the strategic management of missing persons cases within the Richmond PD. DS Ingram considered the new risk assessment procedures and missing person risk assessment questions and conducted a risk assessment of Carley retrospectively. She determined that Carley would have been a "low risk" case under both the MP SOPs in force at the time of Carley's disappearance and the 2020 MP SOPs.

167. By contrast, it was submitted by counsel assisting and the family that Carley was not a "low risk" missing person at any stage of the investigation. Counsel assisting drew attention to the following factors in Carley's case to support her submission:

(a) *Homelessness:*

One of the reasons cited by DS Ingram for her conclusion was that Carley had an extensive prior history of sleeping on the streets. On this basis, any conclusion that Carley may be homeless at that time could not of itself elevate the risk to her safety.

However, the evidence before the inquest indicated that Carley's experience with homelessness was both unusual and recent. Carley had been stable and living with her parents since November 2016 and, for most of 2017, had been engaging in regular therapy and drug and alcohol counselling. Carley had no recent history of "sleeping on the streets" before she started sleeping rough at Lismore Courthouse while experiencing mental health issues.

In addition, Carley had recently exhibited bizarre and disordered behaviour, leading to an ambulance taking her to Lismore Base Hospital on 1 November 2017. The next day, Carley presented to Lismore Community Health Centre exhibiting delusions and disordered thinking. She left the Centre alone, without support and without any known stable accommodation options.

I also find it troubling that any history of sleeping rough several years earlier means that a period of homelessness in the context of experiencing mental delusions after almost a year of stability would not elevate a person's risk rating. Counsel for the Commissioner sought to clarify that the weight placed on Carley's homelessness by DS Ingram was in the context of people arriving in the Northern Rivers area to get away from other people and live their own life, and that "it wasn't someone who just for the first time in their entire life became homeless".

However, there was simply no evidence to suggest that Carley had any recent history of sleeping on the streets prior to her going to Lismore in late October 2017. Accordingly, I find that Carley's recent homelessness placed her at risk.

(b) *Mental health issues:*

In explaining her risk assessment, DS Ingram noted the absence of recorded reports of self-harm or threats of self-harm for Carley, and that the most

recent mental health incident report for Carley was in 2004. She also stated that police would have had knowledge that Carley had been medically assessed in the mental health unit at Lismore Base Hospital and released without admission.

I accept that these facts, of themselves, were accurate. However, they must be viewed in light of the other evidence that was also available, or readily available, to police at the time.

Police were aware that Carley had no access to her regular methadone and anti-psychotic medication. Without that medication, Carley was likely to become psychotic and was a risk to herself and others in that state. Carley had a history of very disturbed psychotic behaviour when she did not take her medication. This was information that was readily available to police because it was known to Carley's parents who presented to the police on 5, 8 and 13 November 2017.

It was also information that was available from Mr Burgess and Dr Hudson, who had a long-standing therapeutic relationship with Carley and knew her history very well. Mr Burgess's contact details were provided to police on 5 November 2017. Dr Hudson's contact details were provided explicitly to police on 8 November 2017 but were available to police earlier; in that they were known to Carley's family who spoke to police on 5 November 2017. Neither Mr Burgess nor Dr Hudson were contacted by police.

The information that Carley had previously stabbed Mr Dervish in a psychotic episode was also available to police. Chris told Officer A about Mr Dervish during their first conversation on 21 November 2017. Mr Dervish was not interviewed until 31 July 2018. I accept the submission of counsel assisting that if police had properly engaged with Chris at an earlier stage, much more useful information about Carley and the level of risk would have been forthcoming.

(c) *Means of support:*

Finally, police were aware from 5 November 2017 that Carley had no ability to independently support herself, as her phone, wallet and clothes were found in Apex Park. This fact made Carley vulnerable and dependent on the good will of others. It also increased the chance she would engage in high risk activity like crime or seeking help from potentially predatory people.

168. Carley's disappearance activated a number of the risk factors identified in the pro forma risk assessment that was available at the time, namely: absence of stable accommodation options, recent mental health issues including delusions, dependence on medication, dependence on methadone, inability to support herself independently, past history of experiencing and participating in violence when psychotic and the grave concerns of those who knew her best.

169. In considering these risk factors, as well as the information known or readily available to police at the time, I find Carley was at, at least, a "medium risk". In making this

finding I am in no way critical of DS Ingram; it is simply a matter of my coming to a different conclusion on the evidence.

170. Detective Chief Inspector ("DCI") Glenn Browne, the head of the Missing Persons Registry, provided a statement addressing the 2020 MP SOPs and gave evidence at the second tranche of the inquest hearing. Mr Evenden, for the family, put a number of these risk factors to DCI Browne in evidence. While DCI Browne made clear that he was not assigning a risk rating as he was not aware of all of the information in this case, he stated that the features that Mr Evenden identified would lead him to a conclusion that Carley was at a medium risk. I accept the submission of counsel assisting that the remaining evidence in this case, being the complete coronial brief of evidence, does not point away from a finding of medium risk. In fact, the information would only confirm this level of risk and perhaps elevate it higher.

Compliance with the NSWPF MP SOPs

171. There should have been serious concern for Carley's welfare from 5 November 2017 on the basis of information that was known or readily available to police. However, I find that the police investigation failed to afford sufficient priority to Carley's case.

172. I also agree with and accept the submission made by counsel assisting, and supported by the family, that the missing persons investigation into Carley's disappearance, particularly in the period from 5 to 13 November 2017, failed to meet the objectives of the MP SOPs. I address each of these factors in turn below.

Promptly taking missing person report

173. As outlined at [102] above, a missing person report was promptly and thoroughly taken by SC Stewart on 8 November 2017. The focus of this issue therefore turned to the earlier presentation of Chris and Max to Byron Bay Police Station on 5 November 2017.

Was Carley reported missing on 5 November 2017?

174. The MP SOPs in force at the date of Carley's disappearance defined a "missing person" as "anyone who is reported missing to police, whose whereabouts are unknown, and there are fears for the safety or concern for the welfare of that person".

175. I find that Carley was reported missing to police by Chris and Max on 5 November 2017. Chris and Max conveyed unambiguously to SC Cartmill that Carley was unable to be located, that her family wished for her to be located, and that they had serious concerns for her safety. It was accepted by SC Cartmill, and was common ground between the parties at the second tranche of the hearing, that this in itself met the definition of a missing person report.

176. Rather, the central evidentiary dispute in relation the conversation on 5 November 2017 was whether Carley's parents specifically asked to report Carley missing. Chris and Max's evidence was that they very clearly asked for SC Cartmill to take a missing person report on that day and that, in fact, it was the focus of the conversation. When their account was put to SC Cartmill in evidence, he stated that he totally disagreed with the suggestion that Carley's parents asked him to take a missing person report.

177. There was additional circumstantial evidence before me to support the family's assertion that Chris asked to report Carley missing. This included:

(a) Chris's initial statement to the inquest, in which she stated that on 5 November 2017: "I spoke to a Policeman named, Jonathon. I realised that we hadn't officially reported Carley as missing when I had spoken with Tegan at Lismore so I asked if we could report her missing." I note that date of this statement, 5 December 2017, was proximate to the conversation in question.

(b) On 3 November 2017, Chris had a conversation with RN Kristen Burns following Carley's presentation to Lismore Community Mental Health the previous day. RN Burns recorded a note that "Christine is going to contact Lismore Police and report Carley as missing".

(c) Evidence also arose during the second tranche of the inquest that Chris received two calls and/or messages from SC Chaffey late in the evening of 4 November 2017 and early in the morning of 5 November 2017 advising that if Chris had serious concerns that she should report Carley as missing because at that moment, she was not being treated as a missing person.

178. Prior to the third tranche of the hearing, Mr Coffey, counsel for the Commissioner and SC Cartmill, prepared supplementary submissions that outlined, in effect, that the voicemail message left by SC Chaffey on 4 November 2017 was not received by Chris as the wrong telephone number had been used. Mr Coffey submitted that it was not open to me to make a finding that contact by police on 4 November 2017 was the trigger for Chris and Max's attendance at Byron Bay Police Station, and that the reference to the message from SC Chaffey on 4 November 2017 was not circumstantial evidence that would favour acceptance of Chris's evidence. This submission did not extend to the call early in the morning of 5 November 2017.

179. In light of my finding at [175] above that Carley was reported missing on 5 November 2017, it is not necessary for me to make a finding regarding the specific words used. Nevertheless, the combination of the evidence above leads me to the conclusion that Chris and Max asked to report Carley missing. I make this finding on the balance of probabilities, and without having regard to the message from SC Chaffey on 4 November 2017 that was likely not received by Chris.

180. This is not to say that SC Cartmill was negligent or that he heard the words spoken by Chris and decided to ignore them. Rather, I accept the submission of counsel assisting that the key problem with SC Cartmill's approach on 5 November 2017 was that he was so fixated on conveying to Carley's parents the boundaries of his power as a police officer – namely, that he had very limited power to schedule people – that he failed to listen to what Chris and Max actually wanted, which was to report Carley missing. Counsel for SC Cartmill agreed with this characterisation of events.

181. I find that SC Cartmill's determination to express a repeated frustration with his own job and its limits meant he ultimately made comments that were insensitive and dismissive to Carley's family. The fact that SC Cartmill accepted that this was wrong and apologised at the inquest cannot be diminished. It is a rare and valuable aspect of an inquest.

Should SC Cartmill have taken a missing person report?

182. Section 5.1 of the MP SOPs outlined that if the definition for a missing person was met, then a missing person report must be taken. There was no minimum time to wait before a report could be accepted.

183. As I have found at [175] above, Carley met the definition of a missing person when Chris and Max raised their concerns to SC Cartmill on 5 November 2017. Accordingly, I find that SC Cartmill should have taken a missing person report that day.

184. SC Cartmill conceded that it was within his responsibility to have created a missing person report on 5 November 2017 and that he failed to do so. He also accepted in hindsight that creating a missing person report alongside the concern for welfare event report would have been the most effective way of handling Carley's situation (although at the time he felt that he was responding appropriately to their concerns).

185. Similarly, DCI Browne gave evidence that it would have been appropriate for a missing person report to have been taken on 5 November 2017.

186. SC Cartmill did maintain for some time that it did not make much practical difference to the investigative trajectory whether or not he took a missing person report on 5 November 2017, and that his COPS event replicated most of the recommended steps in the MP SOPs. Counsel assisting took SC Cartmill through the recommended investigative steps in the MP SOPs during the inquest. SC Cartmill rightly conceded that a number of those steps were not taken, including:

    (a) complete a risk assessment, record the outcome and respond accordingly;

    (b) dispatch an officer to the scene to conduct a preliminary investigation;

    (c) record the details of previous incident reports relating to Carley in the event narrative;

    (d) obtain the names, addresses and telephone numbers of any friends or associates, except for Mr Burgess, and determine when each last saw the missing person;

    (e) conduct a search of where the incident took place, including all surrounding areas and vehicles;

    (f) seal and protect the scene and area of the missing person's home;

    (g) evaluate the contents of her room or residence;

    (h) secure medical and dental records; and

    (i) consider using the media to seek information from the public and advise the Missing Persons Registry.

