CORONERS COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Mitchell Flood-Smith
Hearing dates:	23 - 25 September 2019
Date of findings:	4 December 2019
Place of findings:	State Coroners Court, Lidcombe
Findings of:	State Coroner, Magistrate Teresa O'Sullivan
Catchwords:	CORONIAL LAW – Cause and manner of death – securing scheduled patients – mental health – absconding risk – Triage and Assessment centre (TAC)
Publication:	Publication is permitted under s. 75(5) Coroners Act
File number:	2017/136763
Representation:	Mr Christopher McGorey, Counsel Assisting, instructed by Mr W Nash, Crown Solicitor's Office Mr Patrick Rooney, instructed by Mr M Renwick of McCabe Curwood, for the Nepean Blue Mountain Local Health District Mr Stephen Barnes, instructed by J Kamaras of Avant Law, for Dr A Pusic Ms G Keesing, instructed by Ms E Trovato of the Office of General Counsel, for the Commissioner of Police Ms K Doust of the NSW Nurses and Midwives Association, for Registered Nurse E Maurer

Findings:	**Identity of deceased:** The deceased person was Mitchell Flood-Smith **Date of death:** Mitchell Flood-Smith died on 4 May 2017 **Place of death:** Mitchell Flood-Smith died at Kingswood Railway Station, Kingswood NSW 2747 **Cause of death:** Mitchell Flood-Smith died of multiple injuries, following collision with a train. **Manner of death:** Mitchell Flood-Smith died after absconding from Nepean Hospital Triage Access Centre and standing in front of a train with the intention of ending his life. The resultant collision caused Mitchell to suffer multiple blunt force injuries that were not survivable.

Recommendations	The Minister of Health and the Nepean Blue Mountains Local Health District that each reviews these findings and review: i. the arrangements of the Nepean Hospital's Triage Assessment Centre (**the TAC**) regarding the review by nurses and staff of electronic records submitted by paramedics involved in the admission of patients to the TAC patients under the *Mental Health Act 2007* (**the MH Act**); ii. the practice and procedures as to the timing of making notifications made to the NSW Police Force about involuntarily admitted patients who have absconded and the information to be provided as part of that notification; iii. the arrangements for securing persons involuntarily detained under the MH Act pending psychiatric assessment (the focus of that review being on how detained patients are to be securely contained to prevent their absconding before assessment); and iv. the clinical practice guidelines for the assessment and management and documentation of a patient's risk of absconding including the criteria for determining such risk, the predictive value of past instances of absconding and the education and training of clinical staff about those guidelines.

The Coroners Act 2009 (NSW) *in s. 81(1) requires that when an inquest is held, 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 Mitchell Flood-Smith.

INTRODUCTION

1. This is an inquest into the death of Mitchell Flood-Smith (**Mitchell**) born 21 April 1994. Mitchell died at about 11:45pm on 4 May 2017, aged 23 years.

2. Mitchell was taken to the Nepean Hospital's Mental Health Triage and Assessment Centre (**the TAC**) shortly before 8pm that day by ambulance and police to undergo a mental health assessment. He absconded from the TAC's reception area at about 9pm. Police were looking for Mitchell at the time of his death.

3. Mitchell's passing is a significant loss for the community. The subsequent investigation into what happened and these proceedings reflect the magnitude of that loss.

4. Mitchell's loss is felt most acutely by those who loved him. Mitchell Flood-Smith was the much loved son of Deborah and Phil Flood-Smith. They attended each day of the hearing supported by other family members.

5. I was assisted at the end of the evidence to hear from Ms Flood-Smith about Mitchell as a person. He loved animals, was vivacious and funny with fondness for playing innocent pranks on people. Mitchell's mother spoke eloquently at the inquest of her memories of Mitchell and of the profound loss his family has experienced.

6. I am grateful to Mitchell's family for their dignity and the assistance they provided in these proceedings. They are eager to understand what happened on 4 May 2017 and hope lessons can be derived from their son's tragic passing.

Role of the Coroner

7. The role of a Coroner, as set out in s. 81 of the *Coroners Act 2009* (NSW) (**the Act**), is to make findings as to the identity of the person who died, when and where they died, and the manner and cause of their death. The manner of a person's death means the circumstances surrounding their death and the events leading to it.

8. Under s. 82 of the Act, a Coroner also has the power to make recommendations concerning any public health or safety issues arising out of the death in question.

9. In Mitchell's case, the coronial investigation gathered evidence to answer the questions about Mitchell's identity, where and when he died, and the medical cause of his death. The inquest was primarily focused on the manner of Mitchell's death.

10. It is important for Mitchell's family to know and understand how and why he died and whether different decisions about his care and treatment should have been made when he presented to the TAC on 4 May 2017. Consideration has also been given to making recommendations.

11. In preparing of my findings, I have been assisted by the oral submissions of Counsel Assisting, Mr Chris McGorey, and the oral submissions made on behalf of Dr Pusic, Registered Nurse Maurer, the Nepean Blue Mountains Local Health District (**the NBM LHD**), the Commissioner of Police, and Mitchell's family. Additionally, the Minister of Health provided written submissions dated 11 October 2019 addressing possible recommendations.

12. At the outset I remind myself these proceedings are not about the allocation of blame. Those who participated and I had the benefit of hindsight those in real time did not have. Care must be taken when examining matters in hindsight not to overestimate how obvious or likely the outcome would have been to those involved in real time.

FACTUAL FINDINGS

13. It is necessary to outline Mitchell's background to put events on 4 May 2017 in proper context.

Mental health

14. Mitchell suffered depression in his early teenage years. His illness worsened after finishing school in the context of heavy cannabis use.

15. Mitchell suffered an episode of psychosis in September 2015 resulting in his admission to Nepean Hospital for mental health treatment.

16. Dr Augustus Pusic, Consultant Psychiatrist, treated Mitchell from about October 2015 onwards until Mitchell's death. This occurred both in an inpatient setting at Nepean Hospital and in the community.[1]

17. Dr Pusic diagnosed Mitchell as suffering from a psychiatric illness (Schizophreniform Disorder) characterised by emotional instability, including severe depression and delusional ideation with bizarre idiosyncratic thoughts and behaviours.[2] He also diagnosed Mitchell as suffering from a Major Depressive Illness against a background of chronic cannabis use. Mitchell was prescribed antidepressant and antipsychotic medication.[3]

18. Mitchell had several admissions to the Nepean Hospital's psychiatric unit between 2015 and 2017, which are detailed below.

