STATE CORONER'S COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of JX
Hearing dates:	19-22 August 2014
Date of findings:	19 December 2014
Place of findings:	State Coroner's Court, Glebe
Findings of:	Magistrate Michael Barnes, State Coroner
Catchwords:	CORONIAL LAW – Suicide; mental health assessment; ED triage; police response
File number:	2014/00022127
Non publication order	Pursuant s75(2)(b) I order that no information tending to identify the deceased be published.

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The Coroners Act in s81 (1) requires that when an inquiry is held concerning a death, the coroner must record in writing his or her findings as to various aspects of the death. These are the findings of an inquest into the death of JX

Introduction

On 21 January 2014, while at work, JX sought assistance from his boss, Matthew Dyson, as he realised he was suffering a relapse of the mental illness he had been treated for sporadically over a number of years. He went with Mr Dyson to the rooms of a psychologist who had treated him previously and then to the emergency department of a large public hospital.

There JX was triaged but left before he was seen by a doctor. Despite Mr Dyson and police trying to locate him, JX was not seen again by those trying to help him until his body was found floating in the ocean at Maroubra the next morning.

The Issues

As with all inquests, it was necessary to find, if possible, the identity of the deceased person; the date and place of their death; and the manner and cause of the death. In this case, there was little doubt about most of those issues. Rather, the inquest focused on:

- Whether staff attached to the Ryde Mental Health Acute Team responded appropriately when contacted by Psychologist Mr Geoffrey Dawson on the afternoon of 21 January 2014.
- Whether the Mental Health Acute Team policies and procedures concerning responses to contact of that kind were (are) clear, consistent and appropriate.
- Whether staff attached to the Royal North Shore Hospital responded appropriately when JX presented at the Emergency Department on the afternoon of 21 January 2014.
- Whether staff attached to the Royal North Shore Hospital responded appropriately when JX left the Emergency Department on the afternoon of 21 January 2014.
- Whether Royal North Shore Hospital Emergency Department policies and procedures concerning responses to persons presenting at the Emergency Department, who are reported to be exhibiting signs of psychosis, were (are) clear, consistent and appropriate.
- The nature and appropriateness of the response by NSW Police Force after being advised on 21 January 2014 of concerns for the welfare of JX

The Evidence

Social History

JX was born 18 February 1982. He was the son of DJX and PJX and the older brother to a sister, born in 1992. His mother describes him as a gentle, easy-going, untidy and very kind person who was genuinely interested in other people's opinions.

JX grew up in Rozelle, NSW, and attended Balmain Primary School. He commenced his secondary schooling nearby at Hunters Hill High School. When JX was in year 9 the family moved to Sydney's northern beaches and JX transferred to Pittwater High School. As an adult, JX reflected on the move and felt that he did not cope well with it.

JX completed the HSC in 1999 and commenced a Bachelor of Science degree the following year. After one year of study he transferred to a Bachelor of Mechanical Engineering degree and completed two years of the course. JX had reservations about pursuing his studies further and took a gap year, during which he travelled to the USA to work as a summer camp counsellor and also travelled to Europe and Asia. He returned in December 2003 and was accepted into a Bachelor of Renewable Engineering degree at the University of New South Wales ("UNSW").

The course appears to have suited JX's interests and abilities. He had displayed keen interest in invention and the environment since childhood. His academic results had always reflected his aptitude for mathematics and science. However, he struggled somewhat to meet the demands of his course and consequently, he was suspended from study for one year in 2009. JX's poor academic results that year may be symptomatic of his recognised difficulty reading and writing (apparent since childhood and for which he had obtained occasional learning support and speech pathology) and his distractibility and disorganisation. Testing in 2012 suggested that JX may have Attention Deficit Disorder (ADD) and in 2013, he was diagnosed with Attention Deficit Hyperactivity Disorder (ADHD).

In about 2005, JX experienced a difficult relationship break-up with a girlfriend. He appears to have drunk alcohol heavily and used ecstasy around this time. There is evidence that at least from this time, like many young men his age, JX drank alcohol and used illicit drugs, including cannabis. While the amount and frequency of his intake seems to have varied and is not quantified on the evidence, it appears that JX never consumed either to the extent that it was of acute concern to his friends and family.

The relationship breakdown in 2005 also caused JX to feel suicidal. This led to three months of medication on the anti-depressant Zoloft (sertraline). Between 24 April 2006 and 25 January 2011 he was treated by a number of general practitioners and a psychiatrist attached to the UNSW University Health Service. From that first consultation JX was prescribed the anti-depressant medication Efexor XR (venlafaxine). He continued to be prescribed venlafaxine more or less regularly, and in varying dosages, from that date onwards.

Medical History

First psychotic episode and subsequent treatment

In 2011, JX was 29 years old. He had recommenced his studies at the UNSW; however, he continued to struggle to meet the demands of the course. Prior to 5 August 2011 he became aware that he would or had failed a subject and, prompted by this news, he increased his cannabis use.

At the time, JX was living in a share house in Waterloo. On 5 August 2011, JX's housemates observed him to be very anxious and to have difficulty sleeping. He was saying things that did not make sense and expressed thoughts about being followed and about a conspiracy involving a Chinese businessman. Concerned, they called his parents, who took him to their home in Newport.

JX's parents arranged for him to consult with psychiatrist Dr Andrew Smallman at the Mona Vale Community Health Centre on 9 August 2011. Dr Smallman saw JX as arranged and noted that he made some indirect references to self-harm. It was reported that JX had used cannabis several days ago. Dr Smallman concluded that JX had experienced a psychotic episode precipitated by cannabis use and university exams. He prescribed the anti-psychotic medication Zyprexa (olanzapine). JX's mother noticed an improvement within one hour of its administration. JX declined to see Dr Smallman again.

JX's father took him to see registered psychologist Geoffrey Dawson on 11 August 2011. He was then formally referred to Mr Dawson by his general practitioner, Dr Kate Norris, who formulated a mental health care plan for JX which included consultation with Mr Dawson and psychiatrist Dr Brian Gutkin.

JX saw Dr Gutkin approximately every two to four weeks between August 2011 and 26 June 2012. While JX was still psychotic when seen by Dr Gutkin for the first time, he was considerably improved on the olanzapine. Dr Gutkin increased the dose of olanzapine from 5mg to 10mg nightly. After the first consultation, Dr Gutkin prepared a report dated 18 August 2011. In that report, he considered and discounted a diagnosis of bipolar disorder in favour of the view that JX's psychosis was either drug induced or was due to an underlying Primary Psychotic Disorder such as Schizophrenia or Schizoaffective disorder. In a letter dated 6 August 2014 (prepared for the purposes of this inquest), he expressed the view that JX's condition was probably a type of Schizophrenia – either Schizophrenia itself or Schizoaffective Disorder. In that same letter, he said that although it was possible this condition was drug induced or exacerbated by substance abuse, overall, he felt that there was very strong evidence for a primary psychotic disorder. Dr Gutkin continued to treat JX until 26 June 2012, after which JX declined to attend.

JX saw Mr Dawson four times between 11 August 2011 and 1 September 2011. Mr Dawson gave evidence that he viewed this as *"supportive counselling and reality testing"* following JX's recent mental disturbance. Mr Dawson diagnosed JX with drug-induced psychosis (because the episode was precipitated by cannabis use) and depression. During those sessions, JX continued to exhibit the psychotic

ideation that Chinese spies were monitoring him. He did not have any suicidal intent. Mr Dawson's short term prognosis was that JX had a good chance of recovering from the psychosis provided he stopped smoking cannabis. Mr Dawson was unsure of JX's long term prospects of recovering from depression because it was a long standing mental illness which had not been resolved by medication. On the last session, JX expressed the view that he did not want to continue with counselling. JX missed the next two scheduled appointments on 15 and 20 September 2011.

Medical treatment in 2012 and 2013

JX next saw Mr Dawson on 21 August 2012, when he presented for counselling with a renewed referral from Dr Norris. JX expressed a desire to receive counselling to learn how to regulate his emotions more effectively and to help achieve some of his life goals of having a career, a place to live where he felt comfortable, and to develop a romantic relationship with a woman. Mr Dawson had some reservations as to whether JX was invested in the process or whether he was attending counselling at his mother's behest. Mr Dawson noted that JX did not exhibit any psychotic symptoms. JX denied smoking cannabis.