187. Time is of the essence in missing persons investigations and four days can make a significant difference in locating someone safely. Proper inquiries on 5 November 2017 would have revealed that Carley had spent months living with her parents before her mental health deteriorated, that her belongings were found by a resident in Apex Park, and that a bus receipt from Lismore to Mullumbimby and a receipt from Mullumbimby

IGA on 3 November 2017 were found with Carley's belongings. If police had spoken to Mr Dervish they would also have been aware that Carley had travelled by bus from Lismore to Mullumbimby on 3 November 2017.

188. It was not submitted by any parties that undertaking the investigative steps outlined above would necessarily have resulted in Carley being found. However, the failure to take a missing person report and undertake these initial investigative steps meant that there was a lost opportunity to find Carley.

189. SC Cartmill's narrative report in the COPS event entry on 5 November 2017 also omitted potentially important information relevant to a missing person risk assessment, including when and where Carley was last seen alive, the last person who saw her and the people she might stay overnight with or contact. While SC Cartmill stated that he was focused on Carley's mental health risk factors, the narrative report did not mention that Carley was schizophrenic, her recent attendances at Lismore Base Hospital and Lismore Community Mental Health, that it was likely she was not taking her prescribed anti-psychotic medication and that she had not taken her methadone which tended to suppress psychotic symptoms.

190. While all of these matters would have been relevant to the risk assessment supposed to be conducted further up the police chain of command, there is simply no evidence that a risk assessment was conducted by any police officer at any stage during this investigation. I discuss this issue below.

Risk assessment

191. The MP SOPs mandate that a risk assessment must be conducted on receiving a missing person report. It also requires that the risk rating for a missing person be continually reviewed and re-evaluated throughout the course of the investigation, and the level of police response be adjusted accordingly.

192. The MP SOPs do not explicitly mandate the use of the pro forma risk assessment matrix and questionnaire in annexed to the MP SOPs but require the outcome of the risk assessment to be recorded. The rationale for recording the risk assessment in writing is obvious: it allows for it to be vetted and reviewed by senior officers to ensure that all relevant factors have been considered and that the police response is commensurate to the risk rating. It can also be reviewed by other officers in the event that the officer who conducted the initial assessment is unavailable and enables the result to be easily communicated to other commands and units as necessary (for example, State Crime Command or the Missing Persons Unit, as it was then known).

193. No risk assessments were recorded for Carley. The failure of police to conduct a formal documented risk assessment during the initial stages of the investigation was contrary to the mandatory requirement in the MP SOPs. This was properly conceded by SC Cartmill and was not disputed by the Commissioner.

Contact with Carley's family

194. Communicating with family regularly and compassionately is an explicit goal of the MP SOPs, and one that speaks highly of NSWPF. The MP SOPs identify that it is important that police show sensitivity and undertaking to the involved family and maintain regular contact throughout the investigation, even when there is no new information.

195. I find that this goal was manifestly not met in Carley's case. Minimal contact was initiated by police with Max and Chris between 2–13 November 2017, and no conversation took place with the allocated investigator Officer A until 21 November 2017 (more than two weeks after Max and Chris had tried to report Carley missing and almost three weeks after they first approached the police with their concerns).

196. Prior to the second tranche of the hearing, the Commissioner provided additional evidence of attempts made by police to contact Chris late at night on 4 November 2017 and in the early hours of 5 November 2017 and 7 November 2017. The details of these attempts are outlined at [94]–[95] and [101] above. As DSC Nowland very properly noted in his evidence at the second tranche of the hearing, it is not surprising that no contact was made with Chris when she was called by police in the early hours of the morning or very late at night. I do not accept that this additional evidence from the Commissioner shows, in any way, that contact with the family was diligently pursued or maintained.

197. I also find that Carley's family continually had to initiate contact with police. Their evidence was that this intensified their grief and made them feel worried and alone. Carley's death was the most awful vindication of their fears and they should not have had to endure their daughter's disappearance without support and assistance.

198. Just as importantly, and separate to any goal to maintain contact with the family, Carley's family had information relevant to the investigation. DCI Browne gave evidence at the inquest that the family is a vital investigative resource. I find that the fact that they weren't used in this case was a deficiency in the investigation. Chris and Max knew of many of Carley's friends and associates including Mr Dervish, Anthony "Tony" Joubert, and Ms Doyle. The family were also aware of Carley's close relationship with Mr Burgess and Dr Hudson, who were experienced clinicians and knew Carley well. I accept that police contacting these friends and associates of Carley's may not have changed the course of the investigation because those friends and associates did speak to Chris and Max. However, I find it inexcusable that Carley's family effectively had to run their own investigation.

199. DCI Browne gave evidence that he would expect that contact with the family under the 2020 MP SOPs would be made more frequently than in Carley's matter. He could not see a situation in which it would be necessary for the family to have to follow up with police as to the status of the investigation and regularly need to request to be informed about progress.

Regular investigative activity

200. The MP SOPs require that police continue with enquiries and maintain regular investigative activity to pursue resolution of the missing person matter. The MP SOPs include a 'Initial Response Checklist' ("Checklist") which provide NSWPF with a guide for investigating missing persons cases. The MP SOPs outline that the Checklist "is meant to offer a framework of actions, considerations and activities that can support competent, productive and successful missing person investigations".

201. The investigative activity of NSWPF regarding Carley in the period from 2–29 November 2017 are set out at [92]–[114] above and discussed further below.

Investigative steps from 2–13 November 2017

202. I find that minimal active investigative steps were taken by police to locate Carley between 2 November 2017, when Carley's parents first expressed concern to the police, and 13 November 2017.

203. There was little evidence before me of properly documented investigative steps taken during this period. However, I find, on the balance of probabilities, that the following steps were taken:

 (a) officers generated CAD messages, which were broadcast via VKG on 2, 3, 4 and 5 November 2017;

 (b) SC Chaffey made a "patrol of the area" (likely Apex Park) on 4 November 2017;

 (c) SC Chaffey and Sergeant Thierjung attempted to contact Chris on 4, 5 and 7 November 2017;

 (d) a photo of Carley was obtained by SC Cartmill on 5 November 2017 and circulated to police stations in the region; and

 (e) Sergeant Marr made enquiries with Lismore Base Hospital as to whether Carley was an inpatient on 9 November 2017.

204. The statement of DS Ingram also set out the results of her review of the actions of NSWPF officers attached to the Richmond PD during this period. These included:

 (a) On 8 November 2017, Sergeant Marr accessed Carley's details and enlarged a photograph of Carley. A reverse audit of Carley's CNI also showed that Sergeant Marr conducted a number of enquiries into Carley's CNI around shift changeover.

 (b) Carley was listed as a missing person in the Richmond PD supervisor changeover logs for 10–11 November 2017 (supervisor logs for 8–9 November 2017 were not saved and could not be reviewed).

 (c) At least six other officers attached to the Richmond PD accessed Carley's CNI between 8–10 November 2017.

205. I am appreciative of DS Ingram's review and the Commissioner's efforts to assist the inquest. However, the fact that Carley's records and photos were viewed on those days by different officers and/or used in handovers or daily taskings do not provide any evidentiary basis to infer that any other investigative steps were taken by police. Further, if such steps were conducted, they were not documented.

206. With the exception of the patrol of Apex Park on 4 November 2017, no officer went looking for Carley on foot or by car between 5–13 November 2017. In addition, there was no proper canvas of Apex Park where Carley's belongings had been found. No officers spoke to any of Carley's friends nor to Mr Dervish, who was the last known person to see Carley. Further, while Sergeant Marr made an enquiry with the administrative department of Lismore Base Hospital, no officer interviewed Carley's treating doctors, counsellors or methadone providers.

207. Despite explicit recommendations in the Checklist, there was no request for bank records or Medicare records. Most critically, there was no social media campaign or public plea for assistance and there was no request for any CCTV footage in Mullumbimby, particularly the IGA supermarket which Carley may have visited on during this period.

208. I accept the submission of counsel assisting that the following locations could have been visited during this period:

(a) Carley's home in Myocum;

(b) The area surrounding Apex Park and the disused railway platform;

(c) IGA supermarket in Mullumbimby (where CCTV could have been requested);

(d) LiveLife Pharmacy in Byron Bay, where Carley collected her methadone (which had CCTV footage); and

(e) The Tony Carsburg Holden dealership (within 100 metres of Apex Park, and had CCTV).

209. CCTV from the Lismore bus station and the bus from Lismore and Mullumbimby on 3 November 2017 could have been obtained, and the bus driver interviewed. Police could have taken a statement from Janice Rolley, who found Carley's belongings in Apex Park, and canvassed of the small residential area surrounding Apex Park (not just foot patrols but door knocking of houses and an interview with the security guard who thought he saw Carley).

210. Police could also have discovered from Max and Chris that Carley had been obsessive about the safety of her sons and contacting them constantly. There was no attempt to obtain call records to see if Carley had contacted her sons and no approach to Mr Williams (who was caring for Carley's youngest son) until the case was allocated to Officer A on 14 November 2017. Mr Williams was ultimately never interviewed.

211. I find that the absence of investigative steps and the absence of documentation between 2–13 November 2017 were wholly unsatisfactory. Counsel assisting described this phase of the investigation as grossly inadequate and I agree.

Investigative steps from 14–29 November 2017

212. From 14–19 November 2017, some investigative steps were taken by police (see at [107]–[114] above). However, I find that these steps were too little, too late.

213. From 14 November 2017, Officer A began investigating Carley's disappearance. On that day he attended Federation Bridge, tried to contact Mr Williams and approached the Mullumbimby Community Centre. I find that these steps should have occurred much earlier.

214. It is also clear from the COPS entry on 13 November 2017 that Officer A was aware that Carley had serious mental health issues, that her parents were extremely concerned for her welfare and that Carley was not in contact with her friends. This knowledge made appropriate more action than regular local patrols. In particular, I find that appropriate steps would have included:

(a) a canvas of Apex Park, speaking to Ms Rolley and the security guard;

(b) obtaining CCTV;

(c) obtaining call records;

(d) keeping in contact with Chris and Max and attending their house where Carley had been staying;

(e) contacting doctors at Lismore Base Hospital, RN Joblin from Lismore Mental Health Unit, Dr Hudson and Mr Burgess;

(f) speaking more promptly to local business owners especially the IGA supermarket in Mullumbimby;

(g) obtaining a criminal history from COPS;

(h) more promptly interviewing Mr Dervish;

(i) more prompt proof of life checks with banks, Medicare, Centrelink; and

(j) spearheading a local media campaign.