2015 Admissions

19. On 17 September 2015, Mitchell's housemate called police out of concern for Mitchell's welfare. Mitchell reported being depressed and having not slept for about 3 days. He had also written delusional statements on the walls and floor

[1] Exhibit 1, Vol 1, Tab 7 at [9].
[2] Exhibit 1, Vol 2, Tabs 57-58.
[3] Exhibit 1, Vol 2, Tabs 57, p. 2.

of his unit. [4]

20. Mitchell had a car accident that same day. He was transported voluntarily to Nepean Hospital for assessment and released early the next morning. He was returned to Nepean Hospital later that same morning after he was apprehended by police.[5] He was assessed as experiencing an acute psychosis (likely related to his cannabis use). He had engaged in bizarre behaviour with a recent history of acute depression, suicidal impulse and self-harm attempts, and was suspected of deliberately crashing his car.[6]

21. Mitchell was discharged from Nepean Hospital on 21 September 2015. He returned to live with his parents at 23 Talara Avenue, Glenmore Park.[7]

22. On 11 October 2015, Mitchell was detained by ambulance officers under s. 20 of the *Mental Health Act 2007* (**the MH Act**) and transported to Nepean Hospital for assessment. He was released later that same day.[8]

23. On 13 October 2015, Mitchell was voluntarily taken by ambulance and police to Nepean Hospital. He behaved in a bizarre manner and displayed paranoia.[9] Mitchell then absconded, but was located by police that same day and involuntarily admitted for treatment. Mitchell remained an inpatient until 24 November 2015.[10] A Community Treatment Order (**CTO**) was made prior to his release for a period of 6 months (expiring 23 May 2016).[11]

24. On 19 December 2015, Mitchell went missing from home for a period of time. On his return, he reported having thought about jumping off a cliff. He was seen by mental health staff from the NBM LHD's Community Access Team at his home address.[12]

[4] Exhibit 1, Vol 1, Tab 7, Annexure A.
[5] Exhibit 1, Vol 1, Tab 6 at [9]; Exhibit 1, Vol 1, Tab 7 at [5]-[8].
[6] Exhibit 1, Vol 2, Tab 57 at p. 2.
[7] Exhibit 1, Vol 1, Tab 7 at [8]-[9].
[8] Exhibit 1, Vol 1, Tab 51.
[9] Exhibit 1, Vol 1, Tab 53.
[10] Exhibit 1, Vol 1, Tab 9 at [22].
[11] Exhibit 1, Vol 1, Tab 9 at [22].
[12] Exhibit 1, Vol 1, Tab 9 at [18].

25. On 20 December 2015, Mitchell was detained by ambulance officers under s. 20 of the MH Act to transport him to Nepean Hospital for assessment and treatment.[13] He was admitted as an inpatient until 15 January 2016.[14]

2016 Admissions

26. On 24 January 2016, Mitchell overdosed on medication. He was admitted to Nepean Hospital for treatment. He then absconded, but was returned by ambulance and involuntarily admitted for treatment (**1st absconding event**). He was discharged on 26 February 2016.[15]

27. Between 11 and 15 April 2016, Mitchell was voluntarily admitted to Brumby House, a residential facility for young people with a mental illness. He reportedly displayed low mood and depression.[16]

28. On 28 November 2016, police were called to Mitchell's parents' home as a result of concerns about Mitchell's wellbeing. Mitchell was reportedly acting in a strange manner. He was voluntarily transported to Nepean Hospital and was released later that same day.[17]

29. Between 1 and 8 December 2016, Mitchell was involuntarily admitted to Nepean Hospital for mental health treatment. This was at the direction of Dr Pusic, as Mitchell showing signs of relapsing into a psychosis.[18]

30. Mitchell absconded during his inpatient admission on 2 December 2016. Ms Flood-Smith was notified by the Nepean Hospital that Mitchell had absconded. Mitchell then called his mother and stated he was at home (**2nd absconding event**).[19] Police were notified and returned him to the Nepean Hospital without incident.[20]

[13] Exhibit 1, Vol 1, Tab 9 at [18]; Exhibit 1, Vol 1, Tab 53.
[14] Exhibit 1, Vol 1, Tab 9 at [22].
[15] Exhibit 1, Vol 1, Tab 9 at [22].
[16] Exhibit 1, Vol 1, Tab 9 at [22].
[17] Exhibit 1, Vol 1, Tab 9 at [18]; Exhibit 1, Vol 1, Tab 53.
[18] Exhibit 1, Vol 1, Tab 9 at [22].
[19] Exhibit 1, Vol 1, Tab 7 at [17].
[20] Exhibit 1, Vol 1, Tab 9 at [18]; Exhibit 1, Vol 1, Tab 53.

31. On 21 December 2016, Mitchell was re-admitted to Nepean Hospital following his parents notifying the Community Access Team that Mitchell had ceased taking his medication. Mitchell remained an inpatient until 1 February 2017.[21]

32. That same day, the Mental Health Review Tribunal made a CTO owing to Mitchell's history of non-compliance leading to relapse and his numerous hospital admissions. The order was to expire no later than 31 July 2017.

2017 Admissions

33. On 20 February 2017, Mitchell was taken to Nepean Hospital by his parents owing to a decline in his mental health. He was involuntarily admitted as an inpatient and remained an inpatient until his death on 4 May 2017.[22]

34. During his admission, Mitchell was authorised to undertake supervised leave, ranging from short periods to weekend leave under the supervision of his parents.

35. On 5 March 2017, during a period of leave from Nepean Hospital, Ms Flood-Smith contacted police out of concern for her son. Mitchell had left home and a suicide note was found in his room. An unsuccessful attempt was made to triangulate his mobile phone in an effort to locate him. Mitchell later returned to his parents' home and was returned to Nepean Hospital by his parents.[23]

36. During his admission between 20 February and 4 May 2017 Mitchell presented as melancholic and flat in affect. At various times he reported depressive symptoms including feelings of a lack of self-worth thoughts. A record made on 16 March 2017 noted his report of "*fleeting suicidal ideation…comes and goes*". Occasionally he expressed suicidal thoughts or intent involving

[21] Exhibit 1, Vol 1, Tab 9 at [22].
[22] Exhibit 1, Vol 1, Tab 9 at [22].
[23] Exhibit 1, Vol 1, Tab 49.

overdosing on sleeping tablets and lying on railway tracks.[24]

37. A focus in the latter part of his treatment was on Mitchell securing independent accommodation. Prior to his admission in February 2017, Mitchell had been residing with his parents. Consideration was given to Mitchell residing in a group residence; however that option was not favoured by Mitchell.

