STATE CORONER'S COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Abduelaziz Omerhaj
Hearing dates:	19 – 21 March 2018
Date of findings:	30 May 2018
Place of findings:	State Coroner's Court - Glebe
Findings of:	Magistrate Paula Russell Deputy State Coroner
Catchwords:	CORONIAL LAW – Cause of death, manner of death, involuntary patient absconded, efforts to find
File number:	2013/303072
Representation:	Counsel assisting the Coroner: Mr Peter Aitken of Counsel instructed by Ms Clara Potocki Crown Solicitor's Office Counsel for NSW Commissioner of Police: Ms Justine Hopper of Counsel instructed by Mr Andrew Deards Office of General Counsel, NSW Police Force Counsel for Northern Sydney Local Health District: Ms Elizabeth Raper of Counsel instructed by Ms Olga Sclavenitis Curwoods Lawyers

Findings:	Abduelaziz Omerhaj died in the carport of 7/30 Endeavour Road, Caringbah, New South Wales between the evening of 6 October 2013 and the morning of 8 October 2013. The manner and cause of his death are undetermined.

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1. On the morning of Tuesday, 8 October 2013 the body of Abduelaziz Omerhaj was found in the carport of the premises of Total Access Solutions at 7/30 Endeavour Road, Caringbah. Mr Omerhaj's body was found by an employee of the company.

2. Abduelaziz Omerhaj was, at the time of his death, 36 years old. He held both an Australian and Eritrean passport. He had migrated to Australia in 1998 and settled, first in Melbourne and, later, in Brisbane and northern Queensland where he worked for a mining company.

3. In about 2008 Mr Omerhaj married but the marriage did not last.

4. In 2010 he commenced working in a supermarket trolley collection business and in 2012 he moved to Sydney where he ran a successful business in that line.

5. In the period leading up to his death he was living alone in rented premises at 1/17-21 Bruce Street, Blacktown.

6. Mr Omerhaj had a number of friends among people who had come from Sudan, including Mubarak Ali, a school friend from Kassala located in the eastern part of Sudan towards the border with Eritrea, with whom he spent a happy holiday in Cairo in August or September 2012.

7. Sami Ibrahim, another friend, who had met Mr Omerhaj in Melbourne, also ran a supermarket trolley collection business in Sydney. Mr Omerhaj and Mr Ibrahim were mutually supportive in their business endeavours.

8. Aboubeida Abbaker was a friend who spent time with Mr Omerhaj. After Mr Omerhaj moved to Sydney, towards the end of 2012, they would visit each other in their homes and sometimes have dinner together.

Functions of the Coroner

9. Section 81 of the *Coroners Act 2009* sets out the principal functions of a coroner conducting an inquest. Those are to record the identity of the person who has died, the date and place of his death and the manner and cause of his death.

10. Apart from Mr Omerhaj's identity, each of those matters has, to a greater or lesser extent, been a focus of these proceedings.

The months leading up to Mr Omerhaj's death

11. Mr Omerhaj's behaviour in the months leading up to August 2013 intermittently gave his friends cause for concern.

12. In March 2013 Mr Omerhaj visited Mr Ali in Queensland. Mr Ali thought that Mr Omerhaj was '*the same as always'*. He appeared '*happy and looked very healthy*'. However, in the weeks that followed, when he spoke to him on the phone Mr Ali felt that Mr Omerhaj was, in his words, '*a little shut off from me'*. He was surprised that Mr Omerhaj had travelled to China in May/June without telling him.

13. Mr Abbaker last saw Mr Omerhaj in early July 2013 when, with friends, he went to Mr Omerhaj's unit and had dinner and then, together, they went out to a nightclub in Parramatta. Mr Abbaker had not, at any time, including on that occasion, had concerns about Mr Omerhaj's mental health.

14. Mr Ibrahim became concerned about Mr Omerhaj when, probably on 2 August 2013, Mr Omerhaj attended a Ramadan gathering at Mr Ibrahim's home. His appearance on that occasion led to Mr Ibrahim thinking that Mr Omerhaj may not have been eating well. Mr Ibrahim also became concerned about some of the things Mr Omerhaj was saying. He told Mr Ibrahim that he was worried about Sudanese secret police tracking his computer and that those secret police had accused him of contacting their targets via email.