It was around this time, in August or September 2012, that JX obtained a job at the Carbon Reduction Institute. It was a workplace that was clearly suited to JX's abilities and interests and it appears to have been a supportive workplace.

Ms McKenzie thought JX seemed very happy and positive about the job. However, in subsequent sessions with Mr Dawson, JX spoke about feeling out of his depth and being unable to concentrate at work. The job required JX to complete many written reports, which he struggled with. Mr Dawson suspected that JX may have undiagnosed ADD and in September 2012, he referred JX to neuropsychologist Dr Robin Murray.

Dr Murray came to the opinion that JX probably met the diagnosis for ADD and perhaps also had some kind of learning disorder. Dr Murray prepared a report which was provided to Mr Dawson. Consequently, Mr Dawson spoke with Dr Gutkin informally about medical intervention. He says that Dr Gutkin stated that he was uncomfortable prescribing Ritalin (methylphenidate) or dexamphetamine to JX because it may trigger a psychotic episode.

JX last saw Mr Dawson for counselling on 26 February 2013. He informed Mr Dawson that he wished to cease counselling because he felt he was no longer psychotic and he had achieved some of his goals, including obtaining employment in his field of expertise and living in a share house with friends. Mr Dawson was of the view that JX was not suicidal and that he had improved but he had not entirely resolved his depression. Mr Dawson suggested that JX continue to see a psychiatrist for medication review. He had no further contact with JX until 21 January 2014.

On 2 May 2013, JX saw psychiatrist Dr Kam Seng Wong at the Metta Clinic in Pymble. He attended without a referral (despite Dr Wong's request for one) seeking treatment for ADHD which he said Dr Murray had diagnosed him with. Dr Wong's detailed note of the initial consultation shows that JX provided a history that was

generally consistent. JX said that he was not taking any illicit drugs. Dr Wong diagnosed JX with ADHD and recommended that he manage it medically with Ritalin (methylphenidate) coupled with therapeutic treatment in the form of supportive counselling. He explained the side effects of taking Ritalin including *“that, in rare cases, Ritalin had triggered a psychotic episode if the person had an underlying psychotic condition such as schizophrenia or bipolar disorder with psychotic features.”* Dr Wong asked JX to consider whether he wanted to try Ritalin.

JX called Dr Wong's rooms on 7 June 2013, stating that he wanted to commence on Ritalin because he was concerned about his performance at work. Dr Wong issued a prescription to JX for Ritalin on the proviso that JX provide him with Dr Murray’s report and a referral at the next consultation on 17 June 2013. That prescription was filled on 13 June 2013.

JX was reviewed by Dr Wong four days after receiving his first supply of Ritalin. Although JX was still concerned about his performance at work, he reported an improvement in his concentration and a new ability to self-monitor. JX was specifically asked whether he experienced any side effects, including perceptual disturbance and suicidal ideation, and reported that he had not. He affirmed that he was not taking any illicit drugs. Dr Wong noted no signs of depression, psychosis, or suicidal thoughts.

Some time after the second consultation, Dr Wong received Dr Murray’s report. He noted that JX had told Dr Murray about his psychotic episode after smoking cannabis. He states that this did not cause him to alter his management plan as, based on the history provided, his clinical assessment and his observations of JX, he was of the view that JX was no longer taking any illicit drugs and JX was not exhibiting any signs or symptoms of psychosis or a drug induced psychosis.

JX last saw Dr Wong on 12 August 2013. He reported great improvement and no side-effects from Ritalin, although he reported taking the medication only 80% of the time. JX again confirmed that he was not taking illicit drugs. Dr Wong’s notes record JX's mood was – *"stable, no depression, not suicidal, oriented, not psychotic".* Dr Wong issued another prescription for 100 Ritalin 10 mg tablets to be taken twice daily. He subsequently used this script to obtain Ritalin on 23 August 2013.

JX did not attend a scheduled appointment with Dr Wong on 10 October 2013. On 12 December 2013, he telephoned Dr Wong's rooms, asking for a prescription for Ritalin as he had run out. Dr Wong arranged for this prescription to be sent to him. It appears that JX lost this prescription.

Medication

Relevantly to this inquest, JX was treated with three main types of medication – olanzapine (Zyprexa – an anti-psychotic), venlafaxine (Efexor or Altven – an anti-depressant) and methylphenidate (Ritalin – a stimulant).

As noted above, JX was prescribed olanzapine (Zyprexa) by Dr Smallman and Dr Gutkin to treat his psychosis in August 2011. He responded very well to it. However, it had significant side effects: in her report of 2 October 2012 Dr Murray noted that JX had gained 15kg since starting on Zyprexa and that he was sleeping about 12 hours each night. On 25 September 2012, when JX first saw Dr Murray, in response to the question: "Would you briefly describe your 3 main concerns at this time?" JX wrote only: "Zyprexa causes weight gain". JX appears to have stopped taking olanzapine around December 2012 or January 2013 with the last supply (according to his Medicare records) being on 4 December 2012. Although police found three olanzapine tablets in JX's bedroom after his death, it does not appear that he was using it at that time

JX was prescribed venlafaxine (Zyprexa or Altven) from his first consultation with a UNSW University Health Service doctor on 24 April 2006. On at least one occasion he ran out of the medication and had to obtain it urgently. It seems he obtained prescriptions from a number of doctors (including various doctors at the UNSW University Health Service, GP Dr Norris, and doctors at the Maroubra Medical Centre). However, JX was prescribed it more or less regularly. He was also taking it around the time of his death. Police found venlafaxine tablets in JX's bedroom after his death and post-mortem toxicology screening detected venlafaxine in JX's system.

JX was commenced on methylphenidate (Ritalin) relatively recently. It was prescribed for him by Dr Wong in June 2013. Medicare records show that he purchased 100 tablets on 13 June 2013 and on 23 August 2013. It appears that on the first prescription, JX advised to take the Ritalin three times a day. The dosage was changed to twice daily in August. Assuming that JX took the medication twice daily as advised from about 23 August 2013, his supply should have lasted until about mid-October 2013 (this also coincides with JX's scheduled appointment with Dr Wong on 10 October 2013 which he did not attend). Even if, as some evidence suggests, JX had only taken the medication on weekdays it is possible that he had run out of Ritalin by October or November 2013.

On 12 December 2013, JX called Dr Wong's rooms and asked for a prescription for Ritalin because he had run out. Dr Wong arranged for it to be sent to JX. However, it appears that JX lost the prescription while cleaning his bedroom in the beginning of 2014. On 6 January 2014, he called Dr Wong's rooms requesting a replacement prescription because he had lost the earlier one. Quite reasonably, Dr Wong advised JX that he would not supply it unless JX provided a statutory declaration confirming that he had lost the earlier prescription. No statutory declaration was ever received by Dr Wong. That being the case, it appears the last supply of Ritalin received by JX was purchased on 23 August 2013 and which he had expended by 12 December 2013. Police did not find Ritalin in a search of JX's room and post-mortem toxicology screening did not detect methylphenidate.

General circumstances in 2014

JX last spoke to his mother on a Thursday in January 2014. They attempted to make plans to have dinner. His mother thought that JX's life was going very well. He was still working as a Sustainability Engineer at the Carbon Reduction Institute and he was preparing for a presentation in Melbourne. He had recently started a relationship with Elise Newton, who he had known through mutual friends for about two years. After moving house four times in as many years he appeared settled at Maroubra. He lived there with a number of good friends, among them Jonathan Pye and Nicholas Clark.

Accordingly to Mr Clark, in the days and weeks prior to his death, JX was apparently quite disorganised and using cannabis a few times a week with friends. He says he noticed a change in JX after he reportedly lost his Ritalin prescription – JX became disorganised and had difficulty holding a conversation.

On Saturday, 18 January 2014, JX and Nicholas attended a farewell party in Erskineville. Nicholas gave evidence that JX drank "*a lot*" of alcohol and planned to "*kick on*" elsewhere and smoke cannabis with friends.

The next day, JX arrived late (at about 4.30pm or 5.00pm) to meet Elise for coffee because he had slept in. Elise thought that JX had a *"big night"* at the party. She noticed that JX had trouble focusing when she was talking but she attributed this to his dyslexia, which he had told her he had been diagnosed with, or the effects of the previous night. She did not otherwise think anything was wrong with him.