Release on extended leave on 28 April 2017

38. On 28 April 2017, Dr Pusic authorised Mitchell being released on extended leave to allow Mitchell to trial living in independent accommodation. This was done following a multidisciplinary team meeting involving Dr Pusic, an occupational therapist, a social worker and a primary mental health team representative on 27 April 2017. The record of that meeting noted the following:[25]

> *"If option of moving in with friend is a viable option, then to work towards discharge to that address after Mitchell provides it. Is in Cambridge Park.*
>
> *Mitchell will require case management on discharge. Treating team are recommending Psychological and Occupational Therapy Involvement. Mitchell will require assistance in problem solving and in managing relationship issues with his family. Occupational Therapy involvement for assistance in financial independence, budgeting, and vocational support, as wants to get back into working, or studying."*

39. Mitchell remained classified as an admitted inpatient when released on extended leave. Dr Pusic gave evidence that this was to ensure prompt triage if Mitchell presented to Nepean Hospital for treatment.

40. Ms Flood-Smith recalled receiving a call from Mitchell on 28 April 2017 asking her to collect him from Nepean Hospital. He told her that Dr Pusic had said he

[24] Exhibit 5, Tab 7.
[25] Exhibit 5, Tab 5.

was okay to be released. Ms Flood-Smith did not understand that Mitchell remained classified as an admitted patient whilst on extended leave. [26]

41. In evidence before me, Dr Pusic stated that the possibility of Mitchell being released on extended leave was canvassed at the meeting he had with Mitchell, Ms Flood-Smith, and himself, on 20 April 2017. He accepted, however, that Mitchell's parents were not told when Mitchell would be released to extended leave as Mitchell was yet to secure accommodation in the community.

42. Dr Pusic was not at the TAC when Mitchell was released on 28 April 2017. His expectation was that someone within the TAC would have notified Mitchell's parents as to his status.

43. I find that Mitchell's family were not advised that Mitchell was released on extended leave, rather than discharged, on 28 April 2017. This is regrettable as they were a significant support for Mitchell in the community. However, this does not appear to have been material to the events on 4 May 2017, as Mitchell himself alerted police and the TAC staff to the fact of him being an admitted patient.

44. At the time Mitchell was released, his accommodation arrangements were not finalised. He stayed with his parents for a few days before moving into his granny flat at 55A William Street, Cambridge Park on 30 April 2017. The main house was occupied by his friend. [27]

45. On 1 May 2017, Dr Pusic reviewed Mitchell. He appeared subdued, but reported "*some hope for the future*" and was seeking employment. He reported not having thoughts of self-harm, that he was abstaining from cannabis and alcohol use, and that he continued to want to live independently of his parents. He also reported not being confident that he would succeed in independent living, but being willing to see if it could work

[26] Exhibit 1, Vol 1, Tab 7 at [22].
[27] Exhibit 1, Vol 1, Tab 7 at [22].

out for him. Dr Pusic authorised Mitchell remaining on extended leave. [28]

46. Mitchell's medications at this point included Risperdal (antipsychotic medication; reduced to 1mg nocte) and venlafaxine (antidepressant medication, continued at 300mg/day). Mitchell's Risperdal had been reduced over time owing to him not presenting with psychotic ideation.

47. On or about 2 May 2017, Mitchell attended an employment agency, Penrith Personnel, to seek work. He was offered a day's work as a forklift driver at Emu Plains for 4 May 2017.[29]

48. Dr Pusic was scheduled to see Mitchell again on 4 May 2017.[30]

Events of 4 May 2017

49. Mitchell did not attend for his review with Dr Pusic at Nepean Hospital, scheduled to occur between about 10am and 1pm on 4 May 2017. Dr Pusic did not call Mitchell or his parents about his failure to attend. In his evidence before me, Dr Pusic said he expects he would have followed up on the failed attendance the following day and that Mitchell's non-attendance was not remarkable in the context of their past dealings.

50. Ms Flood-Smith learnt later that day that her son had attended work, but left the site at lunchtime without speaking to anyone.

51. At about 6:20pm, Mitchell had a text message exchange with his mother during which she asked him "…*Ru working tomorrow*…" Mitchell responded, "*I was meant to but I won't*" and "*Can't handle it. Come grab my shit & car with dad when you get a chance. I'm going homeless or 2 kill myself yet again"*.[31]

[28] Exhibit 1, Vol 2, Tab 57 at p. 3.
[29] Exhibit 1, Vol 1, Tab 7 at [23].
[30] Exhibit 1, Vol 2, Tab 57 at p. 3.
[31] Exhibit 1, Vol 1, Tab 7 at [24], Annexure C.

52. At about 6:24pm, Ms Flood-Smith contacted triple zero and reported that Mitchell was mentally ill and had made a threat to take his own life.[32]

53. At about 6:37pm, Leading Senior Constable Douglas Scott (**LSC Scott**) and Constable Luczak (**C/Luczak**) from St Marys Station (call sign "SM35") attended Mitchell's home in William Street in response to Ms Flood-Smith's call to triple zero.[33]

54. LSC Scott and C/Luczak found no one at Mitchell's granny flat and proceeded to search the premises. A resident in the main house said she had not seen Mitchell for several hours and would notify police if he returned.[34]

55. LSC Scott then called Ms Flood-Smith's mobile phone. According to LSC Scott, Ms Flood-Smith stated that Mitchell:[35]

- Had sent her a text message stating "*Can't handle it. Come grab my shit & car with dad when you get a chance. I'm going homeless or to kill myself yet again*" (Ms Flood-Smith also forwarded a copy of this message to LSC Scott);
- Had an extensive mental health history and had only been released from "Pialla" on Friday (28 April 2017);
- Had previously attempted suicide and was suffering depression owing to cannabis use; and
- Was subject to a CTO specifying that he was to be immediately admitted to hospital if he made threats of self-harm.

56. LSC Scott called Mitchell on his mobile phone. Mitchell refused to disclose his location, stating he did not want to return to hospital. He also stated he had "*had enough and won't be around*" and that the police would not be able to find him. Mitchell refused to say what "*had enough*" meant and then

[32] Exhibit 1, Vol 1, Tab 7 at [25].
[33] Exhibit 1, Vol 1, Tab 12 at [5].
[34] Exhibit 1, Vol 1, Tab 12 at [5]-[6].
[35] Exhibit 1, Vol 1, Tab 9 at [4].

terminated the call.[36]

57. By that time Senior Constable Wesley Kennedy (**SC Kennedy**) had arrived at Mitchell's residence. SC Kennedy patrolled the surrounding streets looking for Mitchell.[37]

58. LSC Scott contacted Sergeant Salafia (**Sgt Salafia**), the "inside supervisor", to request triangulation of Mitchell's phone. Sgt Salafia said he would speak to the Duty Officer, Inspector Cruickshank, to commence the triangulation process. This request did not proceed as Mitchell was found soon after.[38]