215. The failure to conduct a public media and social media campaign was also notable in this case. DCI Browne explained that media and social campaigns are an important feature of most missing persons investigations in order to publicise the disappearance, distribute information about the missing person and seek further information from the public. I find that media and social media should have been a central and crucial feature of the investigation.

216. The weight of evidence suggests that Carley was alive for days and possibly weeks in November 2017. However, the only evidence of a local media campaign before the inquest was the Northern Star newspaper article published online on 17 November 2017. The apparent lack of intensity in the police investigation led to an assumption among Carley's associates and other residents of Mullumbimby that she must have "turned up". There is a real chance that Mullumbimby residents, like Ms Bell and Mr and Mrs Morgan, would have come forward to police about their sightings earlier if they knew Carley remained missing and that there were grave concerns for her welfare.

217. Ms Bell saw Carley on or about 23 November 2017 but wasn't contacted by police until DSC Nowland took a statement from her on 19 January 2018. If Ms Bell had been aware of those concerns and immediately contacted police, at the very least, CCTV footage could have been requested from the IGA supermarket. The Morgans saw also Carley in around early November 2017 at the IGA supermarket but didn't come forward until Coroner Stafford's plea for information in December 2019. The lack of any public campaign for information meant a real opportunity to locate Carley alive was lost.

Obtaining of CCTV footage

218. All of the sightings of Carley in early November 2017 were in locations which were covered by CCTV cameras. CCTV footage was available until 10 November 2017. If CCTV footage had received appropriate focus and priority from police it was possible to obtain footage from:

(a) Lismore Community Health Centre;

(b) Lismore Base Hospital;

(c) Lismore Police Station;

(d) the bus from Lismore to Mullumbimby;

(e) the Lismore bus station (which was obtained by DSC Nowland);

(f) the Mullumbimby IGA;

(g) the Tony Carsburg Holden dealership where Ms Henson thought she saw Carley; and

(h) the RSL in Mullumbimby near where Ms Henson thought she saw Carley.

219. I note that DSC Nowland made it a focus of the coronial investigation to obtain this CCTV footage, and where he did – such as from the Lismore bus station – it was extremely valuable. However, in most cases, when DSC Nowland made those inquiries the CCTV footage had been overwritten because the request was made too late. To be clear, this was not a failure of DSC Nowland but of the earlier investigation.

220. The forensic significance of CCTV footage is not always obvious at the time when it is available. For this reason, best practice would be to identify areas where CCTV may be available (including the last known location of the missing person) and preserve the footage even if the footage is not viewed until operational demands allow it. I discuss this further below in relation to recommendations.

Findings in relation to the NSWPF investigation

221. I find that the NSWPF investigation into Carley's disappearance was seriously inadequate. In making this finding I note that the inadequacies in the investigation were not due to the MP SOPs in existence at the time. In fact, the protocol was excellent: it was clear, easy to follow and contained practical tips, risk assessment templates and numbers for help.

222. There was also far from regular investigative activity. The really grave failing in the investigation was between 9–14 November 2017. With the exception of Sergeant Marr contacting Lismore Base Hospital and SC Stirling receiving a photo from Carley's parents, no investigative steps were taken.

223. In making these findings, I do not suggest that responsibility for the investigative deficiencies rests entirely, or even predominantly, on either SC Cartmill or Officer A. SC Cartmill found himself in the position where he was the only police officer involved in the initial investigation who gave evidence at the inquest. I agree with counsel assisting's submission that SC Cartmill's evidence showed courage in many respects. He was open and responsive, appeared to do his best to tell the truth, apologised to Carley's family for deficiencies in his approach and made a number of reasonable concessions. I also accept the submission from SC Cartmill's counsel that SC Cartmill's evidence before the inquest demonstrated how seriously he had reflected on the matter and was willing to assist the Court.

224. In addition, the failings of the investigation were also not the sole responsibility of Officer A. He took a number of steps once allocated the matter, including looking for Carley and speaking to people who knew her. However, without hearing evidence from Officer A or Sergeant Marr it is difficult to know if the investigation was hampered by a lack of experience, lack of awareness of resources, or lack of motivation. I consider that there was clearly a systemic failure to provide adequate supervision and assistance to Officer A.

225. In making this finding I note my disappointment that no steps were taken by the Commissioner to formally apologise or explain to Carley's family what went wrong. I am grateful for the individual comments of SC Cartmill, Inspector Grant Erikson and DCI Browne at the inquest ,who did acknowledge and accept that there were failings in this investigation. Such acknowledgements are proper, responsible and welcome and were of value to this inquiry.

Recommendations relating to the police investigation

226. In light of these findings, it is appropriate to consider if any recommendations ought to be made to the Commissioner.

227. I heard evidence about a number of new key features in the 2020 MP SOPs, including the introduction of:

(a) a comprehensive missing persons checklist, which includes new investigative steps such as obtaining relevant CCTV footage, considering an appeal for public help and circulating details of the missing person to relevant organisations;

(b) specialised missing person coordinators in each police area command ("PAC") and PD in NSW;

(c) systemic levels of supervision, from a local level within the PAC or PD to ongoing supervision by the Mission Persons Registry;

(d) a mandatory risk assessment within the creation of a COPS event for a missing person report, and then continuous risk assessment each time new information is added;

(e) timeframes to ensure that regular and appropriate activity is taking place at all times as appropriate to the risk;

(f) at least weekly contact with the family and access to counselling; and

(g) staged reviews by the Missing Persons Registry at 14 days, three months, six months and nine months.

228. These revisions are thoughtful and impressive. They are also demonstrative of a proactive and intense commitment within NSWPF to improving investigations into missing persons.

229. I am optimistic, after DCI Browne's evidence, that the failures in Carley's case won't be repeated in the future. However, I nevertheless consider that it is appropriate to make recommendations in relation to two specific aspects of the 2020 MP SOPs.

Definition of missing person

230. The 2020 MP SOPs define a missing person as:

> "A missing person is anyone who is reported missing to police, whose whereabouts are unknown, and there are fears for the safety or concern for the welfare of that person. This includes anyone missing from any institution, excluding escapees. For Missing Person reports to be taken, there must be a genuine concern held for the safety or wellbeing of the person."

231. Counsel assisting asked DCI Browne whether the definition required a person to say that they were reporting a person as missing, or whether it would suffice if someone made a report that they could not find a person and were concerned for his or her welfare. DCI Browne agreed that both instances would fit within the definition.

232. When questioned about the necessity of including the phrase "a missing person is anyone who is reported missing to police" in the definition, DCI Browne stated that the particular definition used is one that all law enforcement jurisdictions in Australia and New Zealand have agreed on.

233. Counsel assisting proposed that I recommend the Commissioner consider adding, to the definition, additional wording that made clear that no particular form of words need to be used by an informant. Rather, if it is communicated to police that a person cannot be located and there are concerns for their safety and welfare, that person is a missing person.

234. DCI Browne did not consider that this additional clarification of the definition would cause confusion or undermine the agreed upon definition used.

Collection of CCTV footage

235. Counsel assisting also proposed a recommendation that the 2020 MP SOPs be amended to:

    (a) require that police attempt to identify and obtain the last known CCTV footage of a person as a matter of course early in a missing person investigation, namely within 48 hours;

    (b) make clear that CCTV footage is a valuable resource in a missing person investigation, even if its forensic significance is not immediately apparent and/or there may not be human resources to view it immediately; and

    (c) include "consider obtaining CCTV footage" in the mandatory minimum timeframes for investigative steps, ideally within 48 hours.

236. DCI Browne sought to acknowledge just how difficult and resource intensive it is just to canvas and obtain CCTV footage, without even viewing it. However, he did not see any practical impediment to including consideration of obtaining relevant CCTV footage within the mandatory minimum timeframes, and stated that this would be his expectation anyway.

237. DCI Browne accepted that because obtaining CCTV footage is a time consuming and resource intensive task, and because the forensic significance is not always apparent, there can be an understandable reaction to focus on other things and to not give it the

priority that it might need. I accept the submission of counsel assisting that there needs to be prompting within the mandatory timeframes to ensure that it is considered and to encourage police to get that material notwithstanding those difficulties. For example, in Carley's case, the last known footage from Lismore bus station may have seemed uncontroversial or unnecessary at the time, but became very valuable later on.

238. Accordingly, I consider it appropriate for the 2020 MP SOPs to acknowledge and accept this difficulty. While obtaining CCTV footage from a number of local businesses is not a panacea in a missing person investigation, it is something which is so forensically significant that there needs to be a determination to get over those resource issues.

The medical care provided at Lismore Base Hospital

239. I do not find any causal connection between the medical care provided to Carley at Lismore Base Hospital on 1–2 November 2017 and her death. However, the care Carley received at Lismore Base Hospital was a missed opportunity to help Carley and to change the course of an increasingly downward trajectory.

240. Carley presented to Lismore Base Hospital on 1 November 2017 experiencing an acute psychotic episode relating to her schizophrenia. Unfortunately her presenting symptoms were taken as evidence of acute intoxication by the mental health team, and she was not considered suitable for admission to the mental health unit.

241. Overall, the themes which emerged from this phase of the inquest were succinctly stated by expert psychiatrist Dr Ellis:

> "I don't think it's a matter of giving way. I think it's a matter of giving care … it's seeing the hospital as a whole entity, not as little fiefdoms, and that … the admission could have occurred in either … perhaps if you had a - if the emergency department doctor was able to reassure the psychiatrist that they're physically well enough that they don't require night time physical observation monitoring, then they - that might reassure the psychiatrist that they can safely admit them to their ward. Likewise, if the psychiatrist can adequately reassure the emergency department doctor that there was definitely going to be an assessment promptly in the morning, and will - or maybe there's another ward that accepts these patients … I think there are potentially, you know, ways around, without anybody giving way."

242. In making my findings, I remain grateful for the extensive evidence given by the treating clinicians. They are competent and dedicated professionals who did their best to give thoughtful and considered evidence to the inquest. The concessions that were made about aspects of Carley's care, and the sincere regret expressed that they felt about that, are very much welcomed.

243. The LHD also conceded a number of matters and gave evidence of its commitment to continue to put the patient at the centre of decision making.

Assessment and diagnosis of Carley's condition

What was Carley's condition on 1 November 2017?

244. I accept the evidence of Dr Ellis that Carley was experiencing an acute psychotic episode relating to her schizophrenia when she presented to Lismore Base Hospital on

1 November 2017. I also agree with Dr Ellis's assessment that Carley's condition had manifested in psychotic behaviour for some days prior when she was at the Lismore Courthouse.