On the evening of Monday, 20 January 2014, Jonathan observed JX to be *"a bit depressed*" during dinner at home with friends. He describes JX as having sunken and wide eyes and staring off into space. Jonathan states that he was not engaging in conversation and could not remember where anything went while putting away the dishes.

The events of 21 and 22 January 2014

Jonathan was sufficiently concerned about JX's behaviour to make an effort to wake early on 21 January 2014 to check on him. He saw JX and thought he seemed completely different to the night before and looked normal. He says that JX had risen early and gone for a run and he was, unusually, on time to leave for work. Jonathan mentioned to JX that he had seemed down the day before and JX said it was because of the big weekend. Nicholas has a different recollection of JX's behaviour that morning – he recalls that JX was "*running late for work, as usual."* Nicholas states that he handed JX a slice of pizza to eat on his way to work.

At an unknown time, JX left his home at Maroubra to attend work at the Carbon Reduction Institute in North Sydney.

JX goes to work

JX arrived late to work at about 1.00pm. It is not known where he spent the morning after he left home. On arrival, he entered the office of the General Manager, Matthew Dyson. Mr Dyson asked JX how he was going, to which JX replied, *"Not so good"*. JX said he wanted to have a chat.

The two proceeded to a loading dock in the building where they could chat in private and have a cigarette. JX told Mr Dyson that he had encountered a "*crazy"* individual in Maroubra earlier that day who was trying to get JX to choose a range of books that he wanted to donate to UNSW. JX said he had a coffee with him. JX told Mr Dyson that this person had "*set him off"* and that he wished he had not met him. JX repeated his account of this meeting. He also discussed a range of other topics, including magazines in the office which he thought were about conspiracies. Mr Dyson recognised that JX was speaking randomly about various subjects, noticed that JX appeared to be quite anxious and that JX was perspiring and had an absent focus. He became concerned for JX's welfare and enquired about his past mental health. JX told Mr Dyson he had behaved this way previously and that he had *"some occasional depression and psychosis".* In answer to Mr Dyson's enquiry: *"Have you in the past or even now thought about hurting yourself or someone else?"* JX replied "*Yes"*. Mr Dyson asked JX if there someone he could call, and JX mentioned "*a psychotherapist named Geoff*" in North Sydney (referring to Mr Dawson). It was agreed that they would visit him.

JX and Mr Dyson retrieved JX's bag from the office then left work at about 1.20pm. They walked to Mr Dawson's rooms which were nearby. *En route*, JX continued to repeat himself and was sweating. They stopped twice – once at a café to buy JX coffee and an orange juice and a second time so that JX could sign up to donate to Lifeline. Mr Dyson appears to have been fearful of inadvertently triggering an unexpected reaction from JX and accordingly, did not interrupt these excursions.

JX and Mr Dyson attend Mr Dawson's rooms

They arrived at Mr Dawson's rooms at around 2.10pm. Mr Dawson was with a patient at the time. They spoke briefly with another psychologist, David Brennan, who observed JX to be sweating, agitated and displaying an inappropriate level of emotion. As a result of this brief interaction, Mr Brennan formed the view that JX was in a mild psychotic state, although he did not think that JX was suicidal.

Mr Dawson's wife, Diana Devitt-Dawson, who is a registered nurse and midwife with rooms in the same office complex, also spoke to JX. She recalls that JX spontaneously said, "*There's a problem. There is hot water coming out of the cold tap, and cold water coming out of the hot tap"*. She states that besides this abnormal conversation, JX did not display any signs of concern. However, Mr Dawson recalls that his wife later told him that she had thought JX was in a psychotic state.
Mr Dyson states that he gave Mr Brennan his and JX's full names and mobile telephone numbers and asked him to request Mr Dawson call as soon as his

consultation finished. JX and Mr Dyson then left to wait in a nearby café from about 2.20pm.

They headed back to Mr Dawson's rooms at about 3.15pm. *En route*, Mr Dawson – who had been advised of JX's presentation by Mr Brennan – called Mr Dyson and told him that he could see JX prior to his next appointment at 4.00pm. Mr Dawson then called Dr Gutkin's mobile number but it went to voicemail.

JX and Mr Dyson arrived at Mr Dawson's rooms at about 3.20pm. JX was seen by Mr Dawson immediately and alone for about 15 minutes. Mr Dawson observed that JX *"was sweating profusely, he had a wild look in his eye, he had difficulty controlling his facial features, he had an elevated mood, he was giggling and smiling inappropriately, his speech was disorganised and jumping from topic to topic and not making sense".* Mr Dawson very quickly formed the opinion that JX was in a psychotic state and required medical assistance. He told JX of his opinion. He asked JX whether he was feeling suicidal, to which JX hesitated and then said; "*everything is clear now".* When Mr Dawson asked JX the question again, JX denied any suicidal thoughts. Mr Dawson was unconvinced by his response.

Mr Dawson, with JX's consent, then invited with Mr Dyson into the room. Mr Dyson recounted the events since JX's arrival at work. Mr Dawson told Mr Dyson that he thought that JX was in a psychotic state and required immediate medical intervention. Mr Dawson asked them to wait while he attempted to contact Dr Gutkin.

At 3.40pm, Mr Dawson called Dr Gutkin again, this time on his office number. He was again unable to reach Dr Gutkin.

Mr Dawson contacts the Mental Health Acute Team

At 3.42pm, after being unable to reach Dr Gutkin, Mr Dawson called the Mental Health Line. Mr Dawson was aware of the existence of the service but had not had cause to call it previously. He searched the internet for the number.

Exhibited before me was a NSW Health – Northern Sydney Local Health District webpage entitled 'Acute Team – Lower North Shore' and dated 13 August 2014. Mr Dawson saw the webpage at the inquest and although he did not recall whether that was the webpage he found on 21 January 2014, he recalled that it was similar. Under the heading '*Urgent cases*' was written:

> *There are several options to access urgent mental health care:*
> *Ring the **Mental Health Line on 1800 011 511.** This line is staffed 24 hours a day, 7 days a week. You will be able to speak with a clinician who can provide recommendations about how to manage the situation or put you in contact with the appropriate mental health team.*
>
> *In urgent cases you can attend the **Emergency Department at Royal North Shore Hospital** where there is 24 hour access to specialist mental health care and support.*

*If the situation is urgent or becoming dangerous ring **Triple Zero (000)** and request ambulance and/or police. They will be able to assist the person safely to the hospital Emergency Department to access mental health care.*

The call charge records show that Mr Dawson called the Mental Health Line on the number provided. That call lasted 13 or 14 seconds. The call charge records also show that Mr Dawson called 1800 116 282 three or four seconds after calling the Mental Health Line. The same records show that Mr Dawson called (02) 9585 7777 at 3.43pm and that call lasted 450 or 451 seconds. Mr Dawson does not recall whether he called that number or if he was transferred to it from either of the 1800 numbers.

Mr Dawson thought that he was speaking to a person attached to the Lower North Shore Mental Health Acute Team. However, just prior to the inquest convening, it emerged that the telephone number is that of the Ryde Community Mental Health Centre from which the Ryde Mental Health Acute Team operates. The confusion may have been caused by the Ryde Community Mental Health Centre being the nominated referral point for non-urgent matters on the webpage entitled 'Acute Team – Lower North Shore'. This has now rectified to refer to the Lower North Shore equivalent.

As a consequence of the late identification of the telephone number being that of the Ryde Community Mental Health Centre, there was also late identification of the social worker and intake officer, JVB who spoke to Mr Dawson. Mr Dawson and JVB give different accounts of the discussion between them. Mr Dawson had the advantage of providing a near-contemporaneous account in a statement dated 25 January 2014. JVB did not prepare a statement until 30 August 2014.

When Mr Dawson called, relevant staff members were in a handover meeting which regularly took place between 3.30pm and 4.00pm. Mr Dawson spoke to a person who he believed was a receptionist and was initially asked to call back in an hour. JVB was called out of the meeting and took the call after Mr Dawson indicated that he was calling in regard to an emergency and he needed to speak to someone before his next client arrived at 4.00pm.

On Mr Dawson's account, JVB came to phone and asked, *"Who are you and what do you want?"* She did not identify herself to him. JVB gave evidence that she would not be so brusque to a caller but I have no reason to reject Mr Dawson's account.

It is agreed that Mr Dawson told JVB that he was a psychologist and he was with a client. It is also agreed that Mr Dawson gave her some information about the client. Mr Dawson recalls describing JX's symptoms and advising that in his opinion JX was in a psychotic state. JVB could not recall whether Mr Dawson detailed the client's symptoms. In any event, JVB recalls that she formed the opinion that the client was psychotic.