Mitchell found at about 7:30 pm

59. At about 7:30pm, SC Kennedy located Mitchell at the intersection of Richman Road and Copeland Street, Kingswood. This was a few minutes' drive from his granny flat. Mitchell said to SC Kennedy words to the effect, "*I'm going to Penrith to try and find food at a homeless shelter. I worked today but I don't like it, I don't have any friends and I don't have anything I enjoy*".[39]

60. LSC Scott and C/Luczak travelled to SC Kennedy's location. According to LSC Scott, Mitchell appeared depressed. Mitchell stated:[40]

- He did not want to go back to hospital, that he had "*had enough*" and felt as though he had "*no self-worth*";
- He wanted to walk to Penrith to find a food van to get food to eat;
- He had recently got out of hospital on extended leave although he had not been formally discharged, and was due to attend a meeting at hospital that day but had attended work instead;
- He had been residing at 55A William Street since last Sunday (30

[36] Exhibit 1, Vol 1, Tab 9 at [5].
[37] Exhibit 1, Vol 1, Tab 13 at [5].
[38] Exhibit 1, Vol 1, Tab 9 at [6].
[39] Exhibit 1, Vol 1, Tab 13 at [5].
[40] Exhibit 1, Vol 1, Tab 9 at [6].

April 2017);

- He was employed, but did not enjoy his work;
- He had no friends and no other hobbies save for playing video games and smoking cannabis; and
- His cannabis use over several years had caused him to suffer psychosis and depression, which he could not manage.

61. C/Luczak heard Mitchell state words to the effect "*I'm not going back to the hospital, I was there before and they didn't help me*".[41]

62. I note that Mitchell told LSC Scott he was an admitted patient on extended leave from Nepean Hospital. So whilst Ms Flood-Smith could not have brought that fact to the attention of police, Mitchell did so.

Mitchell detained under s. 22 of the MH Act

63. At about 7:30 pm LSC Scott detained Mitchell under s. 22 of the MH Act.[42]

64. Section 22 of the MH Act provides:

22 Detention after apprehension by police

(1) A police officer who, in any place, finds a person who appears to be mentally ill or mentally disturbed may apprehend the person and take the person to a declared mental health facility if the officer believes on reasonable grounds that:

> *(a) the person is committing or has recently committed an offence or that the person has recently attempted to kill himself or herself or that it is probable that the person will attempt to kill himself or herself or any other person or attempt to cause serious physical harm to himself or herself or any other person, and*

[41] Exhibit 1, Vol 1, Tab 12 at [10].
[42] Exhibit 1, Vol 1, Tab 9 at [6].

(b) it would be beneficial to the person's welfare to be dealt with in accordance with this Act, rather than otherwise in accordance with law.

(2) A police officer may apprehend a person under this section without a warrant and may exercise any powers conferred by section 81 on a person who is authorised under that section to take a person to a mental health facility or another health facility.

65. LSC Scott called an ambulance to transport Mitchell to the TAC.[43] LSC Scott stated in evidence that he called an ambulance rather than drive Mitchell via police vehicle as this was a less restrictive means of transporting Mitchell (this is a relevant consideration under the MH Act). Paramedics Warren Holman (**Mr Holman**) and Rebecca Tulk (**Ms Tulk**) attended the scene at about 7:37pm.[44] Mr Holman drove the ambulance to the TAC, whilst Ms Tulk carried out a mental health assessment on Mitchell.[45]

TAC setup

66. The TAC is a gazetted mental health facility under the MH Act. It is part of the NBM LHD and is on the Nepean Hospital's grounds. It is in a building separate from the Emergency Department.

67. Before the commencement of the TAC, police took detained persons to the Nepean Hospital's Emergency Department for assessment.[46]

68. Ambulance and police can access the TAC via a dock secured by roller doors. The dock leads internally to a secure area. From there, a patient can be placed in a Safety Assessment Room (a secured area) or through a secured door into a main corridor known as the Safety Assessment Area. Staff with swipe card access can move from that area into the public waiting area and reception desk. That reception area can also be entered via the TAC's front

[43] Exhibit 1, Vol 1, Tab 9 at [6].
[44] Exhibit 1, Vol 1, Tab 17 at [7].
[45] Exhibit 1, Vol 1, Tab 18 at [9].
[46] Exhibit 1, Vol 1, Tab 12 at [12].

entrance through double glass sliding doors. The reception desk consists of a counter with a glass screen.[47]

69. Patients brought to the TAC are triaged by the Team Leader, who then allocates patients to a clinician for mental health assessment.[48]

70. Several security officers are employed or contracted to work each shift at Nepean Hospital. At any given time, one security officer is assigned to the TAC unit. That security officer's practice is to sit inside in a chair near the TAC's front entrance, although the officer may have to leave that position to carry out particular duties such as assisting in transferring patients to other areas within the TAC or Nepean Hospital.

Mitchell's arrival at the TAC at 7:52pm

71. Mitchell was transported to the TAC by ambulance, with LSC Scott and C/Luczak following behind. The ambulance arrived at the TAC at about 7:52pm.[49]

72. The ambulance entered via the roller doors which closed after entry. LSC Scott and C/Luczak parked nearby across the road.[50]

73. The ambulance officers were met by RN Elizabeth Maurer (**Ms Maurer**), the TAC team leader (her shift ended at 9:30pm).[51]

74. Ms Tulk gave a verbal handover to Ms Maurer in the dock area. Ms Maurer asked the ambulance officers brief questions about Mitchell's presentation, including whether he was intoxicated, agitated, or had attempted self-harm. One purpose of the questions was to determine if Mitchell was suitable to enter the TAC unit or needed to be admitted through the Emergency Department for treatment. In evidence before me, Ms Maurer recalled being told Mitchell had suicidal ideation, but no specifics about what that

[47] Exhibit 1, Vol 1, Tab 12 at [13].
[48] Exhibit 1, Vol 1, Tab 26 at [11].
[49] Exhibit 1, Vol 1, Tab 23 at p. 2.
[50] Exhibit 1, Vol 1, Tab 12 at [13].
[51] Exhibit 1, Vol 1, Tab 24 at [7].

constituted.

75. Ms Maurer then briefly spoke to Mitchell whilst he was in the back of the ambulance to confirm he was not agitated or intoxicated.

76. Mitchell exited the ambulance and entered the TAC unit with Ms Maurer. He was taken through a secure door to the TAC's waiting room where he was seated. Mr Itilani Latu, security officer, was working as the rostered on security officer for the TAC at the time.[52]

77. Ms Maurer did not know Mitchell before this attendance. When Ms Maurer met him in the dock area she was not aware he was already an admitted inpatient on extended leave. Ms Maurer gave evidence that, had she known this, she expects she would have had Mitchell placed in the secure area until a bed was available rather than placing him in the waiting area.