245. Dr Ellis's conclusion is supported by the facts of Carley ceasing her regular olanzapine, her reduced intake of methadone, her increasingly paranoid and disordered behaviour, and her reduced motivation. In addition, everyone who came into contact with Carley from 28 October 2017 was worried about her mental health. Dr Ellis also noted supporting evidence in the NSW Ambulance records, the triage notes from Lismore Base Hospital, and the records of Dr Shively and Dr Byrne.

246. Finally, in making this finding, I have the benefit of the comprehensive assessment and diagnosis by Dr Eagle in May 2016, which confirms that Carley did suffer from the condition of schizophrenia. As Carley's family submitted, it is unfortunate that this crucial piece of information was not available to the clinicians dealing with Carley at the time of her presentation to Lismore Base Hospital. I discuss this issue later in relation to recommendations.

Was Carley acutely intoxicated on 1 November 2017?

247. I am satisfied that Carley was not acutely intoxicated on 1 November 2017.

248. While I am unable to definitively rule out any drug consumption by Carley, there is no evidence before me to indicate that Carley consumed any drugs after 27 October 2017, including the following:

  (a) No one saw Carley take drugs. Carley was seen regularly outside the Lismore Courthouse by staff members, and no one there observed her consuming drugs.

  (b) There were no drugs or drug paraphernalia in Carley's possessions.

  (c) There were no indicators of acute intoxication: Carley didn't smell of drugs, she showed no signs of intravenous use and she had no physiological signs such as sweating, slurred speech or changes to her heartrate, blood pressure or pupils. Dr Pullen, a highly experienced emergency room clinician, gave evidence that he was looking for those signs when he assessed Carley but did not see them, nor did Dr Shively during his initial assessment.

249. Dr Ellis gave evidence at the hearing that:

  (a) Carley's schizophrenia was a better explanation for the totality of her behaviour at Lismore Base Hospital, and her behaviour in her days beforehand.

  (b) Acute intoxication at the time of Dr Byrne's assessment at 6.00pm on 1 November 2017 (being five to six hours after Carley was brought to Lismore Base Hospital via ambulance) required both recent and heavy consumption of drugs, and one would expect to see physiological evidence of such consumption.

  (c) Carley did not appear to display any or many of the typical features of methamphetamine or cannabis intoxication.

250. I also place some weight on the fact of Carley's strong denial to Dr Donaghy, Dr Shively, and Dr Byrne that she had not consumed methamphetamines. While, of course, denial of drug use cannot be taken at face value, it is consistent with the other evidence before me which points away from acute intoxication.

251. Finally, I also consider relevant, but place less weight on, the fact that Carley knew that Mr Dervish had access illicit substances, and she expressed no interest in any drugs like methamphetamine when she stayed with him on 2 November 2017.

252. Having considered the above evidence, I find that Carley was not acutely intoxicated on 1 November 2017.

Carley's diagnosis in the Emergency Department

253. Carley was showing signs of psychosis when she presented to the Emergency Department of Lismore Base Hospital on 1 November 2017. I accept, as stated by Dr Ellis, that this may have been exacerbated by cannabis consumption, but that it was not likely to be caused by it.

254. At around 2.36pm on 1 November 2017, Dr Shively assessed Carley as medically well. Dr Shively's note from his assessment recorded that Carley:

    (a) "admits to smoking marijuana recently, denies other illicits"; and

    (b) "recently re-started smoking marijuana".

255. Dr Shively had access to the FirstNet system, which included the Byron Community Health drug and alcohol and mental health notes for Carley. There was evidence before me that the drug and alcohol notes on the FirstNet system included a progress note recorded by Dr Donaghy on 26 October 2017, which included the following:

> "recent substance use in the context court order expiring
> Carley maintains it was one episode of THC use, followed by a week of paranoia
> denies other use, and in particular amphetamine use"

256. Dr Shively could not recall whether Carley had told him about her use of marijuana or if he had taken it from her drug and alcohol notes on the FirstNet system.

257. Dr Shively fairly accepted in his evidence that his progress notes were not specific in regard to the meaning of "recently", and that it would have been preferable if he had recorded when Carley had last consumed marijuana and the source of the statement that she had recently consumed marijuana.

258. I do not criticise Dr Shively's conduct in this regard and note the evidence given at the inquest by Dr Ellis and Deidre Robinson, Director of Mental Health and Alcohol and Other Drugs Services at the Northern NSW Local Health District ("NNSW LHD"), about the barriers to good note keeping in the Emergency Department. Dr Shively's actions in looking at the notes on the FirstNet system and taking a careful assessment were commendable. Further, it was consistent with the evidence of the witnesses at Lismore Base Hospital that they did review these notes and take them into account.

259. However, Ms Robinson also noted the importance of good clear clinical documentation, and that Carley's case has illuminated "that clinical documentation is certainly an

emphasis that needs to happen across disciplines". Ms Robinson accepted the evidence of Dr Ellis that the purpose of notes is to allow a practitioner with no background whatsoever to come in and inherit a file, and that is why it is important to record things like date, time and source of information. She noted that this is something that has been reinforced and could continue to be reinforced by the LHD.

260. A lack of precision in recording matters like the time of Carley's drug consumption and the source of this information that Carley had recently consumed drugs creates a real risk of anchoring an inaccuracy. If Dr Shively was referring to the note of Dr Donaghy on 26 October 2017, then Carley may not have "recently" consumed marijuana. There is evidence before me that Carley had lost track of time. For example, after Carley was assessed by Dr Pullen on 1 November 2017, he recorded a progress note which included the following:

> "Patient reviewed. Has been at home and caught a taxi today to come and see a friend. Was not able to see her friend. Strongly denies having taken any street drugs tonight."

261. It is now clear that this was an account of Carley's day on 29 October 2017, not an account of her day on 1 November 2017, because she was taken to hospital after a few days at Lismore Courthouse. Accordingly, Carley may have said that she "recently" consumed marijuana, not knowing that this had in fact been sometime, perhaps days, earlier.

Carley's diagnosis by the Mental Health Services

262. Dr Byrne's progress note on 1 November 2017 recorded Carley's diagnosis as "acute intoxication/withdrawal". I find that this diagnosis was not an accurate assessment of Carley's presentation. I also find that it was premature without, at least, a urine screen to test for substances and a mental health assessment during which Carley was able to engage.

263. Dr Byrne agreed that he did not see any signs of drug use by Carley when he assessed her at around 6.00pm on 1 November 2017. He could not recall asking Carley whether she had taken cannabis or methamphetamines. Dr Byrne stated that, rather, his diagnosis was based on Carley's history and clinical presentation, including her history of drug use prior to 2017. He considered that because Carley had a history of drug use, that it was a reasonable possibility that her presentation was affected by drugs. I make no criticism of the fact that Dr Byrne spent time reviewing Carley's history; in fact, it is to be commended. I also appreciate that Dr Byrne had difficulties in engaging with Carley and, as a result, was unable to conduct what he considered to be a thorough and complete mental health assessment.

264. As part of his assessment of Carley, Dr Byrne also spoke to Chris on the telephone. As noted above at [62], Dr Byrne's notes recorded that Chris reported that ice was Carley's "substance of choice in Lismore". This was disputed by the family. On their behalf, Mr Evenden submitted that Chris never used the words "drug of choice" and that these were not words that were in her vocabulary in terms of describing any ice use by Carley. I do not consider it necessary to make any findings as to what was said between Dr Byrne and Chris during their telephone conversation. It is clear that Dr Byrne had formed his views about Carley's potential intoxication before speaking with Chris.

265. Dr Byrne reiterated his diagnosis of acute intoxication during his telephone conversation with Dr Wardell. Unfortunately, I do not know with any precision the content of the conversation between Dr Wardell and Dr Byrne, because it wasn't documented by Dr Byrne. I find that such documentation should have occurred, as both Dr Wardell and Dr Byrne readily accepted.

266. Dr Byrne gave evidence that he told Dr Wardell that Carley was likely affected by drugs and did not present with "classic positive psychotic symptoms". Counsel for Dr Wardell emphasised that, as the on-call specialist, Dr Wardell could not physically examine Carley nor did he have access to Carley's electronic medical records, and so was ultimately reliant on what Dr Byrne told him. While I accept the difficulties of Dr Wardell's position and the fact that he had a good working relationship with Dr Byrne and trusted his clinical judgment, I also find that, as the on-call specialist, it was incumbent on Dr Wardell to interrogate Dr Byrne's diagnosis and the basis for it. Dr Wardell accepted in evidence that he was Dr Byrne's supervisor and that one of his functions was to prevent Dr Byrne falling into any "traps for young players".

267. Dr Ellis was of the view that there was enough information for Dr Byrne to make an accurate assessment of the presenting cause. He considered that Dr Byrne's assessment was simplistic and lacked specialist curiosity. Dr Ellis noted that there was no any adequate explanation formulated for why Carley was sleeping on the Lismore Courthouse steps, no attempt to ascertain Carley's current beliefs about past recorded delusions, and no examination of any of Carley's ancillary symptoms of schizophrenia including her disorganised thought process and behaviour. Further, Dr Byrne's assessment also failed to interrogate contradictory information, including the length of time that Carley had been in the Emergency Department before the assessment and the lack of physical signs of drug use.

268. I do not consider it necessary to determine in this case how much hindsight bias, which all parties accepted was inevitable, affects a fair assessment of Dr Byrne. Dr Byrne was at a considerable disadvantage to Dr Ellis in making an accurate diagnosis of Carley. He is a more junior and less experienced doctor. At the time of his assessment of Carley, Dr Byrne:

(a) had much less information at his disposal, including the benefit of Dr Eagle's diagnosis;

(b) had challenges in conducting a thorough assessment; and

(c) didn't have the luxury of the time that Dr Ellis had.

269. In addition, Dr Byrne's diagnosis was expressed as final. But, in reality, it was provisional. Dr Byrne had only spent 10 to 15 minutes with Carley, and was unable to complete a proper mental health assessment. Dr Byrne expected that there would be an opportunity to review the results of a urine screen, to speak to Carley in the morning after she had slept and received methadone, and to conduct a more thorough assessment. Dr Byrne's assumption and expectation that Carley would stay in the Emergency Department, which was an assumption based on past practice, is likely to have meant that Dr Byrne did not place as much emphasis as he should have on the possibility of an alternative explanation for Carley's presentation like psychosis and may not have made clear to Dr Wardell just how difficult his assessment of Carley had been.

Nevertheless, while drug use by Carley was possible after a significant time lapse, it was unusual and less likely than psychosis. For those reasons, the time lapse and that period of observation in the Emergency Department of over five hours should have been a point of discussion between Dr Wardell and Dr Byrne.