15. Mr Ibrahim saw Mr Omerhaj the next day at Blacktown. Mr Ibrahim again thought that Mr Omerhaj had lost a lot of weight. Mr Omerhaj, was wearing a suit which he had had made on his recent trip to China. He told Mr Ibrahim that he wanted to throw his suit on the fire.

3 August 2013

Motor vehicle accident

16. At about 7:20pm on that day, 3 August 2013, Mr Omerhaj was involved in a motor vehicle collision on Epping Road Ryde. Following that collision he continued through a red light to leave the scene. He telephoned Mr Ibrahim who advised him to go to the police. As a result he went to the Ryde Police Station (a part of the Gladesville Local Area Command (LAC)) at about 8pm where he spoke to Constable Elizabeth Stoj, who was, at the time, a Probationary Constable.

Ryde police station

17. Mr Omerhaj told Constable Stoj that he had hit the other car because Asian intelligence officers were after him and had pointed a gun at him. He said he had to speed to get away.

18. Constable Stoj observed that he appeared extremely agitated. He was constantly crossing his feet, rubbing his hands together and looking over his shoulders. He told her that he had not had anything to eat or drink in three days. Constable Stoj became more concerned about his mental health when Mr Omerhaj jumped from his seat as a prisoner of Asian appearance was being moved through the station. Mr Omerhaj told her that the prisoner was

an intelligence officer who was 'after him'. He told Constable Stoj that Sudanese intelligence agents were going to harm him.

19. His mobile phone rang a number of times but he did not want to answer it. He told police officers that his friend, Sami, was part of the government conspiracy to get him.

20. Constable Stoj was told, by an officer who had searched Mr Omerhaj's vehicle, that 2 large knives had been found in that vehicle[1].

21. Constable Stoj arranged for ambulance officers to attend the police station to assess Mr Omerhaj. Following that assessment, and pursuant to section 22 of the *Mental Health Act 2007* (NSW) (the Act), it was determined that Mr Omerhaj would be taken to Ryde Hospital. Constable Stoj drove to Ryde Hospital and her colleague, Constable Cooper, accompanied Mr Omerhaj in the ambulance.

Ryde Hospital

22. Ryde Hospital was, at the time, a declared Mental Health Facility pursuant to s109 of the Act. Its function as a Mental Health Facility was limited to the assessment and treatment, in the Emergency Department, of mentally disturbed patients who were brought in by police or ambulance services as involuntary patients. It did not provide inpatient admission for such patients.

23. Ryde Hospital is no longer a declared Mental Health Facility and can no longer accept such patients for assessment and treatment.

24. At Ryde Hospital Mr Omerhaj was initially assessed by an Emergency Department Medical Officer, Sarah Doherty, detained under the Act and referred to Ryde Mental Health Acute Team for psychiatric assessment. Dr Mosadek Miah was the psychiatry registrar on call. At about 11:30pm he assessed Mr Omerhaj and noted that he looked anxious and frightened but was generally cooperative with the assessment. Mr Omerhaj whispered brief responses to Dr Miah's questions out of fear of being overheard. He was suspicious and hypervigilant but Dr Miah found him to be '*help seeking'*. He feared for his life and pleaded with Dr Miah to arrange for him to be taken somewhere safe.

25. Dr Miah diagnosed Mr Omerhaj as having an acute psychotic illness. He assessed Mr Omerhaj:

    as being at considerable risk to his reputation and also at risk of misadventure owing to acute psychosis.

[1] Constable Stoj accepts that she did not, but should have, told staff at Ryde Hospital about those knives.

26. Dr Miah '*decided that Mr Omerhaj needed containment, further assessment and treatment in a secure psychiatric unit'*. Pursuant to what he noted in the form of certification as the then section 27 (a) of the Act, Dr Miah certified that Mr Omerhaj was a mentally ill person, detained him and arranged for his psychiatric admission. In the circumstances of that night that necessitated his transport to Manly Hospital (East Wing). Dr Miah arranged that transfer to Manly Hospital.

27. Constables Stoj and Cooper were, at about this time, called away urgently to attend a public order incident which was getting out of control.