78. LSC Scott and C/Luczak entered the TAC via its front entrance. LSC Scott completed the s. 22 certificate. The certificate recorded the following:[53]

- Mitchell was apprehended by police at 7:30pm and had arrived at Nepean Hospital by 7:57pm; and

- Mitchell had sent a text message to his mother earlier that evening threatening self-harm. When police attended Mitchell's home address they found it unlocked, with all of Mitchell's belongings including his wallet and keys left behind.

79. Ms Flood-Smith exchanged a text message with Mitchell at 7:53pm asking about his whereabouts. Mitchell replied that he was at Nepean Hospital. That was her last direct contact with him.[54]

80. LSC Scott and C/Luczak left the TAC at about 8pm. At that time, Mitchell was seated in the TAC's waiting room with a uniformed male security guard sitting nearby. LSC Scott and C/Luczak briefly conversed with Mitchell before leaving.

[52] Exhibit 1, Vol 1, Tab 33 at [8]-[9].
[53] Exhibit 1, Vol 1, Tab 9, Annexure B.
[54] Exhibit 1, Vol 1, Tab 7 at [26].

It seemed to them like he did not want to be at Nepean Hospital, however he appeared calm and not anxious.[55] C/Luczak gave evidence that Mitchell did not make eye contact and did not interact with them other than nodding his head in answer to questions. Her impression was he did not want to speak to them.

81. After Mitchell entered the TAC unit with TAC staff, Ms Tulk completed the NSW Ambulance's electronic medical record (**Patient Record**) for Mitchell and sent it electronically to the TAC's reception desk. Ms Tulk recorded a narrative as follows:[56]

> *"CT threatening suicide. OA 23YO male standing on the side of the road in the care of NSWPF. NSWPF state they received a call from PT's mother who stated to them he had sent a text message to her stating he was going to kill himself. Pt with recent extended admission to MH unit for initially psychotic episode following by depressive state and suicidal thoughts. OE Pt alert, orientated, well perfused, Pt states he hates his job but he is too worthless to do anything else, states his living arrangements are OK, Pt states was planning on standing on the train tracks, States has attempted suicide 6 times in the past, Pt denies any illicit drugs or medication misuse or ETOH, denies any self-harm or injuries, Pt refusing to attend hospital, paramedics and NSWPF explained to Pt that due to suicidal threats he would be returned under the Mental Health Act. Pt displeased with this but calm and compliant en route. NSWPF following to TAC and will complete schedule."*

82. The Patient Record was likely printed by administrative staff at the reception desk to be scanned and uploaded to Nepean Hospital's electronic medical record for Mitchell.

83. Police were not informed of Mitchell's statement to Ms Tulk that he had

[55] Exhibit 1, Vol 1, Tab 12 at [15].
[56] Exhibit 1, Vol 1, Tab 23 at p. 2.

planned to stand on railway tracks.[57]

Ms Maurer's assessment of Mitchell

84. After receiving a brief verbal overview and the s. 22 certificate from police, Ms Maurer sat with Mitchell in the waiting room and questioned him.[58] Ms Maurer gave evidence this assessment went for about 5 to 10 minutes. Mitchell appeared calm and answered her questions appropriately. He was forthcoming with information, including that he was an inpatient who had been on leave and that he had not attended a scheduled review earlier that day.

85. Mitchell told Ms Maurer he was an inpatient on leave. In her oral evidence, Ms Maurer said she did not move Mitchell into a secure area upon learning this as he had been seated for a period of time in reception without incident. He also appeared calm and forthcoming in information.

86. Ms Maurer did not review the Patient Record for Mitchell prepared by Ms Tulk before assessing Mitchell in the reception area, or before he absconded. This was owing to her workload. It is also possible the Patient Record had not been printed before she spoke to Mitchell on the second occasion while he was seated in the waiting room.

87. Ms Maurer did not know of Mitchell's report to Ms Tulk that he had thought about taking his life by standing on railway tracks. Had she known of that report, she expects she would have asked him directly about it to ascertain what his thinking was.

88. Mitchell's details were entered into the computer system by an administrative officer. With that open, Ms Maurer made a triage entry at 8:17pm recording a brief note about Mitchell's presentation. That included reference to his text message to his mother earlier that evening in which he made a threat of self-harm.

89. It was possible for Ms Maurer to review the electronic management records

[57] Exhibit 1, Vol 1, Tab 6 at [55].
[58] Exhibit 1, Vol 1, Tab 24 at [11].

about Mitchell's past admission and treatment. She gave evidence she did not do so owing to her workload.

90. Ms Maurer did not know that Mitchell had absconded from an inpatient unit in the past (on 2 December 2016) before he absconded that evening. She expects, had she known that fact at the time of assessment, she would have moved Mitchell into the secure area of the TAC. In her view, a prior history of absconding does inform an assessment of that patient's risk of doing so again.

91. Ms Maurer gave evidence that there is a record within a patient's electronic medical record that lists particular alerts for that patient (if any have been entered). It was not mandatory practice for staff to check these alerts in May 2017, although staff are now required to perform such checks.

92. I received evidence about the electronic alerts system. Alerts can be flagged in a patient's triage documents. Risk of absconding is not a pro forma alert to be entered into the system (although staff can still enter such alert in), nor is there a formal practice of requiring a 'risk of absconding' to be entered as an alert because a patient has previously absconded. In Mitchell's case, an alert had been entered before his death indicating a 'risk of falls' which was common for patients administered antipsychotic medication, but none existed to indicate a risk of absconding. I return to this issue below.

93. At about the time the triage entry was made, Maurer called the After Hours Nurse Manager, Nishidh Patel (**Mr Patel**), to request a bed to be arranged for Mitchell. Mr Patel determined there were no beds available in the Acute Mental Health Unit or in the High Dependency Unit or in any other mental health units. The only bed available was within the Psychiatric Emergency Care Centre (**PECC**).[59]

94. According to Mr Patel, he arranged for another patient in the Acute Mental Health Unit to be transferred to the PECC to provide a bed in the Acute Mental Health Unit for Mitchell. This took approximately 45 minutes to arrange.[60]

[59] Exhibit 1, Vol 1, Tab 27 at [15], [17]-[18].
[60] Exhibit 1, Vol 1, Tab 27 at [19]-[20].

95. According to Ms Maurer, she was told at about 8:30pm that a bed in PECC was available and Mitchell was to be given that bed. Ms Maurer's evidence was that the After Hours Nurse Manager tasked staff to attend the TAC to take Mitchell to the PECC, which was in a separate building. Mitchell was still expected to be reviewed by a psychiatric registrar, but that could have occurred either in the TAC or PECC.