Mr Dawson asked JVB what assistance she could provide. He had spoken to a member of a Mental Health Acute Team once prior, although in circumstances following a crisis. He expected that the Mental Health Acute Team would *"take over the situation"* by coming to his premises or speaking to JX and making an

assessment. He gave oral evidence that he was willing to stay on the phone as long as was required to provide the background information necessary for the service to perform its functions and that, despite not having seen JX for a year and having no access to JX's file at the time, he had sufficient recall of JX's history to inform JVB of the salient aspects. Mr Dawson says that he was told the Mental Health Acute Team could not assist. This is disputed by JVB, who gave evidence that she would *"never"* inform a caller that the service could not help. Again, I have no basis on which to reject Mr Dawson's account, although it could be that they were at cross purposes and JVB was merely trying to convey that the service could not send somebody to assess JX at Mr Dawson's rooms.

JVB states that from the description that Mr Dawson was providing, she formed the opinion that JX should attend a hospital emergency department where he could undergo an assessment by a mental health practitioner in a safe environment. She does not recall the exactly what she said but she believes she said words to the effect; "*You need to call an ambulance to take him to an ED so that he can be assessed by a mental health person".* Mr Dawson agreed that he was advised to have JX taken to hospital by ambulance. He also recalls he was warned psychotic patients often *"do a runner"*.

Mr Dawson recalls discussing the possibility of having Mr Dyson take JX to the hospital because JX seemed to have a good and trusting relationship with Mr Dyson and JX appeared to want help because he came to his rooms. Mr Dawson gave evidence that JVB agreed with his suggestion and said that the most important thing was that JX was safe. JVB does not recall being told about any alternative plan for JX to be taken to hospital by his boss but concedes that it could have been said. She gave evidence that she would not have encouraged transport by any means other than by ambulance. In her opinion, whether a psychotic patient should be transported privately was a matter of clinical judgment and she would not have made that judgment call without having assessed the patient.

Mr Dawson returned to JX and Mr Dyson. He recommended that JX attend the Royal North Shore Hospital Emergency Department ("RNSH ED"). JX hesitantly agreed to Mr Dyson accompanying him there.

Mr Dyson recalls that at some point prior to them leaving Mr Dawson's rooms, Mr Dawson asked JX whether he wanted him to contact his family, to which JX replied, *"No".* Somewhat in contradiction to this, Mr Dawson states that he went into his office to search for JX's file with the intention of informing them of JX's visit. Upon doing so, he realised that he had archived the file since he had not seen JX for a year. Mr Dawson gave evidence that when he took steps to contact JX's parents later in the evening it was an emergency situation which overtook any confidentiality concerns and did not mean that the conversation did not take place.

Meanwhile, JVB had returned to the handover meeting. At some point, an 'Intake Log' was complete which recorded *"Jeff Dosan"* (sic) called at 3.45pm on 21 January 2014 and the "Brief Reason" for the call was recorded as *Call to Julia".* The note was initialled *"JB".* This was to be the Ryde Mental Health Acute Team's only record of the telephone call between Mr Dawson and JVB. Not even JX's name was recorded.

JVB stated that she probably intended to complete the paper triage module after the handover meeting but it slipped her mind. She gave evidence that it was her usual practice to do so after finishing a call. However she also said she would not normally attempt to alert a hospital of a patient's impending arrival because, if transported by ambulance, it was impossible for her to know which hospital they would be taken to. JVB noted that she would often expect a referring clinician (like a psychologist) to provide a referral letter which would accompany the patient to hospital.

I will return to this issue in the recommendation section of this report.

JX attends the RNSH

JX and Mr Dyson travelled by taxi to the RNSH in St. Leonards (a distance of less than 2km). Although the time stamp on the taxi receipt shows that they arrived at 3.59pm, according to the RNSH CCTV recorded vision they walked into the Emergency Department at about 3.56pm. On arrival, they spoke to a person at the reception area and then waited in the waiting room for a triage nurse to attend to JX.

The electronic triage record notes that JX was triaged by registered nurse Angela Becker. JX was in fact triaged by registered nurse Emma Curtin who appears to have entered the record while RN Becker remained logged into the system. Both recall that the shift was busy. RN Becker has provided a statement to the effect that she has amended her practice to ensure that she logs out of the system on completion of each entry. She no longer provides her password to other staff. RN Curtin states that she now ensures all of her entries are entered under her password. No issue arose from this record-keeping error.

According to the electronic triage record, triage commenced at about 4.08pm. The record notes the following in relation to JX's presentation:

> *PRESENTS WITH WORK COLLEAGUE, REPORTS ANXIETY TODAY WHILE AT WORK, WALKED INTO EMPLOYER AND REOPORTED* [sic] *HE FELT HE WAS NOT DOING WELL, O/A PT ALERT, TALKING, GCS 15/15, PEARL, VAGUE AT TIMES, NIL PRESSURESED* [sic] *SPEECH, DENIES ANY CHEST PAIN/SOB …*
> *FVERS/VOMITING* [sic], *MILD HEADACHE AT TRIAGE, PMH: DEPRESSION, ADHD, ANXIETY, PT CALM AT TRIAGE, DENIES ANY HALLUCINATION, NIL ETOH, HAD "JOINT" AT WEKEND* [sic]

JX had appeared reluctant to admit to drug use when seen with Mr Dyson. He admitted to having a "joint" when spoken to alone. RN Curtin recalls that JX remained calm and alert and was walking and talking throughout the triage process. She gave evidence that the triage probably concluded at about 4.14pm.

Mr Dyson was concerned that JX was downplaying the seriousness of his condition and so, according to his statement, following the assessment, he approached RN Curtin and the following is said to have occurred:

> *…I approached the nurse on my own and said that whilst I didn't want to overstate the events of the afternoon I also wanted to make sure that Royal*

> *North Shore wasn't getting a lessened version from JX. I further stated that JX's psychologist Geoff DAWSON, who we'd just come from, had said he thought JX experienced a psychotic break. I gave the nurse Geoff's card which he had given to me to give to the hospital if needed. The nurse was thankful and said she was going to have a member of the mental health team come down to Emergency and evaluate JX as soon as possible.*

In her statement, RN Curtin makes no reference to this discussion with Mr Dyson and said in evidence that she did not recall it occurring. Mr Dawson's business card was apparently not on the patient file and Mr Dyson's account could not be tested by cross examination as he was not available to give evidence. Nevertheless, his statement was made only eight days after the events and I have no reason to doubt its accuracy. Accordingly, I accept Mr Dyson's version of what occurred.

RN Curtin recorded the reason for the triage visit as *"MH* [mental health] *– behavioural disturbance".* She gave JX a triage category of "3". She said in evidence that she categorised JX as such because he had *"a change in his behaviour that day and he had a past history of depression".* This meant that JX should be assessed by a doctor within 30 minutes from the time at which triage commenced.

The RNSH Emergency Department uses the Australasian Triage Scale which classifies patients presenting to it into categories 1 to 5 according to urgency (with 1 being the most urgent). On a NSW Health webpage describing the triage process, a Category 3 patient is described as follows:

> *People who need to have treatment within 30 minutes are categorised as having a potentially life-threatening condition. People in this group suffer from severe illness, bleed heavily from cuts, have major fractures, or be dehydrated.*

RN Curtin states that at approximately 4.20pm she spoke to Mental Health Clinical Nurse Consultant ("CNC") Colleen Olmstead. They discussed JX's presentation in terms generally consistent with that recorded in the electronic triage record. CNC Olmstead states that, based on that information, she had no reason to think that JX presented as a risk of suicide or a risk to others.

RN Curtin says that after speaking to CNC Olmstead she asked Mr Dyson to stay with JX as his account of the events would be important for the mental health team and medical assessment. She then escorted JX and Mr Dyson to the waiting room and asked them to wait for further assessment.

The medical assessment of JX was initially assigned to Dr Jacqueline Ward at about 4.22pm. However, Dr Ward was called away to an emergency resuscitation and it was not until about 5.03pm that JX was reassigned to another doctor. By that time, the recommended thirty minute period had elapsed and JX had left the hospital.