28. Dr Miah prescribed oral psychotropic medication (olanzapine and lorazepam) to ease Mr Omerhaj's symptoms. He recommended one-on-one nursing for support and observation of Mr Omerhaj while he was awaiting transport to Manly. Staffing constraints meant that that level of nursing was unavailable.

29. Shortly after midnight, Mr Omerhaj was given the olanzapine wafer and lorazepam tablet but spat the tablets into the sink and ran out of the acute assessment area of the Emergency Department via the back door which leads to the ambulance bay and then to the street.

30. Nursing staff notified the police shortly thereafter.

31. Mr Omerhaj was initially listed on the computerised operational policing system (COPS) as a person who had absconded from a mental health unit. Over the days and weeks which followed police made various, unsuccessful, attempts to find Mr Omerhaj. During that time Mr Omerhaj had interactions with a solicitor, the Australian Federal Police, members of the New South Wales Police and a mosque at Tempe. I will return to that evidence.

32. In those weeks leading up to his death Mr Omerhaj did not resume his normal life. There is evidence, to which I will return, that he was living the life of an itinerant, homeless person.

Place of death

33. Total Access Solutions, a Scaffolding Business located at 7/30 Endeavour Road, Caringbah, operated out of one of several industrial units at 30 Endeavour Road. A double carport was at the front of the business which was used to store rubbish from worksites prior to its collection. On 8 October 2013 that rubbish included sheets of wood, pallets, shade cloth, two wheelbarrows and some cardboard. The carport is not enclosed by a fence and has open access to the street.

34. On the morning of 8 October 2013 Ronald Foden and Stuart White, employees of Total Access Solutions, found Mr Omerhaj's body in the right rear corner of the carport. The body was in a seated position against the rear wall of the carport. Mr Omerhaj's legs were partly covered by cardboard, his

head was bent and his chin was on his chest. The body was in an early stage of decomposition. He was extremely thin and looked malnourished.

35. Items in bags found next to Mr Omerhaj's body included jumpers, dress shoes, passports, deodorant and a plastic fork. The clothing which Mr Omerhaj wore was dishevelled and dirty.

36. The condition of Mr Omerhaj, his clothing and, what would appear to be, his possessions were all suggestive of a person who was living the life of a homeless person.

37. Lividity was present on his back and, to some extent, on the anterior aspects of his upper body. There were areas of blanching at the top of his back where it had been in contact with the brick wall. An autopsy was conducted by Dr Rianie Janse Van Vuuren, forensic pathologist, who said that, while she could not conclusively determine that Mr Omerhaj died where his body was found, the lividity pattern fitted the position in which his body was found.

38. I am satisfied that the lividity pattern on Mr Omerhaj's body, taken together with the circumstances in which his body was found, establish, on the balance of probabilities, that Mr Omerhaj died in the carport of 7/30 Endeavour Road, Caringbah.

Date of death

39. In the two months leading up to his death Mr Omerhaj had not been attending to his business and had isolated himself from his friends and contacts. Investigating police have not been able to locate any persons who interacted with him in the days leading up to his death. Two telephone sim cards were found on Mr Omerhaj. Neither had been used to make or receive calls in the period between 1 and 8 October 2013.

40. The last possible contact identified by police was an undated letter received by First State Real Estate, Blacktown, on 26 September 2013, in which a person identifying himself as Mr Omerhaj cancelled the lease on his Blacktown unit.

41. Seven days of CCTV footage, commencing on 1 October 2013 and continuing up until the time at which the body was found, from a camera which provided only partial coverage of the entrance to the carport at 7/30 Endeavour Road, Caringbah, provided no clue as to when Mr Omerhaj arrived at that carport. The footage revealed that the last time the carport was used by anyone connected with Total Access Solutions (before Mr Omerhaj's body was found) was on the afternoon of Friday, 4 October 2013.

42. Dr Van Vuuren's evidence was that establishing the date and time of death was made more difficult because Mr Omerhaj's body was outside and he was thin with not a lot of muscle mass. She was of the opinion that he had not died as long as three or four days before he was found because, in that event, she

would have expected to see more decomposition. As I understood her evidence it was that it was most likely that death occurred within the period from the night of 6 October 2013 to the morning of 8 October 2013 on which his body was found. She could be no more accurate than that.