270. I find that Dr Byrne was a diligent and caring clinician. However, his diagnosis, as recorded in the immediate action plan and reported to Dr Wardell, was not an accurate assessment of Carley's condition as at 6.00pm on 1 November 2017. While Dr Byrne gave evidence of the more considered elements of his diagnosis, these were not, and should have been, recorded in the immediate action plan. It was incumbent on Dr Byrne to know this.

Mental health services' treatment plan for Carley

271. Dr Ellis considered that Dr Byrne's intended plan was reasonable and appropriate. That is, that Carley would stay overnight in the Emergency Department, sleep, have a urine screen, and receive methadone and a more thorough mental health assessment in the morning.

272. Dr Byrne's counsel submitted fairly that it "can only be regretted that the plan wasn't able to be carried out". However, I find that the reason for this was in large part due to the way that the immediate action plan recorded in Dr Byrne's progress note was expressed. The immediate action plan stated:

> "If [Carley] remains in Emergency Department, mental health would be happy to review again in the morning, if not she will be followed up in the Community".

273. Dr Byrne and Dr Wardell gave evidence that this choice of words had been chosen with care, recommended by Dr Wardell, to ensure that the Emergency Department specialists were not offended by the notion that it wouldn't be their decision to keep Carley in the Emergency Department. Dr Wardell stated that he felt it was his place to try to lessen any adverse impact on Dr Byrne by modifying what he wrote to ensure that he did not cause any unintended offence.

274. Regrettably, this well-meaning motivation resulted in a vague and ambiguous recorded plan. It was a missed opportunity to say clearly in writing what the mental health team's clinical recommendation actually was; namely, for Carley to remain in the Emergency Department, sleep, get dosed with methadone and be further assessed by a mental health clinician in the morning. As Dr Ellis stated in evidence, documenting a treatment plan that someone else is going to follow needs to be clear, definitive and unambiguous about what is to happen with the patient. The driving consideration cannot be to avoid offence: "clarity is the most important thing and that's more likely to achieve a good patient outcome, which is the goal of everybody in a health service".

275. It was common ground between the parties that neither Dr Byrne nor Dr Wardell said to Dr Pullen that the mental health team recommended that Carley stay overnight. While Dr Byrne thought he made it clear to Dr Pullen that he didn't consider that Carley was ready to be discharged, he couldn't recall specifically what he said. He accepted that if given another chance, he would have put it much more clearly to Dr Pullen.

276. Both Dr Byrne and Dr Wardell accepted, with hindsight, that their advocacy was not as effective as it could have been. At the inquest, they expressed sincere regret for not

advocating more forcefully for Carley to stay in the Emergency Department and appeared genuinely upset about the fact that they had not done so.

277. I accept the submission of counsel assisting that both Dr Wardell and Dr Byrne were impressive witnesses who gave evidence for a long time and who seemed to be doing their best to be both truthful and helpful. This Court relies upon people reflecting and accepting mistakes, and Dr Wardell and Dr Byrne should be commended for doing that.

Communication between Departments about Carley

278. I heard extensive evidence at the inquest of conversations between the Emergency Department and Mental Health Services. Three conversations were focused on, namely:

    (a) a conversation between Dr Byrne and Dr Wardell at a time prior to 8.39pm;

    (b) a conversation between Dr Byrne and Dr Pullen at around 9.00pm; and

    (c) a conversation between Dr Wardell and Dr Pullen at a time prior to 9.26pm.

279. All parties accepted that the communication between the services was deficient and inadequately recorded, and that the failure in communication meant that Carley's needs were not met.

Conversation between Dr Byrne and Dr Wardell

280. I have set out my findings in relation to the first conversation between Dr Byrne and Dr Wardell above at [265]–[266].

Conversation between Dr Byrne and Dr Pullen

281. As outlined above at [67], Dr Byrne and Dr Pullen had an in-person conversation about Carley following Dr Byrne's telephone conversation with Dr Wardell. No written records were made by either doctor as to this conversation, which I again find should have occurred, especially in light of the doctors' differing recollections of what transpired during the conversation.

282. Both Dr Byrne and Dr Pullen agreed that, during the conversation, Dr Byrne suggested that Carley was likely acutely confused due to drug intoxication but did not currently demonstrate psychotic symptoms.

283. Dr Pullen gave evidence that Dr Byrne had conveyed that he had difficulty in conducting the mental health assessment of Carley, but did not convey in a straightforward manner that he hadn't been able to do a proper mental health assessment and that he wanted Carley to stay in the Emergency Department until one could be done. Dr Byrne's evidence was that he had made an assumption that Carley would stay overnight in the Emergency Department; a practice that he says was fairly common and standard at the time. He accepted that another option would have been to clearly say to Dr Pullen that he:

    (a) hadn't had an opportunity to do a proper assessment; and

    (b) needed time to get the results of the urine screen and let any delirium subside so that he could reassess Carley.

284. Dr Byrne thought that this was what he had said to Dr Pullen, but that he had said it "far less eloquently". Dr Byrne stated that if he was given another chance, he would hope to put it much more clearly.

285. It was also common ground between the parties that Dr Byrne expressed to Dr Pullen that he did not consider Carley to be eligible for admission to the mental health unit. However, Dr Byrne said that he told Dr Pullen that this was because he had not yet been able to properly assess Carley and that he did not consider that Carley was ready to be discharged. In contrast, Dr Pullen recalled Dr Byrne saying that Carley did not need to be admitted to the mental health unit based on the assessment that he had conducted. Dr Pullen stated that the impression he received from Dr Byrne was that:

> "Dr Byrne had reached sufficient conclusion that she was not a mental health patient. She did not need to be managed further by mental health and there was no other plan beyond that other than if she was discharged they would arrange some community health follow up."

286. Dr Pullen then expressed to Dr Byrne his view that Carley should either be admitted to mental health or, if there were no concerns about Carley's mental health, that she should be discharged as there were no apparent medical issues to keep her at Lismore Base Hospital. Again, the doctors' recollection as to the nature of this view differed:

   (a) Dr Pullen's evidence was that he didn't present the options quite as specifically as a binary decision, but that it was the impression he was trying to give; namely, that he needed a clear answer one way or another.

   (b) Dr Byrne's evidence during the second tranche of inquest was that Dr Pullen was "pretty blunt" and that he was taken aback by the forcefulness with which Dr Pullen put his view.

287. Dr Byrne's counsel submitted that Dr Pullen overbore and raised his voice to Dr Byrne to the point where Dr Byrne confided to Dr Wardell that he was upset. This was not put to Dr Pullen when he gave evidence at the first tranche of the inquest. Counsel for Dr Byrne only put to Dr Pullen that he and Dr Byrne hadn't been able to agree, which Dr Pullen accepted. I do not consider it appropriate or necessary to make a finding on this issue.

288. The crucial point is that both Dr Byrne and Dr Pullen considered that Carley was not the responsibility of their respective teams. The end result was a lost opportunity to provide Carley with the care and support she needed.

289. The conversation concluded with Dr Pullen advising Dr Byrne that he would examine Carley himself and call Dr Wardell to discuss further.

Conversation between Dr Pullen and Dr Wardell

290. Sometime after 9.00pm there was a telephone conversation between Dr Wardell and Dr Pullen. Dr Wardell described it as a "short and heated" conversation. Dr Pullen recalled it being short, but would not have described it as heated. Dr Pullen explained that the two clinicians "clearly had a different impression of the situation and what was the right way to manage a patient in this situation". A record of this conversation was

made by Dr Pullen in the clinical note of his assessment of Carley and is set out at [73] above.

291. I find that during the conversation Dr Pullen gave Dr Wardell an ultimatum: that if Dr Wardell didn't admit Carley as an inpatient to the mental health unit, she may well be discharged from the hospital. Both clinicians agreed that this was the effect of the conversation.

292. Dr Pullen's evidence was that:

(a) He was managing a busy Emergency Department and was working within management guidelines that specified a four hour rule for assessing patients. Carley had been in the Emergency Department for almost nine hours at that stage.

(b) He felt there was an absence of a clear plan for Carley.

(c) He did not recall Dr Wardell specifically saying that Carley could not be admitted to the mental health ward because she was intoxicated and had no acute psychotic symptoms. He gave evidence that if such a comment had been made, he would expect that it would have triggered a further discussion and he could not recall having a long discussion about intoxication with either Dr Byrne or Dr Wardell.

293. In addition, Dr Pullen was not aware of collateral information that might have raised a red flag about Carley's mental health, such as Carley's false account of her day (see at [261] above).

294. Dr Pullen's counsel submitted that:

(a) In these circumstances and on his training, it was appropriate for Dr Pullen to deal with Dr Wardell on the basis of presenting a binary option in forceful terms.

(b) Dr Pullen's ultimatum to Dr Wardell set out for Dr Wardell the consequences before he gave his final decision and that there was nothing wrong in doing that.

(c) The evidence of Associate Professor John Raftos, an expert emergency physician engaged by Dr Pullen, was that Dr Pullen's approach was consistent with good emergency department practice.

295. I find that there were real pressures on Dr Pullen, and that he was within his rights to ask for clarity from the mental health team about the immediate action plan for a patient in the Emergency Department. I also find that Dr Pullen was right to resist a casual assumption that a patient brought in before 1.00pm would just sleep in the Emergency Department until morning. He had to consider the needs of other patients, his management guidelines, and the need to ensure patient flow.

296. Dr Wardell's evidence was that:

(a) He was not prepared to admit Carley as an inpatient on a safety basis, because of what he considered to be her level of intoxication. I accept that

Dr Wardell believed that Carley was affected by drugs and in withdrawal based on Dr Byrne's assessment.

(b) He didn't put as forcefully as he should have what the plan was. He considered that this was due to a breakdown in the communication between the two clinicians and the conversation ending.

297. Dr Wardell's counsel submitted that:

(a) It was a difficult conversation between Dr Pullen and Dr Wardell. The very real difficulty was the binary choice that Dr Pullen put to Dr Wardell.

(b) The binary choice that was adopted by Dr Pullen was an unreasonable one, and Dr Wardell reacted to it.

298. Evidence emerged late in the third tranche of the hearing that the conversation between Dr Pullen and Dr Wardell went beyond "heated" to include intimidation and yelling. Again, this serious allegation was not put to Dr Pullen during his evidence nor had it been raised earlier in evidence. Similar to my findings regarding Dr Byrne at [287] above, I do not consider it to be necessary nor appropriate in the circumstances to resolve the accuracy, or extent, of the claimed of aggression or intimidation. In part it is not necessary to resolve, because, ultimately, Carley did stay in the Emergency Department until the morning.

299. The main point is that there was a suboptimal communication that was not in the best interests of the patient. I find that there was no real in depth discussion of Carley's needs or her presenting condition between Dr Wardell and Dr Pullen. I accept the submission of counsel assisting that the responsibility for that lies on both sides of the conversation.