Mitchell absconds from the TAC at about 9pm

96. Dr Musthafa, a psychiatric registrar, was asked by Ms Maurer to assess Mitchell. Dr Musthafa was finishing paperwork with another patient, but was expected to attend forthwith.[61]

97. At about 7:24pm, before Mitchell's arrival at the TAC, another patient had presented voluntarily to the TAC. That patient was in the TAC's waiting room awaiting assessment. He was subsequently "scheduled" (involuntarily admitted under the MH Act) by a nurse and became progressively more agitated. At about 8pm, a staff member locked the double glass egress doors at the front entrance owing to this patient's presentation. Extra security officers were called from the main section of Nepean Hospital to attend.

98. Shortly before Mitchell absconded, three Nepean Hospital security officers, Mr Latu (the TAC security guard), and a TAC nurse (Ms Shanice McCormack) transferred the agitated patient to the High Dependency Unit.[62] The security officers assisted in escorting that patient at the direction of clinical staff.[63]

99. The High Dependency Unit is a secure area separate to the waiting room. The security officers remained in the High Dependency Unit while the handover took place.[64] The security officers were away from the TAC's waiting area for about 5 to 10 minutes.[65] Mitchell remained in the waiting room without any security officers present. The security officers were not given a direction about

[61] Exhibit 1, Vol 1, Tab 24 at [8].
[62] Exhibit 1, Vol 1, Tab 26 at [22].
[63] Exhibit 1, Vol 1, Tab 30 at [11].
[64] Exhibit 1, Vol 1, Tab 31 at [14].
[65] Exhibit 1, Vol 1, Tab 30 at [17].

Mitchell before escorting the other patient to the High Dependency Unit.[66]

100. After the security officers left the waiting room area, Mitchell approached the wall on the western end of the TAC's waiting room (near the glass sliding door entrance) and pressed a button on the wall. This button overrode the lock and caused the front entrance sliding doors to open. Mitchell then walked out. This happened sometime between 8:53pm and 9pm.[67]

101. Ms Maurer saw Mitchell leave and followed after him outside. She saw Mitchell walking away from TAC and called his name. When he did not respond, she went back inside to get the assistance of the security officers who had just returned from the transfer.[68]

102. A social worker and security officers followed after Mitchell to persuade him to return. They saw Mitchell run towards Derby Street and exit the Nepean Hospital grounds. They ceased following after him at this point.[69]

TAC's response to Mitchell absconding

103. Ms Maurer completed a "Missing Patient" form to report to police that Mitchell had absconded. This was done by 9:10pm when Ms Maurer performed a handover to the oncoming Team Leader, whose shift commenced at 9:30pm.[70]

104. At about 9:17pm, before completing her shift, Ms Maurer called and left a message on Ms Flood-Smith's phone stating, "*Hi Debbie, its Liz in TAC. Can you give us a call on* [number]. *Just letting you know that Mitchell didn't stay in the Unit to be moved to another bed. Thank you. Bye".*[71]

105. At about 9:30pm, the Team Leader taking over from Ms Maurer called Penrith Police Station and notified police of the fact of Mitchell absconding. This was at least 30 minutes after he had left the TAC.

[66] Exhibit 1, Vol 1, Tab 32 at [17].
[67] Exhibit 1, Vol 1, Tab 24 at [15].
[68] Exhibit 1, Vol 1, Tab 24 at [16].
[69] Exhibit 1, Vol 1, Tab 29 at [12].
[70] Exhibit 1, Vol 1, Tab 9, Annexure C.
[71] Exhibit 1, Vol 1, Tab 7 at [28].

106. Section 48 of the MH Act provides:

> ***48 Apprehension of persons not permitted to be absent from mental health facility***
>
> *(1) An authorised medical officer of a mental health facility may apprehend a person, or direct a person to be apprehended, if:*
>
> > *(a) the person fails to return to the facility on or before the expiry of a permitted period of absence granted under this Part or fails to comply with a condition of the permission, or*
> >
> > *(b) the person absents himself or herself from the facility otherwise than in accordance with this Act.*
>
> *(2) The person may be apprehended by any of the following persons*
>
> > *(a) an authorised medical officer or any other suitably qualified person employed at the mental health facility,*
> >
> > *(b) a police officer,*
> >
> > *(c) a person authorised by the Minister or the authorised medical officer,*
> >
> > *(d) a person assisting a person referred to in paragraph (a), (b) or (c).*
>
> *(3) A person who is apprehended is to be conveyed to and detained in the mental health facility from which the person absented himself or herself (whether directly or indirectly by way of another mental health facility).*

107. Section 48 of the MH Act permits an authorised medical officer to direct that a person be apprehended because he or she had absented himself from a mental health facility otherwise than under that Act. Pursuant to s. 48(2), such a direction authorises a police officer to apprehend that person and to convey that person to the relevant mental health facility.

108. The “Missing Patient” form completed by Ms Maurer was faxed to Penrith Police Station at about 9:36pm.[72]

109. Ms Maurer gave evidence the call to police and the faxing of the missing patient form did not occur immediately after Mitchell absconded owing to the handover she performed at about 9:10pm.

Notification to police about the deceased absconding at 9:40pm

110. At about 9:40pm, Penrith Police Station received the Missing Patient form faxed by the TAC. That was brought to the attention of Senior Constable Galvez (**SC Galvez**). SC Galvez was performing station duties. The faxed form recorded:[73]

- Mitchell’s description;
- That his mother was his next of kin, along with her mobile number;
- Mitchell had absconded from the TAC at 9:10pm;
- Mitchell’s “*risk level*” was “*moderate*”, his mental state “*settled*” and that he was “‘s*uicidal*”;
- Mitchell had run out of the TAC when “*security had exited the unit*”; and
- Security had chased after Mitchell (unsuccessfully) and he had left the Nepean Hospital grounds.

111. The Patient Record was not included in the material faxed through to police and police were not made aware of Mitchell’s report to Ms Tulk in the ambulance that he had thought about taking his life by standing on the railway tracks.