43. It is not possible to determine the date that Mr Omerhaj died but the evidence establishes on the balance of probabilities that he died between the evening of 6 and the morning of 8 October 2013.

Cause of death

Agency of another person excluded

44. A comprehensive police investigation both of the immediate scene at which the body was found and of the circumstances of Mr Omerhaj's life revealed no evidence suggestive of the involvement of another person in Mr Omerhaj's death.

45. On autopsy Dr Van Vuuren observed no suspicious injuries or any other indication that Mr Omerhaj's death was at the hands of another person.

Observations on autopsy

Ethylene glycol poisoning

46. Dr Van Vuuren was unable, in her autopsy report, to identify a cause of death but noted the presence, in Mr Omerhaj's kidneys, of '*focal scattered polarising crystals in keeping with calcium oxalate crystals*'. Calcium oxalate crystals, she said, '*produce renal tubular necrosis leading to kidney failure'*.

47. Dr Van Vuuren said that '*increased calcium oxalate crystals in the urine and kidney stones are caused by primary hyperoxaluria, excess calcium intake or poisoning*'.

48. The poisoning to which Dr Van Vuuren referred was poisoning by ethylene glycol (used in antifreeze and coolant products). She distinguished between the appearance of the crystals caused by ethylene glycol and those which would be the result of dehydration. The crystals Dr Van Vuuren saw were indicative of ethylene glycol poisoning.

49. Ethylene glycol was not detected in Mr Omerhaj's blood. A test for the presence of ethylene glycol was not undertaken for some considerable time. Dr Van Vuuren explained that ethylene glycol has a very short half-life, of about three hours, and that post-mortem decomposition change has the effect of removing ethylene glycol from the blood. The fact that ethylene glycol was not detected is not evidence that it was not present in Mr Omerhaj's blood at, or in the period leading up to, the time of his death.

50. Dr Van Vuuren's evidence was that the calcium oxalate crystals resulting from ethylene glycol poisoning would not necessarily form immediately on the ingestion of ethylene glycol, and death, if it resulted, would not necessarily occur within 12 hours of ingesting it.

51. In light of Dr Van Vuuren's evidence as to when, if at all, ethylene glycol poisoning occurred there remains the significant possibility that Mr Omerhaj had consumed the ethylene glycol at a place other than the carport at 7/30 Endeavour Road, Caringbah.

52. The carport in which Mr Omerhaj's body was found contained a significant quantity of building material. On 8 October 2013 only the immediate vicinity was inspected and photographed by police officers. No substance likely to contain ethylene glycol is discernible in those photographs. No active search for the substance was undertaken on 8 October 2013.

53. In response to information from Dr Van Vuuren, the area was later searched for such a product. None was found. That fact does not absolutely exclude the presence of ethylene glycol in the form of antifreeze or coolant in the carport at the time of Mr Omerhaj's death. It does, however, make it more likely that, if Mr Omerhaj drank such a substance, he did that elsewhere and, after he drank it, made his way to the carport at 7/30 Endeavour Road.

54. It is likely that Mr Omerhaj, either in answer to thirst or otherwise, consumed ethylene glycol on the day or days leading up to his death.

Ethylene glycol poisoning the cause of death?

55. Dr Van Vuuren's evidence, as I understood it, was that calcium oxalate crystals form when ethylene glycol is at a toxic, but not necessarily lethal, level. There was no basis, on the evidence obtained at autopsy, for her to conclude that the calcium oxalate crystals she saw resulted from a lethal dose of ethylene glycol.

56. Although I am satisfied on the balance of probabilities that Mr Omerhaj did suffer ethylene glycol poisoning in the days leading up to his death, I am unable to determine whether that poisoning was the cause of his death.

Other possible causes of death

57. Dr Van Vuuren noted the presence of mild coronary atherosclerosis and that the left anterior descending coronary artery showed myocardial bridging. That myocardial bridging can, she said, in rare cases, lead to arrhythmia. Dehydration, she said, would have increased the potential to develop an arrhythmia.

58. Dr Van Vuuren also observed mild fibrosis and mild myocardial disarray in the heart. Mr Omerhaj's lungs showed evidence of chronic obstructive pulmonary disease.