300. Dr Pullen and Dr Wardell accepted that there should have been a longer and more collaborative discussion between the senior clinicians about Carley's needs and interests.

301. Dr Wardell gave evidence that, on reflection, he could have taken the following steps:

(a) Escalate the situation up to the senior executive from mental health, alcohol and other drugs who could have spoken to his or her counterpart within the emergency department.

(b) Arrange for an extra staff member attend the mental health unit to monitor Carley.

Adequacy of the communications between the teams

302. Each of these conversations were not good examples of effective, collaborative communication between skilled medical practitioners. Carley's care was reduced to an ultimatum when it didn't need to be, and it should not have been. It was a missed opportunity to offer the comprehensive care that Carley needed. Carley became a victim of a demarcation dispute, and she deserved better.

303. Further, the communications between the teams were inadequately recorded. As a result, the co-ordination of Carley's care was somewhat chaotic and information

suffered from verbal repeats which changed nuance. As Carley's family submitted, the evidence of these conversations demonstrated the importance of clinical notes and the need to accurately document when an assessment or request for a test took place, or the source of a particular piece of information, or a discussion with or direction from a senior staff specialist.

304. There is no evidence to indicate that there is a connection between the conversations between the clinicians and the manner and cause of Carley's death. However, I accept the submission of counsel assisting that it was necessary to explore these issues at the inquest.

305. First, Carley's case demonstrated that guidelines and demarcations impede comprehensive patient care, and that there is a responsibility on all practitioners to collaboratively and collectively override guidelines if they do impede care. As Dr Ellis stated: "if policies lead clinicians to making ultimatums, then they're bad policies".

306. Dr Ellis gave evidence of a "not insubstantial cohort of patients" who present like Carley and that having a routine response created by practitioners *focused on the needs of the patients* is the most effective and efficient way to manage such patients. He stated:

> "patient care is the most important factor and - yes, if there are admission criteria or policies that block effective patient care, then, that they need to be either, you know, collaboratively overridden by the clinicians on the ground at the time, or brought to - you know, if it's an ongoing problem, brought to clinical managers to resolve."

307. Second, the clinicians could quite easily had had a conversation about the best way to offer Carley the treatment she needed. There were many aspects of Carley's presentation which the clinicians could have interrogated further, including:

    (a) why Carley didn't remember the last three days;

    (b) whether it was true that Carley couldn't stay in the Emergency Department or be voluntarily admitted into inpatient care in the mental health unit; and

    (c) of Carley really did present a safety risk.

308. Dr Wardell's counsel submitted that the rhetorical question, "Was there really a safety risk?", posed by counsel assisting in her submissions, was an entirely reasonable question, but one based in hindsight. I do not accept this submission. Dr Wardell considered Carley to be a safety risk because he believed that she was acutely intoxicated. However, Dr Wardell had not been presented with any objective evidence of Carley's intoxication. While Dr Wardell relied on the views of his registrar Dr Byrne, he was also aware that:

    (a) Carley had been at Lismore Base Hospital since midday;

    (b) Dr Byrne had been unable to do a proper mental health assessment;

    (c) no urine screening results had been obtained; and

    (d) Dr Byrne had not identified any clear objective signs of drug intoxication.

309. Dr Wardell said that he would have deferred to or at least taken very seriously the opinion of an experienced emergency doctor like Dr Pullen as to the level of Carley's

intoxication. While Dr Pullen had not yet examined Carley when he first spoke to Dr Wardell, it was open to Dr Pullen and Dr Wardell to speak after Dr Pullen examined Carley and concluded that she was not intoxicated. Dr Pullen thought Carley wasn't.

310. Dr Wardell agreed that Dr Pullen's view that Carley didn't appear intoxicated militated towards an episode of psychosis. He further stated that such an opinion does change what he would have done "in hindsight or not even in hindsight" and that:

> "if I had known that a senior emergency physician had assessed [Carley] and found that she wasn't grossly intoxicated and felt that she was safe to be admitted to a psychiatric unit, I would have accepted her admission, yes."

311. However, of course, this didn't occur. Dr Wardell's counsel characterised this as "a lost opportunity".

312. I do not need to make a finding about what might have been if those conversations had occurred. However, it was important for the inquest to go through these options and to show the importance of those messages.

Was voluntary admission appropriate as a treatment option?

313. The evidence given by the clinicians was to the effect that the applicable admissions policies limited the treatment options for Carley. The emergency physicians outlined that under the time guidelines in the Emergency Department, and having been medically cleared by Dr Shively, Carley could not remain in the Emergency Department. She was not considered suitable for scheduling under the *Mental Health Act*.

314. On the other hand, the mental health team considered that Carley could not be admitted to the mental health unit under their admission guidelines because she was "acutely intoxicated". Dr Wardell gave evidence that it would have been difficult to admit Carley to the mental health unit because she posed a potential risk to the safety of herself and others. In addition, due to her confusion and delirium she would have required constant observation.

315. As I have outlined above, this resulted in an inflexible approach from both sides.

316. There were resources available in both the Emergency Department and the mental health unit to accommodate Carley. In making this finding, I do not deny that the pressure on resources was, and is, ever present. But the fact remained that there was no guideline in either department that prevented Carley from staying overnight, sleeping, being dosed with methadone and reassessed by the mental health team. In any event, this is what in effect occurred, as Carley stayed overnight in the Emergency Department. This illustrated that some flexibility was possible.

317. Carley was not precluded, on the basis of the mental health admission guidelines, from being admitted. Dr Ellis gave evidence that: "if you're applying very rigid admission criteria, you want to have very stringent information to apply it". In relation to an assessment of acute intoxication, there was a potential for medical compromise. This is evident in the fact of the differing opinions between the mental health and emergency physicians during the afternoon and evening of 1 November 2017 as to whether Carley was intoxicated. I find that, in hindsight, the best place for Carley to

wait to be reassessed was in the mental health unit, not in the Emergency Department, and I accept the evidence of Dr Ellis in that respect.

318. There was also no evidence to suggest that Carley would decline voluntary admission if it had been raised with her. There were insufficient attempts to offer Carley voluntary admission to the inpatient unit. The evidence of Dr Byrne and Dr Wardell was, in effect, that Carley wasn't an appropriate candidate for voluntary admission due to her level of confusion (which they considered was due to intoxication). Dr Byrne stated that even if he had asked Carley if she wanted to be admitted, her answer wouldn't hold weight as she did not know where she was.

319. I pause here to note the evidence given by Dr Hudson during the third of tranche of the hearing:

> "there's a land in between of voluntary and involuntary that falls under duty of care. … Sometimes when someone is substance-affected or someone is in a state where neither of those apply, but we still have a duty of care for somebody to ensure their safety".

320. Dr Hudson's evidence illustrates that the key issue in Carley's case was that neither side was willing to show some compromise or flexibility, or to even discuss alternative options. There were no constructive conversations between the practitioners about the available options.

321. I find, with the benefit of hindsight and all available information, that it would have been preferable to:

    (a) discuss voluntary admission with Carley;

    (b) conduct another mental health assessment, perhaps after she had been dosed with methadone; and

    (c) seek collateral information, particularly from Dr Hudson and Mr Burgess who knew Carley well and had serious concerns for her mental health and welfare.

322. A longer admission may or may not have been warranted. It may or may not have been welcomed by Carley; but it was certainly considered appropriate by Dr Hudson, Mr Burgess and Carley's family.

Decision to discharge Carley and the adequacy of discharge plan

323. I accept that Carley was not, in actual fact, ever discharged from Lismore Base Hospital. She remained in the Emergency Department overnight due to what I was told was a practice at Lismore Base Hospital that single women would not be released out into the streets alone at night. Carley left of her own accord and undetected early in the morning of 2 November 2017.

324. However, the inquest still considered the decision to discharge Carley and the adequacy and appropriateness of the discharge plan, as it is relevant to my recommendations role in preventing future deaths.

325. Dr Pullen told Dr Wardell during their conversation that, if Carley would not be admitted to the mental health unit, then she was going to be discharged from the Emergency Department.

326. It was submitted by counsel assisting that a conversation between Dr Wardell and Dr Byrne needed to occur at this point about the appropriate plan for Carley. I agree with and accept this submission. There was some evidence before me that a further telephone conversation did take place, but it wasn't recorded and neither doctor had a clear recollection of what was discussed. Dr Byrne and Dr Wardell should have discussed whether Carley was safe to be discharged, or whether she could be admitted to the mental health ward as an inpatient.

327. Instead, Dr Byrne left Lismore Base Hospital when his shift concluded at 9.30pm without following up on Carley or arranging follow-up care in the community. This wasn't best practice, and that was accepted by Dr Byrne.

328. The Emergency Department had responsibility for Carley's discharge because she was not admitted under the mental health team or another department at Lismore Base Hospital. In his progress note recorded at 9.26pm, Dr Pullen outlined that Carley could be discharged that night, and that she was keen to go home with a friend who she would call. Similarly, the discharge referral for Carley prepared by Dr Shively set out that Carley said a friend was collecting her and that she was happy to be discharged.

329. A/Prof Raftos considered that Dr Pullen's decision to discharge Carley from the Emergency Department, following his assessment of Carley and discussion with the Mental Health team, was appropriate. Dr Ellis did not take issue with this, but raised concerns with the lack of clarity around discharge planning and which clinician was ultimately responsible. Dr Ellis was of the opinion that the documented discharge plan was vague and failed to account for the individual circumstances of Carley's case. He noted that there was no documentation to indicate that staff had confirmed any person was coming to pick Carley up and there was no documented discharge address.

330. However, Dr Pullen gave further evidence at the inquest that he communicated to his night team that Carley had been cleared by mental health and that she was free to be discharged and leave the Emergency Department when someone came to pick her up. He had asked Carley who her friend was and whether staff could call him or her, but she declined to give him any further information. I accept that it was Dr Pullen's intention to communicate to his team that Carley could leave once a friend arrived to collect her. He did not consider it safe for Carley to leave at that point without a friend, and gave evidence of a standard practice at Lismore Base Hospital not to let vulnerable people leave the Emergency Department at night without a responsible adult.

331. Dr Ellis also raised concerns with the lack of follow up appointments in Carley's discharge plan. There was evidence before me of a common practice in discharges from the Emergency Department that any mental health arrangements would be done by the mental health team. The parties accepted that this should have occurred but didn't, and both Dr Byrne and Dr Wardell expressed their regret for that fact. In particular, Dr Byrne rightly conceded that by the time he left Lismore Base Hospital he needed to have clearly recorded something in the notes about Carley's follow up care in the community, whether that was done by him or foreshadowed that it needed to be done by someone else.

332. In considering this evidence, I find that there was clearly a lack of clarity around the discharge process and planning. This was accepted by the NNSW LHD.