JX leaves the Royal North Shore Hospital

JX was restless while waiting to be seen. He told Mr Dyson that he intended getting a cold drink. Mr Dyson thought nothing of the plan, as JX had felt hot and dehydrated throughout the afternoon and the coffee shop was adjacent to the waiting room. No one had told Mr Dyson that JX was at risk of absconding.

RNSH CCTV footage shows that at about 4:41pm, JX walked out of the Emergency Department. In that footage, JX appears to be calm and walking steadily. The waiting room was accessible by administrative staff, the triage nurse and a Clinical Initiatives Nurse ("CIN") who is a registered nurse assigned to that area to visually observe patients, perform formal observations and start treatment. This inquest did not identify the administrative staff and CIN and accordingly, no evidence was obtained by them as to whether they observed JX leaving the hospital.

JX did not return to the Emergency Department. At about 4:52pm (according to the RNSH CCTV footage) Mr Dyson left the waiting room looking for JX. He told staff at reception that JX had left. From 4.58pm, Mr Dyson called and sent text messages to JX to attempt to find out his whereabouts and ensure his safety.

At 5.03pm, Dr Thomas Uebergang, after consultation with Dr Ward, assigned JX's medical assessment to himself. He called JX's name twice but by that time, unbeknownst to him, JX had already left. He said that the ward clerk told him that JX had gone out with his friend to buy a drink. Dr Uebergang gave evidence that he called JX's name again about 15 minutes later but there was no response. He states that he may have asked the ward clerk whether there was a mobile telephone number to contact JX or Mr Dyson, which either they could not find or they had tried with no success. As noted previously, Mr Dawson's card, which Mr Dyson states was provided to RN Curtin, was not included in JX's RNSH medical records produced for the purposes of this inquest.

Dr Uebergang said he enquired of the triage nurse as to whether JX exhibited any sign of suicidal ideation or risk of self-harm, to which he was told *"No".* He said that, after discussing the matter with an ED Registrar (who told him that he had done all that he needed to do), he asked the ward clerk to mark JX on the system as "*did not wait".*

Staff at the reception desk told Mr Dyson that a doctor had called for JX. Mr Dyson left the hospital just before 5.30pm in a taxi and returned to the Carbon Reduction Institute to collect his belongings. He then headed to a local pub to meet with friends. He spent the evening attempting to locate JX via his mobile telephone.

JX travels to Kingsford and Maroubra

JX's precise movements after he left hospital are unknown. However, his bank records show that at about 6.45pm, he bought beer, whisky and cigarettes in Kingsford.

It is apparent that JX later travelled to Maroubra.

Mr Dyson and Mr Dawson attempt to locate JX

Between 4.58pm and 11.41pm, Mr Dyson made many attempts to contact JX and his friends and colleagues by telephone. After Mr Dyson told Mr Dawson that JX had left the RNSH before being seen, Mr Dawson also attempted to locate him and his parents by telephone. It is clear that both were concerned for JX's welfare and took steps to try and to ensure his safety.

Mr Dawson sent a text message to JX at 6.30pm. He let JX know that he had his and Mr Dyson's support. At 7.01pm, Mr Dawson received two text messages from JX which read: *"Hey. Might go sit on cliff and stare at the see"* and *"Sorry sea".*

Following this, Mr Dawson used Google to search for JX's parent's phone number. Mistakenly believing them to live in Avalon, he searched for the family name in Avalon to no avail. At around this time he contacted Dr Gutkin and left a message. Mr Dawson states that Dr Gutkin called him later that evening and said that the best thing for JX was to get him to a casualty ward. Dr Gutkin otherwise had no involvement in the events of 21 January 2014.

At around 7.36pm, JX's friend and colleague, Dean Redman, spoke to JX by telephone. JX told Dean that he had had a strange day, but *"everything is normal"* and he would not be at work the next day. Mr Redman reported this to Mr Dyson.

After numerous calls and text messages went unanswered, Mr Dyson was finally able to make contact with JX at 7.53pm. The call was of about four minutes' duration. Mr Dyson recalls the conversation as follows:

> *After several attempts JX took my call initially asking, "Who is this?" which I found odd given I was confident my number was programmed in his phone. My goal on this call which ended up being the last was to find out where JX was so I could go to him. The best I could determine was that he was most likely down towards his home at Maroubra. I determined this as throughout the conversation I asked whether JX was on the north or south of the Harbour and he said "South". I said "Oh so you're close to home then?" and JX said words similar to "Something like that". During the call he mentioned he was on the edge of a cliff. I told him I'd like to have a beer with him [to] which he replied that he was having a beer. After a bit of back and forth and doing the best I could to let him know everything would be okay, JX said "I fucked everything up". He then said "I am going to do the wrong thing" insinuating suicide. I was constantly trying to reassure JX that everything would be*

alright. I just wanted to find out where he was. JX ended up hanging up on me. I cannot recall the last words spoken.

Between 8.00pm and 8.05pm, the following text messages were exchanged between JX and Mr Dyson:

Dyson:	*JX you're a great guy mate with plenty of friends including myself so would you please go home and either call or text me from there? Thanks Matt*
JX:	*Shit happens*
Dyson:	*Come on mate*
JX:	*I hate everyone*
Dyson:	*Let's have a beer. Where are you?*

Mr Dyson immediately reported the contents of his recent communication with JX to Mr Dawson in a text message which read:

Hi Geoff sorry to call and text you again but I just spoke with JX and in short he is now threatening suicide, more specifically jumping off a cliff because he's screwed everything up. I also know from the conversation that he's having a beer and he's down near home near Maroubra. Below is my text to him just now with which he replied 'Shit happens' so I think a call to family is needed.
Thanks Matt

Mr Dyson missed a call from JX at about 8.20pm. He returned the call one minute later but that went to voicemail. At 8.22pm Mr Dyson received a text from JX which simply said *"Hello".* Despite Mr Dyson's continued attempts to contact JX he heard nothing further.

Mr Dawson was leading a meditation group between 7.00pm and 9.00pm. During a break at around 8.30pm he saw the text message sent by Mr Dyson advising him of his fear that JX was contemplating suicide. They each tried to make contact with the other and managed to do so at 9.03pm. At that point, Mr Dyson reiterated the contents of the text message and said that he had now lost telephone contact with JX and his calls were going to voicemail. Mr Dawson told Mr Dyson that he was going to call 000.

Mr Dawson then tried to call JX. He also got JX's voicemail. He did not leave a message. He searched again on Google for JX's parent's phone number and this time, managed to find a number which might have belonged to them; however, he got voicemail when he called it and did not leave a message because he was unsure whether it was the right number.

Mr Dyson calls 000

Mr Dawson called 000 at 9.16pm. He identified himself by name and occupation. He reported that JX was a 29 or 30 year old patient of his with a history of depression and schizophrenia who was taken to RNSH by his boss to be admitted in a psychotic state but he *"did a runner".* He said that JX's boss had told him that JX was sitting on

a cliff hear his home in Maroubra drinking beer and in the last conversation JX said he was feeling suicidal.

Mr Dawson provided his and Mr Dyson's name and contact details. He provided JX's name (emphasising that his surname was hyphenated) and JX's mobile telephone number. He did not know JX's street address.

Police search for JX

The information passed on by Mr Dawson in the 000 call was broadcast over the NSW Police Force VKG radio system and the NSW Police Force Computer Aided Dispatch (CAD) system at 9.27pm. Similar information was broadcast over both. The narration of the CAD log entry 'Incident Header' relevantly reads as follows:

> *INFT HAS RX INFORMATION THAT CLIENT JX 29 OLD – PH:0000000000 IS SITTING ON A CLIFF FACE DRINKING BEER OVERLOOKING SEA – IN PSYCHOTIC STATE – FEELING SUICIDAL – PERSON OF INTEREST HISTORY DEPRESSION – SCHIZOPHRENIA – INFT HAS RX CALL FROM POIS EMPLOYER MATT DYSON [mobile number entered] WHO HAS BEEN IN CTC WITH PERSON OF INTEREST. PERSON OF INTEREST BELIEVED TO RESIDE IN MAROUBRA. IS POSS IN MAROUBRA AREA – NFI RE PERSON OF INTEREST LOC. CHKS OTW.*

Despite the reference to JX possibly being in the Maroubra area, the CAD job was allocated to North Sydney, possibly because that was the location from which Mr Dawson had called or JX was last seen. It was also broadcast on the Rose Bay list instead of the Maroubra list, possibly because Rose Bay would encompass The Gap. Because of this, the early police response involved a number of Local Area Commands.