Conclusion as to cause of death

59. I am unable to determine the cause of Mr Omerhaj's death.

Manner of death

60. In the circumstances in which I am unable to determine the cause of Mr Omerhaj's death, I am also unable to determine the manner of Mr Omerhaj's death.

61. It is possible that Mr Omerhaj died as a result of ethylene glycol poisoning. It is also possible, however, that he died from natural causes.

Mr Omerhaj's known movements from 4 August 2013

62. Mr Omerhaj contacted Sami Ibrahim on the afternoon of 5 August 2013. He told Mr Ibrahim that he blamed him for the fact that police were looking for him.

63. On that morning Mr Omerhaj had rented an Avis hire car from a franchise located on Victoria Road, Parramatta. That vehicle was returned after 5:30pm on 12 August 2013. During the time it was in Mr Omerhaj's possession it did not use any toll roads but travelled about 136 km.

64. On 12 August 2013 Mr Omerhaj attended an appointment with Mr Ashraf Jawas, solicitor at Australian Criminal Law Specialists in Elizabeth Street Sydney. Mr Jawas noted that Mr Omerhaj appeared '*very paranoid'*. He '*was locking the door behind him*' and was constantly looking over his shoulder. He told Mr Jawas that he had been forced to cash fraudulent cheques.

65. Mr Jawas accompanied Mr Omerhaj to the Surry Hills Police Station on the afternoon of 12 August 2013. There Mr Omerhaj was given a 'fraud pack' and advised to attend Blacktown Police Station.

66. Mr Omerhaj went by taxi from his solicitor's office to the Blacktown Police Station. There he spoke to Constable Stefanie Smith (now Detective Senior Constable Tebbenhoff and to whom I will refer as DSC Tebbenhoff), who was working on the enquiry counter. He spoke to DSC Tebbenhoff in a soft voice, was vague and changed his story often. He told her that Mr Ibrahim and his associates were in possession of stolen cheques that were being cashed at various bank locations. DSC Tebbenhoff handed him a Fraud Assessment Form and asked him to complete it. Mr Omerhaj handed her the completed form. She read over the form but was '*unable to substantiate*', she said, '*how or when the alleged frauds had been committed*'. She conducted a check on Mr Ibrahim through the COPS and found nothing adverse to him on that system. DSC Tebbenhoff did not interrogate that system for information about Mr Omerhaj. I will return to that evidence.

67. On 14 August 2013 Mr Omerhaj contacted Mr Jawas in apparent reference to his conversation with DSC Tebbenhoff at Blacktown Police Station.

68. On the morning of 19 August 2013 Mr Omerhaj went to the Sydney office of the Australian Federal Police (AFP) and there spoke to Federal Agent John Weekes in the presence of two AFP investigative assistants. Mr Omerhaj referred to espionage, Iran and Saudi Arabia and said that his phone and email were being intercepted.

69. At about 1:30pm on 28 August 2013 Elgaili Elfaki, who had first met Mr Omerhaj on 2 August 2013 at Sami Ibrahim's house, saw Mr Omerhaj at the Al Hijrah Mosque at Tempe. Mr Elfaki was aware that his friends had not seen Mr Omerhaj for quite some time. Mr Omerhaj looked very tired and thinner than he had on 2 August. At lunch at the mosque Mr Elfaki observed that Mr Omerhaj did not eat much.

70. Mr Elfaki was concerned about some of the things Mr Omerhaj was saying. Mr Omerhaj complained to him that a close friend was trying to take him back to Sudan.

71. Mr Elfaki rang Mr Ibrahim and, at Mr Ibrahim's suggestion, rang the police. He left the mosque. Police attended but were denied entry to the area of the mosque by a person, who it later emerged, had no connection with the management of the mosque and no authority to deny access. Police officers contacted Mr Elfaki who returned and entered the mosque but, by then, Mr Omerhaj had left.

72. Mr Omerhaj again contacted his solicitor on 29 August 2013 and told him that he had received a voicemail message from police advising him that he was classified as a missing person. He asked his solicitor to contact Blacktown police and advise them that he was not missing. He told his solicitor that he was completing an Islamic religious course for 40 days. The solicitor contacted Blacktown Police Station but was told that Mr Omerhaj must attend the police station and present himself if he were to be regarded as no longer missing.