112. SC Galvez determined that LSC Scott had dealt with Mitchell earlier that day. He called LSC Scott by phone at about 9:40pm and advised Mitchell had

[72] Exhibit 1, Vol 1, Tab 15 at [4].
[73] Exhibit 1, Vol 1, Tab 9, Annexure C.

absconded from the TAC before being seen by a doctor.[74]

113. LSC Scott and C/Luczak attended Mitchell's granny flat, but found no one home. LSC Scott spoke to the other occupant at the home. She said she had not seen the deceased for some time, but would immediately notify police upon his return. Whilst at Mitchell's granny flat, LSC Scott saw that Mitchell's wallet was not where he had earlier sighted it.[75]

114. A CAD report records that LSC Scott and C/Luczak were "*On scene*" (at Mitchell's residence) at 9:50pm. It further records that their status changed from "*On Scene*" to "*Finished*" and "*Back on Available*" at 10:14pm.[76]

115. At about 10:13pm, C/Luczak made a radio broadcast to VKG advising that "…*we've just returned to this umm address for this missing person. He's not there, and we spoke to his house mate. Umm, we've asked her when he comes back to give the station a ring. Umm, so we're back on*."[77]

116. SC Scott and C/Luczak carried out a patrol along the northern side of the railway tracks near Kingswood Railway Station looking for Mitchell, but did not sight him.[78]

117. During the patrol, C/Luczak called Mitchell on his mobile phone. Mitchell answered the call. In C/Luczak's opinion, it sounded like Mitchell was out walking, but no sounds could be heard in the background. Mitchell refused to say where he was or where he was headed. C/Luczak told Mitchell that they needed to see him to make sure he was okay. Mitchell responded to the effect he was "*not going back there*" and terminated the call. C/Luczak made a record of her conversation with Mitchell in her police notebook.[79]

118. At some point, LSC Scott contacted SC Galvez and updated him on their response to that point. SC Galvez advised he would create a "*Keep a Look*

[74] Exhibit 1, Vol 1, Tab 9 at [7].
[75] Exhibit 1, Vol 1, Tab 10 at [5].
[76] Exhibit 1, Vol 1, Tab 12, Annexure A, CAD Log 377097-04052017.
[77] Exhibit 2.
[78] Exhibit 1, Vol 1, Tab 10 at [6].
[79] Exhibit 1, Vol 1, Tab 12 at [17], Annexure C.

Out for" ("KLO4") on CAD.[80]

LSC Scott and C/Luczak's activities between 10:22pm and 11:50pm

119. Whilst patrolling, LSC Scott and C/Luczack came across an accident at the intersection of Bringelly Road and the Great Western Highway, on the southern side of the railway line near Kingswood Railway Station. CAD records indicate that they were assigned to his incident at 10:13pm, and were on scene between 10:21pm and 11:09pm.[81]

120. In terms of the VKG dispatch to officers to locate Mitchell, the status of that job was changed to "KLO4" at 10:28pm (meaning "Keep a Look Out For"). This means that all police on that channel were requested to keep a look out for Mitchell in the course of performing their other duties. The VKG operator followed that up with the following radio broadcast at 10:37pm:[82]

> *"Just a memo for cars on channel thanks, Penrith and St Marys please in particular. Keep a look out for a Mitchell Flood hyphenated Smith. Twenty one, four, ninety four. He absconded from Nepean Emergency before being seen. He was conveyed there about 6 o'clock by Police. St Marys 35 spoke to him over the phone about 10 pm, wouldn't say where he was, sounded like he was walking. Possibly in the Penrith area. Solid build, black hair, olive complexion, with a black leather jacket, dark jeans long hair. Not under a Schedule, still under a Section22. Forms are at the Hospital and at Penrith Police Station. Cars keep a look out, thanks."*

121. According to C/Luczak, the KLO4 message was broadcast on radio channel "J" district, which covers all vehicles and stations within that district namely St Marys, Penrith, Hawkesbury and the Blue Mountains.

122. At Penrith Police Station, SC Galvez completed a Missing Person Risk Assessment form. A COPS record made at 10:49pm recorded the creation of

[80] Exhibit 1, Vol 1, Tab 15 at [7].
[81] Exhibit 4, pp. 3-6.
[82] Exhibit 1, Vol 1, Tab 15, Annexure A.

that report. It noted that Mitchell had absconded from a mental health facility and specified a "high" risk rating for him.[83]

123. LSC Scott and C/Luczak gave evidence that after finishing at the accident scene they continued their patrol in and around Nepean Hospital and the Kingswood area. They could not recall how long exactly they patrolled actively searching for Mitchell. C/Luczak recalled that they were still mobile in their vehicle near to Kingswood Railway Station when the radio broadcast regarding Mitchell was made at about 11:53pm (discussed further below).

124. There is no evidence that any other vehicle (other than LSC Scott and C/Luczak in SM35) were actively searching for Mitchell after the KLO4 broadcast was made.

125. The scene of the car accident that LSC Scott and C/Luczak attended was close to the Kingswood Railway Station's entrance on the Great Western Highway. That entrance to the train station is on the north side of the roadway. Nepean Hospital is south of that roadway. Mitchell's location between about 10:21pm and 11:09pm is not known. If he crossed the Great Western Highway and used that entrance to Kingswood Railway Station at about 11:36pm, it is possible he might have been nearby the accident scene and aware of the presence of police there. If so, he did not bring attention to himself.

Triangulation

126. In oral evidence, LSC Scott said he considered the possibility of requesting a second triangulation of Mitchell's mobile phone.

127. Triangulation involves a telecommunication provider disclosing to police information without a warrant regarding the location of phone handsets based on which cell tower picks up that device's' phone signal. A cell tower that picks up the signal will indicate whether a particular cell within that tower has detected it (for multi-directional cell towers) or simply whether the signal has been detected within a 360 degree area of that tower (for omni-directional cell

[83] Exhibit 1, Vol 1, Tab 50, pp. 2-3.

towers).

128. The police are usually provided a map with a shaded area indicating the likely area where the handset is located. In dense urban environments that area might capture many streets and homes. Its accuracy is affected by surrounding geography and other factors.

129. A telecommunication provider is authorised to provide such information assuming satisfaction of s. 287 of the *Telecommunications Act 1997* (Cth). Essentially, that requires an authorised person forming a belief on reasonable grounds that the disclosure or use of that information is reasonably necessary to prevent or lessen a serious and imminent threat to the life or health of a person.

130. The procedure for submitting a request generally involves an officer in the field first contacting his or her Shift Supervisor (rank of Sergeant) to make the request for triangulation. The Shift Supervisor will then raise the matter with the Duty Officer (rank of Inspector) for that shift. Generally, before submitting a triangulation request, officers in the field must make inquiries such as ringing the person to check on their welfare and attending the person's address to check if they are there.[84]

131. In oral evidence, LSC Scott said he was not satisfied that the necessary grounds existed to justify making a triangulation request. I return to this issue below.

132. Independently of SC Scott, SC Galvez considered whether triangulation of Mitchell's phone should be requested, however he did not make inquiries regarding this until around the time of the VKG broadcast at 11:53pm. SC Galvez contacted Sergeant Salafia to discuss triangulation and was told Mitchell was believed to be deceased by that point (which puts that conversation after the 11:53pm broadcast).

[84] Exhibit 1, Vol 1, Tab 42 at [16].

Mitchell enters Kingswood Railway Station at 11:36pm

133. CCTV cameras recorded Mitchell entering the Kingswood Railway Station, on the southern side via the Great Western Highway, at about 11:36pm.