333. I find that if Carley was to be discharged, she needed a clear and well documented discharge plan which included arrangements for collection, accommodation and supported follow up in the community. Clear lines of communication and documentation and a clear chain of command as to decision making and planning – i.e. calling Carley's parents and sending her discharge summary to Dr Hudson – should have been evident and were not. Dr Wardell fairly accepted that there was a failure to arrange a follow up with community mental health and that, in hindsight, such steps should have been taken. Dr Pullen similarly submitted that, in hindsight, more should have been done to ensure that some practitioner was taking responsibility for a follow-up plan.

334. Finally, I find that Carley's parents should have been contacted in relation to her planned discharge. Ms Robinson accepted this proposition. This was not the fault of any one person, but was a systems error that arose out of a series of miscommunications and oversights that happened throughout the night.

335. However, I do not consider it necessary to make any recommendations in this regard. In summary, an e-referral system has been developed for notification from the Emergency Department to Community Mental Health services when a known patient (that is, one who is accessing mental health services), is in the Emergency Department. Ms Robinson gave evidence that this system means that, had Carley left the Emergency Department today, there would have been an automatic referral made to community mental health.

Recommendations regarding Carley's medical care

336. This leads to the question of whether any recommendations are necessary or desirable.

337. During the third tranche of the inquest, Carley's family and Dr Wardell provided me with a number of considered and thoughtful draft recommendations regarding the medical care issues in this matter. I am very grateful for their assistance in this regard. I discuss these proposed recommendations and my determinations below.

Summary "go to" document

338. Dr Eagle's 2016 report, which recorded Carley's schizophrenia diagnosis, was undoubtedly a crucial piece of information for the clinicians dealing with Carley at the time of her presentation to Lismore Base Hospital. However, Dr Eagle's report, and a Justice Health Custodial Mental Health Liaison Report which noted that diagnosis, were not available to them.

339. The evidence of Dr Shively and Dr Byrne showed a clear practice of reviewing the most recent notes from a patient in order to gauge their recent history. Dr Shively had read the triage notes indicating "known schizophrenia and bipolar" but accepted in evidence that there was no "go to" or summary document on FirstNet to assist clinicians identify critical information contained within the file. Dr Byrne indicated that it was "extremely difficult" to assess patients with the lack of information that existed at any one time, particularly with the disparate records systems between different hospitals and community health centres. He considered that it was a "massive concern" that information in terms of Carley's diagnoses was not readily available to him in the records he reviewed on 1 November 2017.

340. The family submitted that a summary or "go to" document be developed and utilised within the NNSW LHD for individuals, particularly those identified as presenting a risk of harm to themselves or others, which sets out their past admissions, any psychiatric diagnoses, any mental health-related incidents (including incidents of violence, or self-harm or suicide attempts), and any other information that may be significant for an assessing clinician to know when undertaking an assessment within the Emergency Department or elsewhere. The intention is that this document would distil core pieces of information in relation to a particular patient.

341. Dr Wardell also gave evidence that it was extremely difficult to find important information in the electronic medical records ("eMR") system. Unless the clinician knew the date that a piece of information was written, they were required to sift through a large amount of uncategorised material. Dr Wardell considered that it would be much better to have a go-to document.

342. After the conclusion of the hearing, the NNSW LHD provided a letter from Ms Robinson which stated, *inter alia*, that structures were now in place through the "HealtheNet Portal" to enable a summary document page in the FirstNet system. Ms Robinson's letter also outlined that in late 2019 two speciality filter Result tabs were developed to facilitate ease of access to specific documentation types. The two Result tabs are "Mental Health" and "Drug & Alcohol" and allows the clinician to view a summary of either mental health or alcohol and other drugs service encounters from Port Macquarie to Tweed Heads.

343. Unfortunately I was not provided with an example of the new summary document page in the FirstNet system, so am unable to make an assessment as to whether this summary page records key aspects of a patient's mental health diagnosis and treatment, as was contemplated by the evidence at the inquest.

344. In these circumstances, I do not consider it necessary to recommend that the NNSW LHD develop a go-to document on FirstNet for mental health patients. However, I recommend that the LHD ensures that the information in the summary document page includes a patient's past admissions, any psychiatric diagnoses, any mental health-related incidents (including incidents of violence, or self-harm/suicide attempts), and other relevant information that may be significant for an assessing clinician to know when undertaking an assessment within the Emergency Department or elsewhere.

Access to paper records

345. Dr Wardell gave evidence that there are often excellent reports sitting in paper-based files in other facilities in the NNSW LHD, which are not available to clinicians at Lismore Base Hospital (or other facilities in the area) and which can only be requested during the day. Dr Wardell considered that even if Dr Eagle's report had been received by Byron Community Mental Health, it would have remained as a paper-based report at that centre and would not have been uploaded onto the FirstNet system. The report therefore would not have been accessible to those clinicians at Lismore Base Hospital who treated Carley on 1 November 2017.

346. Dr Wardell proposed that paper records held for mental health patients be scanned so that they are available as part of the eMR system. Similarly, the family proposed a recommendation that NNSW LHD develop a capability within FirstNet for the retention

of important documents relevant to a patient's mental health history (such as psychiatric assessments or discharge summaries), such that these documents are readily accessible in electronic form to all mental health clinicians working within the NNSW LHD.

347. The letter from Ms Robinson provided to the Court after the hearing did not explicitly address these recommendations. However, during the hearing, Ms Robinson gave evidence of a new scanning project within NNSW LHD for the purposes of ensuring that a new hospital was completely digital. As part of that project, NNSW LHD was seeking input from various services about which documents should be scanned and uploaded.

348. In light of this evidence, I recommend that NNSW consider expanding the scanning project within NNSSW LHD to cover all hospitals and medical centres in the LHD.

Categories of mental health records

349. Dr Wardell further submitted that NNSW LHD should consider reconfiguring its eMR system so that a clinician can easily find the following categories of records with regard to a mental health patient:

- most recent 13 week mental health review by community mental health;
- discharge summaries;
- current medication;
- specific management plans;
- community treatment orders;
- letters from the patient's GP; and
- other psychiatric reports received, including those from Justice Health.

350. Ms Robinson advised the Court of a number of existing and new efforts taken by the NNSW LHD which address Dr Wardell's proposed recommendation. These include:

(a) The implementation of a "HealtheNet Portal" since Carley's death, with provisions for a summary page in FirstNet, SurgiNet and PowerChart.

(b) A patient's most recent 13-week mental health review, their discharge summaries, current medication and letters from the patient's GP are available in FirstNet or HealtheNet.

(c) Consultation with the Ministry of Health to develop processes for specific management plans.

(d) Discussions within NNSW LHD regarding proposed changes to enable the Mental Health Care Plan to be easily accessible for three- and six-month viewing.

(e) Any Community Treatment Orders are available under the documentation tab on Powerchart and FirstNet for mental health reports to the Mental Health Tribunal.

(f) Psychiatric reports received from other providers such as Justice Health, remain paper based and are requested when NNSW LHD is aware of Justice Health involvement (see further below).

351. In light of these existing features and new developments, which go a significant way towards addressing Dr Wardell's proposed recommendation, I do not consider it necessary to make a recommendation in this regard.

Information sharing between agencies

352. The psychiatric report from Dr Eagle and the Custodial Mental Health Liaison Report were important documents for the future management of Carley. I accept the evidence of Dr Ellis that these reports should have been in the possession of her treating clinicians in the community to guide her treatment and diagnostic formulation, and to manage risk to Carley and others. Unfortunately, Dr Eagle's report, which was held by the courts, and the Liaison Report, which was held by Justice Health ,were not available to community mental health providers or staff at Lismore Base Hospital.

353. In light of this evidence, the family proposed a recommendation that NNSW LHD develop a written procedure for inpatient mental health units and community mental health services which requires those services to obtain medical records and any assessment reports from Justice Health or any other available source (including a court or legal practitioner) in circumstances where a patient has been psychiatrically assessed whilst in custody, and the medical records and assessment reports are likely to be of clinical relevance.

354. NNSW LHD submitted that this is a state-wide issue outside of its control and that, currently, medical records remain paper based and are requested when the LHD is aware of Justice Health involvement. I note that no such request appeared to have been made in Carley's case, although it was unclear whether this process existed at the time of her engagement with Byron Hospital Community Mental Health.

355. I received evidence during the inquest of the following initiatives:

(a) Ms Robinson and Dr Wardell both referred to a joint committee comprised of senior members of both Mental Health Services and Justice Health that meet quarterly to discuss shared care of forensic mental health patients and ensure management plans are in place. The meetings allow for discussion of potential new consumers of NNSW LHD community mental health services and plans for the management of such. Dr Wardell, in his current position as Director of Medical Services for Mental Health, Alcohol and Other Drugs, NNSW LHD, chairs the joint committee. He advised the inquest that he would raise the possibility of implementing a more streamlined procedure for the provision of records.

(b) Dr Ellis referred to a series of service level agreements between Justice Health and LHDs as being a forum where these issues can be raised.

356. I appreciate that any improvements to information sharing are not solely within the control of the NNSW LHD and that there do exist processes for information sharing to occur. However, it appears that the current protocol is reliant on the discretion of a clinician to request these records. The evidence before me regarding Carley's matter

indicated that information sharing is an area where there is real potential for improvement.

357. In light of this evidence, I recommend that NNSW LHD give consideration to developing its own written procedure or policy to mandate that inpatient mental health units and community mental health services within the LHD must obtain important medical records from Justice Health where a person has been psychiatrically assessed while in custody. I also recommend that the NNSW LHD take measures to press for those records to be scanned or otherwise made easily available electronically to clinicians.

Substance testing

358. As outlined above at [68], no action was taken when Dr Byrne asked for a urine drug screen of Carley after he had assessed her at around 6.00pm on 1 November 2017. The results of this drug screen would have yielded crucial information, particularly if it had shown that Carley was negative for all substances. If so, it would have strongly indicated the presence of psychosis. It also may have influenced Dr Wardell's decision not to admit Carley as an inpatient, on a safety basis, because of what he considered her level of intoxication.

359. In evidence, Dr Wardell stated that a saliva test, used in Victorian hospitals, can yield results within minutes, and can indicate the presence or absence of a number of substances including methamphetamines, opiates, benzodiazepines, and cannabinoids. It could have indicated within minutes whether Carley had recently used either ice or cannabis. At the hearing, Ms Robinson said the current urine drug screens are equally quick and easy, and can be completed within minutes but having an alternative means of drug testing available within the Emergency Department could be beneficial.

360. In light of this evidence, the family proposed a recommendation that NNSW LHD consider the introduction of instant saliva-based testing for the detection of illicit drug use by mental health clinicians within NNSW LHD Emergency Departments and elsewhere as required.