73. Mr Jawas informed Mr Omerhaj of what was required. Mr Omerhaj later that day rang him and said '*I've done my duty, I have informed them*.'

Efforts by the NSW Police to find Mr Omerhaj

74. Police officers from the Blacktown LAC went to Mr Omerhaj's Blacktown address on the afternoon of 4 August 2013 but could not gain access. There was no answer from Mr Omerhaj's intercom.

75. Blacktown police went to his unit block, in an attempt to locate Mr Omerhaj, on a number of occasions in August 2013 and, on a number of those occasions, spoke to neighbours who said they hadn't seen him. During that period Blacktown police officers periodically checked Mr Omerhaj's mailbox.

76. Those efforts to locate Mr Omerhaj were unsuccessful.

Blacktown Police Station 12 August 2013

77. Shortly after 6pm on 12 August, during the period Blacktown police were actively searching for him, Mr Omerhaj went to Blacktown Police Station. There he spoke to the now DSC Tebbenhoff.

COPS entry

78. Mr Omerhaj was initially listed on the COPS as a person who had absconded from a mental health unit. In entries on that system from 9 August 2013 reference was being made to Mr Omerhaj as a missing person. It is clear that had DSC Tebbenhoff made an enquiry of that system specifically directed to Mr Omerhaj it is likely that she would have learnt those facts. It is also possible that she would have learnt that Mr Omerhaj was missing, having absconded from a mental health unit, if she had entered Mr Omerhaj's complaint into the COPS.

79. DSC Tebbenhoff gave Mr Omerhaj the Fraud Assessment Form because she could not understand his oral description of the fraud. When he handed her the completed form she briefly read over it and asked him further questions so that she could appreciate the nature of the fraud. Mr Omerhaj was unable to provide her with the further details she sought, such as, from where the cheques were stolen and to whom they were made out.

80. Mr Omerhaj told DSC Tebbenhoff that the people involved in the fraud had threatened his safety and he was afraid to go home. When she questioned him about that, apart from saying that they would try to say he was stealing the money and make him look bad, he was unable to provide her with any information about why he was afraid of them. DSC Tebbenhoff asked Mr Omerhaj if he would like to wait while she arranged for other police to speak to him about those threats but he said he couldn't wait.

81. Elements of Mr Omerhaj's claims with respect to the fraud, including that one of the participants owned a gold mining operation and millions were being '*inject[ed] out of Australia'*, DSC Tebbenhoff found strange but that fact, in itself, did not distinguish Mr Omerhaj from a range of other people who made reports at the station. DSC Tebbenhoff observed that '*people make strange reports of crime all the time*'. Mr Omerhaj's behaviour, at the police station on that evening, was not such that she thought he was suffering from a mental illness or a mental health condition. DSC Tebbenhoff said that, had she thought that, it was most likely she would have conducted checks to see if there was anything about Mr Omerhaj on the police system.

82. DSC Tebbenhoff created an intelligence report about the allegation of fraud rather than an entry on the COPS. She did not put an entry into the COPS,

she said, because Mr Omerhaj had not provided sufficient information about the fraud to warrant such an entry.

83. DSC Tebbenhoff accepted that *'[i]n hindsight it would have been a good idea'* to make a check on Mr Omerhaj on the COPS.

84. DSC Tebbenhoff's shift had just commenced when Mr Omerhaj entered the station. It was at a time when the station counter was very busy. Other people were waiting to speak to her. Mr Omerhaj was the person making the complaint, albeit a strange one, about the actions of other people. His behaviour did not give her specific cause for concern. In the circumstances, although it may have been prudent to check Mr Omerhaj on the COPS, DSC Tebbenhoff cannot, properly, be criticised for not doing so.

Information available to officers at Blacktown Police Station

85. Morning briefings were conducted at Blacktown Police Station in which cases of missing persons actively being sought were likely to have been mentioned. Counter officers, such as she was on that night, did not attend such briefings. In any event DSC Tebbenhoff's recollection was that she may only have worked two of the days between 4 and 12 August 2013 and, on 12 August, she was on the night shift.