By 10.15pm (i.e. 48 minutes after the incident was broadcast on VKG and CAD), police had taken the following steps:

- At 9.28pm, a link to JX's CNI record was found and broadcast on CAD;
- At 9.29pm, police had searched COPS and found JX's last recorded address, being the Waterloo address.
- Constable Daryl Johnson, who was stationed at North Sydney, contacted Mr Dawson. Mr Dawson provided a physical description of JX. He said that he did not think JX was violent.
- Constable Johnson contacted Mr Dyson who provided him with information about JX's presentation that day and him leaving the RNSH before being seen. Mr Dyson continued to make attempts to contact JX by telephone, without success, until 11.14pm.
- By 10.13pm, police were aware that JX's last known address was in Maroubra. Constable Johnson with his supervisor, Senior Constable Stephen Bell, requested triangulation of JX's phone.
- An "all resources" broadcast was made at 10.13pm.
- By 10.15pm, Rose Bay police were monitoring cameras at The Gap for any sign of JX.

- By 10.15pm, Acting Sergeant Ashley Callaghan of Maroubra Police (who was rostered on duty as the external supervisor) had arrived at the cliffs at Maroubra beach to look for JX.

Acting Sergeant Callaghan was notified of the incident by Inspector Stephen Egbers, the Duty Officer for Eastern Beaches Local Area Command, which includes Rose Bay and Maroubra. He was monitoring the Rose Bay channel for an unrelated matter. While monitoring that incident, he noticed the CAD message relating to JX. Confused as to why it did not appear on the Maroubra list, he monitored the message for a short time as it appeared that Harbourside LAC (which includes North Sydney) was making enquiries. At about 9.55pm, Inspector Egbers brought the incident to the attention of Acting Sergeant Callaghan and directed her to gather some police and arrange for a search of the coast line south from Mistral Point in Maroubra. He told her that police should start searching for JX despite there being no confirmation that JX was in Maroubra.

The area specified by Inspector Egbers is known by police as an area frequented by those contemplating taking their lives. Maroubra beach spans a reasonably large area of shoreline east of Marine Parade. To the north is the Jack Vanny Memorial Parklands which leads into the cliffs on the east side of the park. The Arthur Byrne Reserve is situated to the west of the beach. At the southern end of the beach, there are cliffs which lead into the Malabar Rifle Range. An area of cliffs on the southern end of the beach is known as Magic Point. Photographs of Maroubra beach, Magic Point and its surrounds show areas of steep cliff faces and scrubby bush. Unbeknownst to police at the time, JX would sometimes walk with friends to old, abandoned WWII bunkers at Magic Point.

On arrival at Maroubra beach, Acting Sergeant Callaghan asked police radio to check whether JX had any vehicles registered to him and was told that he did not. She proceeded to conduct mobile patrols around Marine Parade and the Jack Vanny Memorial Parklands, the latter using high beam lights on the police vehicle to search the cliffs on the northern end of the park.

After she heard the all resources job broadcast, she requested Eastern Beaches vehicles meet her to assist with a search. A short time later, Constables Timothy Bujeia and Greg Adams arrived in one vehicle and Senior Constable Danielle Rogers and Senior Constable Tegan Smith in another. The Constables were directed to search the northern cliff top by foot. The others were directed to patrol further south including the beach and Arthur Byrne Reserve. Acting Sergeant Callaghan conducted a foot search easterly through the parklands to the cliffs and the Jack Vanny Memorial Park. She made enquiries of members of the public who reported that they had not seen JX.

By 10.36pm the searches by the Maroubra police had proved fruitless. Acting Sergeant Callaghan then directed Constables Bujeia and Adams to attend a Clovelly address to which JX was linked. They returned having found out that JX did not live there.

Police received the results of triangulation of JX's mobile telephone at 10.54pm. It showed that JX's mobile telephone was bouncing off the Village Green shopping

centre on Malabar Road, Maroubra. The triangulation suggested that JX could be within 500m of that location. This was the first direct evidence confirming that JX was in Maroubra.

Senior Constable Bell contacted Acting Sergeant Callaghan and told her of the triangulation results. Responding to that information, Acting Sergeant Callaghan directed Constables Bujeia and Adams to search the southern end of Maroubra Beach, while she and other police searched other locations surrounding Maroubra beach.

While conducting a foot search of the south end of Maroubra beach, Constable Bujeia, on his own initiative, attempted to contact JX using his personal mobile telephone. JX answered at 11.14pm. Constable Bujeia told him that he was from Maroubra Police Station and asked JX to meet him so they could have a chat. They spoke for about 11 minutes while Constables Bujeia and Adams tried to work out where JX was. Although a precise location was never revealed, JX did say that he was near cliffs on the headland near the shooting range. JX, at one stage, said that he could see a torchlight (held by Constable Adams) and agreed to walk towards it. However, shortly after this JX's mood seemed to change and he told Constable Bujeia that he was *"getting his things together".* He said; *"it just has to be done", "it's too late"*, and that he was *"going to end it"* or *"going to do it"*. Constable Buejia told him that *"nothing is ever that bad"* to which JX responded *"I have to go"* and hung up.

JX had told Constable Bujeia that he had been drinking whisky. Constable Bujeia later said that he sounded drunk and depressed. The officer not unreasonably formed the impression that JX had suicidal intent and soon after told Acting Sergeant Callaghan and Inspector Egbers of this.

It was at about 11.25pm that JX terminated the call. Triangulation of JX's mobile telephone shows that it was last active at 11.26pm, meaning that, at that time the telephone was either switched off or destroyed. Subsequent attempts by Constable Bujeia, Inspector Egbers and Mr Dyson to call JX went to voicemail.

Maroubra police continued their search and were joined by Inspector Egbers. However, they were restricted by the dangerous conditions facing them as they searched around cliffs at night time. A police dog who attended at about midnight also faced a similar difficulty; 'Horace' had to be kept on a leash during the search as he would be unable to sense depth and could fall. Due to what Inspector Egbers assessed to be dangerous surf conditions he decided not to request the assistance of water police. His request for an air search by PolAir was met with the response that they were no longer on duty. Further, evidence obtained in this inquest indicated that it could not have flown in any event due to the weather conditions. Inspector Egbers states that he considered whether to instruct police to conduct further searches but decided against it because he was satisfied as to the searches undertaken and because of the risk to officers' safety.

Inspector Egbers stayed at Maroubra beach until 1.00am on 22 January 2014. He then returned to Maroubra Police Station and conducted computer searches to locate JX's current address. In his experience, searching with a hyphen can produce an inaccurate result. Inspector Egbers managed to find an address in Glebe and

then located JX's, Maroubra address on Roads and Maritime Services records. Inspector Egbers checked the address against the triangulation maps and saw that while it was outside of the area logged at 12.28am, it was within the area logged at 12.10am.

Inspector Egbers attended the Maroubra address at about 1.10am. He saw lights on upstairs but there was no answer to his knock. Other police attended the Glebe address at his direction with nil result.

Further triangulation showed that JX's mobile telephone was still turned off at 3.30am.

Inspector Egbers shift was rostered to conclude at 6.30am. At a handover at about 5.30am, he instructed the incoming Duty Officer, Acting Inspector Daniel McKerrow, to conduct an air and ground search at the earliest opportunity after day break.

Those instructions were followed. Constables Dean Byrne and Kyle Thompson attended the Maroubra address at about 6.00am. They entered the residence (which was unlocked) and spoke to Nicholas Clark, who told them that he had not seen JX since the previous day. They inspected JX's bedroom and saw that the bed was made and looked like it was not slept in. From about 7.20 am, Maroubra police continued searches of Maroubra beach and its surrounds. A request for assistance was made to PolAir at 9.41am. Polair was in the air and searching at 10.58am.

JX's parents are notified

The events of 21 January 2014 unfolded unbeknownst to JX's parents. It was at about 7.30am on 22 January that they first became aware of his disappearance, after one of JX's friends contacted them to advise that Maroubra police were looking for JX. The family then travelled together to Maroubra beach and Maroubra Police Station to make inquiries.

Mr Dawson contacted Dr Gutkin's rooms the following morning and obtained JX's fathers mobile telephone number. He called JX's father at about 9.30am and informed him of the situation. JX's father told him the family was already aware of the situation.