361. However, in the letter provided following the hearing, Ms Robinson advised that the NNSW LHD did not support a recommendation to introduce salvia -based drug testing. In support of its position, the NNSW LHD submitted that:

    (a) the Australian College of Emergency Medicine ("ACEM") does not have a policy to support the practice;

    (b) the literature suggests that urine sampling is superior to saliva-based testing in terms of accuracy, sensitivity, specificity to detect commonly used substances, and ease of collection; and

    (c) this superiority is demonstrated by the fact that Emergency Departments within NNSW LHD complete definitive testing for NSWPF when a person in the community tests positive on a saliva test. This is done by either a urine or blood test.

362. While I acknowledge the reasonable considerations raised by the NNSW LHD above, I cannot overlook the abundance of evidence given at the hearing as to the difficulties

with urine tests and the benefits of having another form of test, such as a saliva test, available in the mental health setting. In particular:

(a) *Distinguishing substances:*

The LHD referred to literature which indicated that urine sampling is superior to saliva-based testing in terms of accuracy, sensitivity and specificity to detect commonly used substances. However, I note that such considerations – while of course important – do not appear to be as crucial in a mental health setting where distinguishing substances is not as important as quickly finding whether any are on board. In Carley's case, the issue was not the type of substance she had taken but whether she had in fact taken any.

(b) *Ease of collection:*

The LHD also submitted that the literature indicated that urine sampling is superior in terms of ease of collection. The evidence given by Dr Byrne and Dr Wardell at the inquest paints a different story. They noted that it can be difficult to obtain a sample from a person who is non-compliant or in a state of confusion, or if they were not sufficiently hydrated to be able to give a sample. Collection of a urine sample may also require a patient to be escorted to a bathroom, which can cause delay and requires a staff member to be available to do so. The evidence before me was that Carley was uncooperative, unable to respond to Dr Byrne's questions, and had urinated on the floor hours earlier. Even had a urine test been attempted (and there is no evidence that one was), I do not consider it obvious that it would have been easy for staff to collect. By contrast, saliva testing, which Dr Byrne himself could have done, likely would have been easier to collect.

(c) *Rapidness of results*:

Finally, Dr Byrne and Dr Wardell gave evidence that urine tests can take hours to complete. Dr Wardell also stated that, in Carley's case, given the test had not been undertaken by the time he spoke to Dr Byrne between 6.00pm and 8.39pm, it would not be processed by the laboratory until the next day. By contrast, saliva-based testing is almost instantaneous.

363. I also accept the family's submission that the absence of an ACEM policy is irrelevant, as it is not proposed that saliva testing be used by Emergency Department doctors.

364. Carley's case demonstrates the importance of mental health clinicians working in the Emergency Department having access to a rapid drug screening test that they can readily apply to confirm or exclude the presence of intoxicating substances, where appropriate. The recommendation proposed by the family is suitably narrowed to this very situation and I make such a recommendation below.

Psychiatric Emergency Care Centre

365. Information regarding Psychiatric Emergency Care Centres ("PECCs") was explored during the third tranche of the hearing. A PECC is a section of an Emergency Department, staffed jointly by emergency department staff and mental health clinicians, which is dedicated to providing short term medical and psychiatric

monitoring. According to NSW Health policy, the patients most likely to be considered for a PECC admission are those with low to medium acuity, that have a low risk of behavioural disturbance and aggression and low medical risk, and are likely to require a brief admission of up to 48 hours.

366. Dr Ellis agreed in evidence that there would always be cases where a psychiatric illness presented in combination with intoxication leading to a lack of clarity in any diagnosis. He considered that the best way to ensure that the failures that occurred in Carley's case do not occur again would be to identify a department of the hospital that would take responsibility for the monitoring of people during the resolution of intoxication. He identified the establishment of a PECC as a potential solution for people who present with both a psychotic disorder and a substance abuse disorder.

367. Dr Wardell similarly agreed that a PECC would be a place where people who are intoxicated could go, who would otherwise remain in the Emergency Department overnight, and that the addition of a PECC unit within the Emergency Department of Lismore Base Hospital would improve the current situation.

368. Following the hearing, NNSW LHD informed the inquest that it would not be able to establish a PECC at Lismore Base Hospital due to a lack of funding and commitments to existing structures including:

    (a) the 24 hour Mental Health Emergency Care ("MHEC") Service (a team of mental health clinicians within the hospital that is now available 24 hours a day); and

    (b) Safe Havens (a state wide initiative providing support and referral services for people in acute psychological distress).

369. The LHD further outlined that it had commenced applying the principles within the PECC guideline, with the exception of a dedicated short stay unit within the Emergency Department. It stated that, however, beds have been identified in the Emergency Department for patients experiencing mental health and substance use issues.

370. The initiatives referred to by the LHD are excellent and needed. However, I cannot overlook the evidence given at the inquest that it was the features of a PECC that were most appropriate for a patient like Carley. Every witness who was asked about PECC saw this as being an ideal opportunity to deal with a person in Carley's circumstances. Dr Ellis considered that a PECC "might potentially solve the issue of the psychiatric ward not having the medical monitoring and the medical ward not having the psychiatric monitoring."

371. Further, Dr Wardell's evidence was that almost all of the PECC admission criteria were relevant to Carley's situation on the night she was at the Lismore Base Emergency Department. I am unable to find that the aspects of the MHEC and Safe Haven initiatives are comparable to those of the PECC. In particular:

    (a) The increased staffing provided by MHEC notably does not provide the greater level of bed availability within the Emergency Department that a PECC would. This was accepted by Ms Robinson at the inquest. Bed availability was a key issue in Carley's case. Further, while the additional resources provided by the MHEC team can provide assistance in contacting community health

care provides (which was an issue in Carley's case), I have found that the new eMR referral system implemented by the NNSW LHD goes a long way to addressing this issue (see at [335] above).

(b) Safe Havens aim to support persons who are feeling distressed or having suicidal thoughts. They are only open at specific times, so would not have provided a secure, supported place for Carley to remain overnight.

372. If someone in Carley's situation presented to the Emergency Department today, a similar situation could occur where she was not admitted to the mental health ward and not provided with adequate treatment. I remain of the view that a PECC would have worked much better in Carley's case than Safe Havens and MHEC, and offers much more support.

373. I also acknowledge that the thrust of the family's recommendation as drafted involves exploration of the feasibility of a PECC. It is clear that PECC units exist in other LHDs, and are introduced to address a known demand within the health system for mental health consumers. There is no apparent reason why such a unit should not exist within the NNSW LHD.

374. In light of this evidence I recommend that the LHD carefully assess the need and feasibility of a PECC at Lismore Base Hospital.

Findings pursuant to s. 81 of the Act

375. I make the following findings pursuant to s. 81(1) of the Act:

Identity

The person who died was Carley Metcalfe.

Date of death

Carley died between 3 November 2017 and 29 November 2017. While I am unable to determine the exact date of death, I find that Carley was alive for a number of weeks after she disappeared on 3 November 2017.

Place of death

Carley died in or around Mullumbimby, NSW.

Cause and manner of death

I am unable to determine the cause or manner of Carley's death.

Recommendations

376. I make the following recommendations arising from the evidence pursuant to s. 82 of the Act:

To the Commissioner of Police, NSW Police Force

(1) That the Missing Persons Registry ("MPR") consider amending the definition of "missing person" in the Missing Persons Standard Operating Procedures ("MP SOPs")

to make it clear that no particular form of words need be used by an informant when reporting a missing person. If it is communicated to police that a person cannot be located and there are concerns for their safety and welfare, that person is a missing person.

(2) That the MPR consider amending the MP SOPs to:

(a) Require that police attempt to identify, and obtain and safely store the last known CCTV footage of a missing person as a matter of course within the first 48 hours of a missing persons investigation.

(b) Make clear that CCTV footage is a valuable resource in a missing persons investigation, even if its forensic significance is not immediately apparent and/or there may not be human resources to view the footage immediately.

(c) Include "identify any obtain any potentially relevant CCTV footage" in the mandatory maximum investigation timeframes for the Officer in Charge of an investigation, ideally within 48 hours.

To the Northern NSW Local Health District

(1) That the Northern NSW Local Health District ("NNSW LHD") ensure that the summary document page on HealtheNet includes information that easily identifies a mental health patient's past admissions, any psychiatric diagnoses, any mental health-related incidents (including incidents of violence, or self-harm/suicide attempts), and any other relevant information that may be significant for an assessing clinician to know when undertaking an assessment within the Emergency Department or elsewhere.

(2) That the NNSW LHD consider expanding the scanning project within NNSW LHD to cover all hospitals and medical centres in the LHD, so that paper records for mental health patients so that they are available as part of the Electronic Medical Records System.

(3) That the NNSW LHD:

(a) formalise, whether by way of a written procedure or similar, the practice of inpatient mental health units and community mental health services obtaining medical records and any assessment reports from the Justice Health and Forensic Mental Health Network and where appropriate, from any other available source (including a court or legal practitioner) in circumstances where a consumer/patient has been psychiatrically assessed whilst in custody, and the medical records and assessment reports are likely to be of clinical relevance; and

(b) take measures to press for those records to be scanned or otherwise made easily available electronically to clinicians.

(4) That the NNSW LHD introduce the use of instant saliva-based testing for the detection of illicit drug use by mental health clinicians within NNSW LHD emergency departments and elsewhere as required.

(5) That the NNSW LHD assess and determine the need for a Psychiatric Emergency Care Centre at Lismore Base Hospital.

Conclusion

377. Carley's disappearance and death is a tragedy and her family have been deeply affected by her loss. At the end of the third tranche of the hearing, Chris spoke of the profound and devastating effect Carley's death has had on her two boys and the rest of their family.

378. Accordingly, I offer my heartfelt condolences and sympathy to Carley's family. I thank Chris and Max for participating in the inquest with such dignity and determination, when it has been so difficult and sad for them. While I acknowledge the painful and persistent uncertainty they will continue to feel in not knowing exactly what happened to Carley, I hope that the inquest has assisted by providing some answers to their many questions.

379. I would also like to extend my thanks to the officer in charge, Detective Senior Constable Scott Nowland, for his thorough and comprehensive investigation of this matter and assistance at the inquest. He followed up multiple lines of inquiry prior to and during the inquest and maintained contact with Carley's family. His dedication, and the compassion and respect that he displayed towards the family throughout the inquest, is a testament to him and the NSWPF.

380. I also thank the interested parties and their legal representatives for their co-operation and the constructive approach that they took throughout this inquest.

381. Finally, I thank my counsel assisting, Ms Kirsten Edwards, and her instructing solicitor from the Crown Solicitor's Office, Ms Caitlin Healey-Nash, for their exquisite assistance with this inquest.

I close this inquest.

Teresa O'Sullivan
NSW State Coroner
Byron Bay

Date: 25 February 2022