86. It is unlikely, then, that DSC Tebbenhoff would have learned that Mr Omerhaj was missing from the morning briefings.

87. DSC Tebbenhoff had not had the opportunity to see a photograph of Mr Omerhaj such as might be circulated with respect to a missing person. No photograph of Mr Omerhaj had been circulated to police or police stations for the reason that the police did not have such a photograph. I will return to that evidence.

88. Mr Omerhaj had not committed an offence for which he was being sought. He was being sought by police because of concerns for his welfare. He had absconded from the hospital after having been detained pursuant to the Act on a certification, made on 3 August 2013, that he was a mentally ill person. Certainly by 8 August 2013 Mr Omerhaj could not have been admitted or detained at a mental health facility on that certificate alone[2]. Had DSC Tebbenhoff identified, or any other officer found, Mr Omerhaj in the period following 8 August, in order to detain him, the relevant police officer would have had to satisfy her or himself of the matters set out in section 22 of the Act.

[2] S 19 *Mental Health Act 2007.*

Efforts by police after August 2013 to find Mr Omerhaj

89. On 1 September 2013 police from the Blacktown LAC handed the search for Mr Omerhaj back to the Gladesville LAC. Sergeant Kerri McDonald, from the Gladesville LAC, arranged for the Missing Persons Unit to carry out further enquiries with immigration authorities and Centrelink.

90. The matter then, again, became the responsibility of Constable Stoj. In August 2013 Constable Stoj was a young Probationary Constable. There was some lack of clarity on the part of Constable Stoj, at that time, as to who, after 1 September 2013, had responsibility for the matter.

91. Constable Stoj said that she was aware of attempts which had been made to obtain a photograph of Mr Omerhaj, for circulation, from Mr Ibrahim. Those attempts were unsuccessful. She acknowledged that she should have continued to conduct inquiries, including into any use by Mr Omerhaj of his bank accounts and the canvassing of Mr Omerhaj's neighbours. She also acknowledged that she did not, at the time, have a sufficient understanding of the role of the Missing Persons Unit of the New South Wales Police Force and thought that they were involved in the active investigation of missing persons.

92. Constable Stoj is a much more experienced officer now. Her lack of experience in August/September 2013 is not something for which she should be criticised.

Role of Missing Persons Unit

93. Detective Sergeant Whiting of the Missing Persons Unit said that about 12,000 people are reported as missing in New South Wales, and about 38,000 people nationally, each year. In that context she described the role of that unit as one of oversight not investigation.

94. Detective Sergeant Whiting said that for the last few years the Missing Persons Unit has conducted education sessions for student police officers at the police academy. I can conclude from that evidence that probationary constables are now better informed than they were in 2013 about the role of the Missing Persons Unit.

Consideration

95. Dr Miah had, on 2 August 2013, observed Mr Omerhaj to be suspicious and paranoid. Suspicion and paranoia were features of his behaviour, in so far as it is known, throughout the period he was missing. He did not attend to his shopping trolley business or to the payment of its staff. He moved out of his unit and avoided his usual friends and his usual activities. It was an aspect of Mr Omerhaj's mental illness that he thought that he was being sought by

malign persons and agencies and that those closest to him were complicit with those persons and agencies. In that context, while he made complaints at police stations and visited a lawyer, he was otherwise taking active steps, including, it would seem, living a relatively itinerant life, in order to avoid detection.

96. Police officers, throughout August 2013, actively sought Mr Omerhaj. Although it was unfortunate that he was not identified on 12 August 2013, I am satisfied that the fact that he was not identified did not represent any significant individual or collective failure on the part of police.

97. In the context of the efforts which had been made to find Mr Omerhaj in August 2013 and the steps he was taking to avoid detection, I am satisfied that any failure on the part of Constable Stoj, in September 2013, to make further enquiries of the sort made in August 2013 did not have an effect on the tragic outcome.

Findings

Abduelaziz Omerhaj died in the carport of 7/30 Endeavour Road, Caringbah, New South Wales between the evening of 6 October 2013 and the morning of 8 October 2013.

The manner and cause of his death are undetermined.

I close this inquest.

Magistrate P Russell

Deputy State Coroner
Glebe

Date