The death is discovered

At about 10.58am, PolAir 3 arrived and commenced searching around Magic Point and Maroubra generally. At 11.06am, PolAir officers sighted a naked body floating about 300 metres north of Magic Point, Maroubra

The investigation

The NSW Police Force initiated Strike Force Pavlo to investigate the circumstances surrounding JX's death. Detective Senior Constable Andrew Sheehy was assigned to that investigation.

Scene examination

Although searches on foot and by air were subsequently conducted of the land around Magic Point and Boora Point (to the south) no signs of any property associated with JX were ever found. The exact location from which JX entered the water is therefore unclear.

A police search of JX's bedroom relevantly found medication, including Altven and an empty Talisker whisky bottle. Nicholas Clark gave evidence that they collected spirit bottles to use as water bottles. It is unknown whether the bottle found in JX's bedroom was that purchased by him on 21 January 2014.

JX's body was identified by his mother on 23 January 2014.

Autopsy results

Forensic pathologist Dr Liliana Schwartz conducted a post-mortem examination on 23 January 2014 limited to an external examination, radiography and toxicological sampling. Following receipt of a Certificate of Analysis showing the results of toxicology screening, Dr Schwartz prepared a Limited Autopsy Report dated 3 June 2014. Dr Schwartz also prepared a letter dated 8 August 2014 addressing specific questions.

Dr Schwartz summarised the contents of her report as follows:

> *At autopsy, there was evidence of extensive multiple injuries including bruises and abrasions of the face, bruises, abrasions and lacerations of the trunk and limbs, and fracturing of long bones.*
>
> *The x-rays taken from the skull and neck showed compound fractures of the calvarium and base of skull with possible frontal bleeding and possible fracturing of the upper cervical spine.*
>
> *The toxicological analysis of the post mortem blood and ocular fluid specimens showed small amounts of alcohol and venlafaxine*.

It was certified that alcohol (0.084g/100mL in the femoral blood preserved and 0.057g/100mL in the vitreous humour preserved) and venlafaxine (<0.05mg/L in the femoral blood preserved) were detected. Despite the evidence that JX had smoked cannabis at the farewell party on 19 January 2014, no metabolites of cannabis were detected. Supplementary toxicology screening did not detect olanzapine or methylphenidate.

Dr Schwartz expressed the opinion that the level of venlafaxine detected was "*very likely below the therapeutic range*" and that the level of alcohol detected "*may have caused an increasing impairment of reaction times, visual acuity and judgment*".

In her report, Dr Schwartz concluded that JX died from multiple injuries. She supplemented this opinion in her letter, in which she expressed the opinion that if JX's head injuries were caused at the time of the fall from a cliff, the cause of death would be "multiple injuries". If however, the injuries were caused during the peri-mortem or post-mortem period, then the cause of death would be "drowning complicating multiple injuries" because the other injuries would have incapacitated him causing the drowning.

Expert reports

The inquest received the expert report and oral evidence of consultant psychiatrist, Associate Professor Michael Robertson.

Associate Professor Robertson was asked to provide a report on the following questions:

1. Is cannabis, alcohol, Ritalin, Zyprexa (olanzapine) or Efexor (venlafaxine) and/or any combination of them, known to contribute to or cause a psychotic episode?
2. Was it appropriate for Dr Kam Seng Wong to prescribe Ritalin to JX?
3. Was JX in a psychosis or other altered mental state at any time on 21 January 2014?
4. Were the actions of Mr Geoffrey Dawson on 21 January 2014 appropriate?
5. Was the response of the Lower North Shore Mental Health Acute Crisis Team appropriate?
6. Were the actions of staff at the Royal North Shore Hospital appropriate?
7. Are there any recommendations that the State Coroner could make to prevent similar deaths occurring in similar circumstances?

He was also invited to make any other relevant comments.

In answer to the first question, Associate Professor Robertson expressed the opinion that:

> *Of the listed medications, cannabis and methylphenidate are associated with induction of psychotic symptoms. Excessive consumption of alcohol can exacerbate an underlying diathesis to psychosis and in some circumstances alcohol withdrawal delirium may be associated with psychosis. A rare syndrome, known as 'alcoholic hallucinosis' is usually seen when there is an abrupt cessation of consumption of alcohol or reduction of alcohol.*
>
> *Venlafaxine and other newer antidepressant medications have been associated with some psychotic symptoms, de novo (much of this evidence is anecdotal). Antidepressants such as venlafaxine can induce mania or hypomania in vulnerable patients as part of a so-called 'anti-depressant switch'.*

> *Olanzapine is an anti-psychotic medication and rarely contributes to psychosis unless there is a severe complication to treatment such as neuroleptic malignant syndrome.*

Associate Professor Robertson noted that whether it was appropriate for Dr Wong to prescribe Ritalin to JX is a *"controversial issue which could divide opinion".* He referred to the fact that Dr Wong was not availed of JX's history of the psychotic episode in August 2011 (although I note that he was sometime after the initial prescription of Ritalin when he received Dr Murray's report). Importantly, he also notes that Dr Wong "*was able to justify the decision to use methylphenidate post hoc in that lived experience of JX's use of methylphenidate was not associated with any destabilisation of his mental state or the onset of psychotic symptoms".* Associate Professor Robertson expressed some disquiet as to the manner of Dr Wong's second Ritalin prescription without clinical review. However, he formed the opinion that this did not *"necessarily deviate from a reasonable standard of care as Dr Wong had been quite thorough in identifying any potential side effects to therapy with methylphenidate."*

Associate Professor Robertson concluded that JX was, in all probability, amidst a psychotic episode at the time of his death. He gave oral evidence that:

> *Some severe mental illnesses, such as bipolar disorder or better prognosis forms of paranoid schizophrenia are characterised by an episodic clinical course. What is evident was that JX suffered an acute severe deterioration in his mental state in the period from 18 to 21 January 2014. The presentation was likely significant of an affective psychosis and the only factor that can be established was that he had consumed alcohol at the time of his death… he had consumed alcohol habitually and… this may have been the permissive substance which accounted for the deterioration in his mental state.*

He also gave evidence that in light of the toxicology results, it was highly unlikely that JX had consumed any cannabis.

Associate Professor Robertson had no criticism of the actions of Mr Dawson or staff at the RNSH Emergency Department. Indeed, he refers to the actions of Mr Dawson and Mr Dyson on 21 January 2014 as displaying *"a supererogatory commitment to JX's welfare".* I agree with that assessment.

In relation to staff at RNSH, he noted that JX presented with an acute mental health crisis, was categorised appropriately (with the only alternative being JX having been admitted under the *Mental Health Act 2007,* which was not considered at the time). Save for JX being seen within the benchmark 30 minute timeframe for a category 3 patient, Associate Professor Robertson could not see how any other action could have brought about a different outcome.

Conclusions

Before proceeding to my conclusions, I pause to note that while JX's family and at least some of his friends and colleagues knew of his previous psychotic episode and his ongoing treatment for mental health issues, his death was nevertheless unexpected. It is clear that his loss remains deeply felt by them. I extend to his family my sincere condolences for their sad loss.

There is little uncertainty about most of the matters on which findings must be made. The identity of the deceased, the place of death and its medical cause are clear on the evidence.

Because JX's body wasn't found until the day following the incident it is not completely clear when he died. However, the evidence indicating his phone was switched off or destroyed a minute after the last call was terminated at 11.25pm on 21 January leads me to conclude that is when he went into the water.

I accept the submission that it is possible that JX was so psychotic that he did not intend to end his life when he went into the ocean. I am unable to reach a firm conclusion as to the cause of that psychosis. However, having regard to the comments he made in his last phone conversation, I conclude JX did have sufficient presence of mind – cognitive capacity - to form the intention to take his life and that he put that into effect by deliberately jumping from the cliff-top at Magic Point.

There are however, other aspects of the circumstances of the death – its manner – which require more detailed analysis to determine whether they may have contributed to the death and/or whether they raise prevention issues which might warrant recommendations being made. I will deal those matters after recording my findings in relation to the particulars of the death.

Findings required by s81(1)

As a result of considering all of the documentary evidence and the oral evidence given at the inquest, I am able to confirm that the death occurred and make the following findings in relation to it.

The identity of the deceased

The person who died was JX.

Date of death

JX died on 21 January 2014

Place of death

He died in Maroubra, NSW.

Cause of death

He died from multiple injuries sustained in a fall from height

Manner of death

JX intentionally caused his own death by jumping from a coastal cliff-top near Maroubra while suffering a psychotic episode.

Recommendations

Pursuant to s 82 of the *Coroners Act 2009*, Coroners may make recommendations connected with a death investigated at an inquest. This case raises a number of issues that warrant consideration from that perspective.

In particular:-

- Whether the staff member of the Ryde Mental Health Acute Team called by JX's psychologist responded appropriately to the information about JX's psychosis;

- Whether JX was treated appropriately when he presented at the emergency department of the Royal North Shore Hospital; and

- Whether police to whom JX's absconding was reported reacted reasonably in discharge of their duty to preserve life.

These issues naturally require consideration of the policies and procedures of NSW Health and the NSW Police Force, both in terms of assessing the adequacy of the actions taken and whether any improvements could be made.

The response of the Ryde Mental Health Acute Team

There is some inconsistency in relation to the precise details of the call by Mr Dawson to the Ryde Mental Health Acute Team. However, I accept he told the intake officer he had with him a patient who was psychotic and she told him the patient should be taken to an ED. There was some discussion about whether an ambulance should be utilised. I am unable to be sure as to what was said, but in any event I am of the view that the decision for Mr Dyson to take JX to hospital was reasonable having regard to the obvious rapport between them.

As detailed earlier, the intake officer who was called out of a hand-over meeting to take the call, made no note of its content and passed on no information to any hospital ED where JX was likely soon to be taken.

The NSW Health *Mental Health Triage Policy* in force at the time required, among other things, that the *Mental Health Clinical Documentation* triage module be completed whenever it is considered that a caller may need further mental health service intervention, including but not limited to admission to a hospital. One of the reasons for that is because that policy provides:

> *When a consumer has been asked to self-present to an emergency department, or is to be brought to an emergency department by police or ambulance, the triage clinician is to ensure that the emergency department staff are notified by telephone of the expected presentation and provided with*

a copy of the completed triage. The responsible local mental health team is also to be notified of the presentation.

This policy was not complied with. It seemed to me that the intake officer was not fully aware of her responsibilities under it: she could not otherwise adequately explain her failure to implement it.

The intake officer did not recall completing the mental health triage training program or equivalent training programs referred to in the Mental Health Triage Policy and required to be completed by clinicians undertaking the telephone triage function. Absent any evidence to the contrary, I conclude she had not been given this training.

Counsel Assisting submits that it is not possible to say the failure to follow the mandatory telephone triage procedures made a difference to the outcome; however, nor can the converse be dismissed.

I also accept the submission made on behalf of JX's family that the gathering of clinical information by the Acute Team members by telephone could in many cases be critical to good risk assessment; effective triaging at the ED; and ultimately a good outcome.

The intake officer gave evidence that an electronic triage module has since been implemented. Her practice is now to complete the triage module while she is taking a call. That record can be accessed by staff at another part of the Northern Sydney Local Health District, including the RNSH Emergency Department.

The Clinical Director of the Lower North Shore Ryde Mental Health Service, Dr Nick O'Connor, wrote to the court advising that the relevant policies were to be discussed at a Ryde Mental Health Acute Team staff meeting and all clinicians were to be asked to acknowledge that they have read and understood them. This action, taken very late in the piece, may obviate the problem but I feel obliged to make a more formal response.

Recommendation 1- Training in telephone triage services

I am satisfied the existing policies for telephone triaging of mental health calls for service to the Ryde Mental Health Acute Team are sound and appropriate – the deficiency apparent in this case relates to their implementation. That the intake officer who dealt with JX's case did not appreciate even by the time of the inquest that she had failed to comply with significant aspects of relevant guidelines suggests that she is probably not the only intake officer who had an inadequate understanding of what is required in cases such as this.

Accordingly, I recommend the Chief Executive of the Northern Sydney Local Health District cause to be undertaken a training needs analysis of the intake staff members of the Ryde Mental Health Acute Team and address any identified gaps in knowledge of the relevant policies and procedures.

Response of the Royal North Shore Hospital ED staff

The triage category 3 given to JX's case soon after he presented at the RNSH ED was appropriate, having regard to JX's presenting symptoms and the limited history available to the triage nurse.

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The triage category meant that the benchmark for JX being seen by a doctor was 30 minutes after the triage commenced. That did not occur. JX left the hospital about 3 minutes after the 30 minute benchmark had passed and a doctor did not seek to see him until 5.03pm – 25 minutes after the expiration of the target time-limit and over an hour after he had presented at the hospital.

There is evidence that on the day in question, the ED was relatively busy. In the circumstances, I do not consider the failure for JX to be seen within the benchmarked time-limit indicates any inadequate performance by the staff involved or systemic failing at the hospital.

However, a policy directive current at the time, *Emergency Department Patients Awaiting Care,* lists as a mandatory requirement that*: All waiting patients should be regularly reassessed, particularly if they wait longer than the allotted triage category time* by the Clinical Initiatives Nurse in departments that have this position.

No re-assessment of JX's case was ever conducted, although, as noted above, he left the ED only three minutes after the target time limit expired and in the period he was at the hospital there was nothing observed by Mr Dyson or obvious on the CCTV vision that indicated that JX was in need to immediate attention. It is of some concern that his absence was not even noticed until the assessment time-limit target was well passed. There does not seem to be any policy in place at the hospital to operationalize the need to monitor and reassess mental health patients in particular as their wait to be seen by a medical officer is prolonged.

The circumstances of this case also brought into focus whether the hospital should have been more proactive once it became apparent JX had left without being assessed by a doctor. In fact, in this case there was little they could have done and there is no basis to conclude that even had they alerted police or tried to contact JX directly a different outcome would have ensued.

Recommendation 2 – Re-assessment of mental health patients

As the mental health patient in this case was not seen within the target time-limit of his triage category, was not reassessed as that time limit approached and was exceeded and as staff in the RNSH ED did not notice for a further significant period that he had left without being seen by a medical practitioner, there is cause for concern about the efficacy of patient monitoring in the ED.

Accordingly, I recommend the Chief Executive of the Northern Sydney Local Health District cause to be undertaken a review of the implementation of policies in place at the RNSH ED for monitoring mental health patients awaiting psychiatric review.

Response by NSW Police Force

Police responded promptly to the 000 call indicating JX was suffering from psychosis and had absconded from the RNSH ED. Although the job was initially allocated to North Sydney and Rose Bay for action, it was soon identified as a matter warranting a response from Maroubra police and that occurred.

In view of the ultimate tragic outcome, it is understandable the family would query the wisdom of an untrained junior officer making telephone contact with the at-risk person, rather than having a trained negotiator involved from the outset.

I accept that the first priority was to locate JX and ascertain his situation. The best way to do that was to telephone him. It may have been advisable for the junior officer concerned to have sought in-put from a more experienced colleague but I do not consider his actions to have been unreasonable or unwarranted.

Nor do I accept that a negotiator should have been called out before the then current situation was established. I accept the evidence that the volume of similar matters that are effectively deescalated without harm to the persons involved indicates such a resource intensive approach would be impractical. Further, although no expert evidence was received on the issue, having reviewed numerous cases in which trained negotiators have been involved, I am inclined to the view that the Constable who spoke with JX attempted to establish a rapport and sought to move him to a future focus as effectively as a negotiator would have in the limited time during which contact was maintained. I have no confidence that involving of a negotiator or a psychologist would have led to a different outcome.

I readily accept and appreciate the distress of JX's parents that they were not sooner notified of the incident unfolding. They did not become aware of their son even being at risk until some 8 hours after his death and 10 hours after police were first alerted to his situation. I accept that police assiduously attempted to locate them. Part of the problem involved digital data searching challenges which are not something that the NSW Police Force can readily resolve. However, I do see merit in a voluntary next of kin register.

Recommendation 3 – Voluntary next of kin register

In numerous circumstances, ready access to contact details for a person's next of kin could enable police to more effectively preserve the person's safety and provide to the person's next of kin timely information they would want to know. Individuals would need to consent to information being disseminated in stipulated circumstances to nominated people and there would be technological challenges in storing and retrieving the data. However the potential benefits warrant the matter being further investigated in my view.

Accordingly, I recommend that the Minister for Police consider establishing a project team to investigate the benefits, costs and practicalities of such a facility.

I close this inquest.

M A Barnes
NSW State Coroner
State Coroner's Court, Glebe
19 December 2014