134. He was recorded on camera walking in an easterly direction along the southern platform and then entering the rail corridor at the end of the platform. Mitchell was recorded walking east along the rail tracks, before leaving the view of cameras.[85]

135. Mitchell was struck by a train at approximately 11:43pm.

136. A radio broadcast was made at 11:53pm, alerting police that a person had been struck by a train between Werrington and Kingswood and requesting police attendance at Kingswood Railway Station.[86]

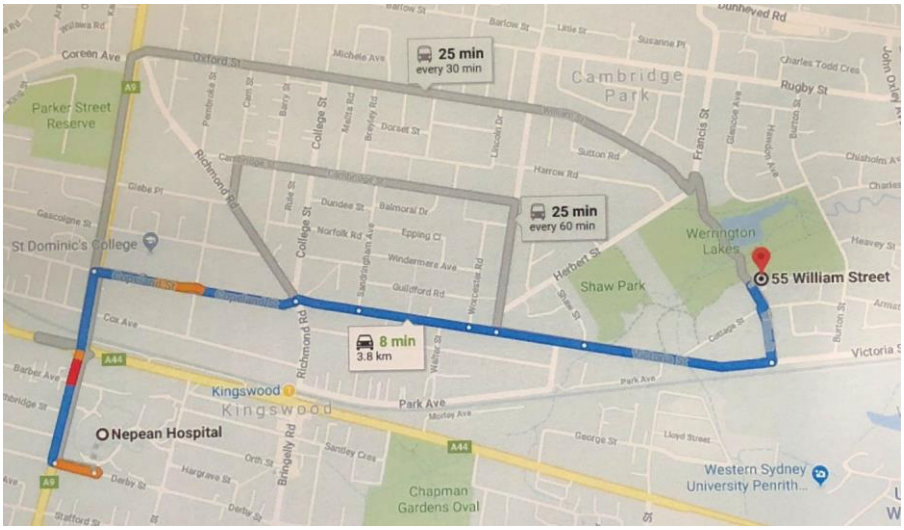
137. LSC Scott and C/Luczak arrived at the scene shortly thereafter. At this time, the passenger train in the westbound lane was stationary approximately 400 metres east of the railway station. LSC Scott located Mitchell deceased and found his drivers' licence, bankcard and mobile telephone nearby.[87]

138. LSC Scott spoke with Leigh Lawton, Sydney Trains' Incident Rail Commander, who advised that CCTV footage showed Mitchell entering the rail corridor.[88]

139. LSC Scott also spoke to the train driver who returned a negative reading when breath tested. The train driver advised that at about 11:43pm his train was travelling at approximately 100km/h. As the train rounded a slight bend, he saw a person (Mitchell) on the tracks. He applied the emergency brake (after impact) causing the train to stop at the location it was at when LSC Scott attended.

140. The location of the TAC relative to Kingswood Train Station and Mitchell's residence is depicted below:

[85] Exhibit 1, Vol 1, Tab 40.
[86] Exhibit 1, Vol 1, Tab 9 at [9];
[87] Exhibit 1, Vol 1, Tab 9 at [15].
[88] Exhibit 1, Vol 1, Tab 9 at [10].



141. At about 1am on 5 May 2017, police attended Ms Flood-Smith's home and notified her of Mitchell's death.[89]

142. Sometime later on 5 May 2017, Ms Flood-Smith learnt of the message left by Ms Maurer on her phone earlier the previous evening reporting that Mitchell had absconded from the TAC.[90]

ISSUES

143. Prior to the inquest, a list of issues to be explored was circulated to the parties. I turn now to consider each of these issues.

Manner and cause of Mitchell's death

144. I am satisfied that Mitchell suffered fatal injuries due to an intentional act by him to take his own life. I accept the conclusion of Dr Lorraine Du Toit-Prinsloo, forensic pathologist, that Mitchell died instantly on impact.

Police response on 4 May 2017

145. LSC Scott gave evidence he did not believe Mitchell was at a risk of serious harm based on the information known to him. He therefore did not consider it appropriate to make a request of his superiors for a triangulation of Mitchell's

[89] Exhibit 1, Vol 1, Tab 7 at [27].
[90] Exhibit 1, Vol 1, Tab 7 at [28].

phone.

146. LSC Scott was satisfied that the grounds existed to justify making a request for triangulation earlier that evening. Circumstances had not materially changed so the risk that existed earlier that evening had reduced. To the contrary, the fact of Mitchell absconding before assessment, his refusal to disclose his location to police, and his termination of his call with C/Luczak all point to an increased risk of self-harm.

147. I received evidence about the limitations that arise with triangulation. It does not pinpoint someone's precise location, rather it identifies an area within which his or her phone signal has been detected. The area located may not be accurate for several reasons. I accept that triangulation of Mitchell's phone may not have led to him being located. I also accept the final decision to submit a request for triangulation, had LSC Scott requested it, rested not with him but with a superior.

148. I am satisfied a request by LSC Scott for triangulation, assuming such request was approved, may have assisted police in locating Mitchell. However, it is not possible to know what difference such a request would have made.

149. I am satisfied that LSC Scott acted in good faith on the night. His decision not to request triangulation did not result from a lack of concern on his part or complacency. I have no doubt LSC Scott would have acted differently had he known what was to transpire.

150. I also note the prompt response of LSC Scott and others to Ms Flood-Smith's concern for welfare report earlier that evening. That response resulted in Mitchell being taken to the TAC for assessment and treatment, and included LSC Scott arranging for an ambulance to attend to transport Mitchell to Nepean Hospital so as to avoid him being taken in a police vehicle.

Mitchell's care and treatment at the TAC on 4 May 2017

Patient Record

151. It is apparent from the Patient Record that Mitchell reported to Ms Tulk that he

had thought about taking his life by standing on train tracks. This report extended beyond merely thinking about self-harm and indicated some thinking or planning as to how that could be affected. Planning as a predicative factor elevates the risk of the person going on to self-harm.

152. Mitchell's report of standing on train tracks was not something Ms Maurer knew when she spoke with Mitchell, as she had not read Ms Tulk's electronic record. This was important information that preferably should have been considered and explored in Mitchell's initial assessment while he was in the reception area. It is possible this information could have resulted in Ms Maurer forming a different view about Mitchell's risks and a different decision where he should await assessment. I emphasise this as a possibility, as a definitive finding cannot be made either way.

153. Whether the Patient Record was available to Ms Maurer when she assessed Mitchell, or whether it could have been brought to her subsequent attention before he absconded, is not known.

154. Ms Maurer gave evidence as to her shock and distress at Mitchell's death which I accept was heartfelt. I am satisfied that Ms Maurer acted in good faith, and that she had a very busy workload that evening and did not have the opportunity to review Mitchell's electronic records before assessing him. Taking into account the whole of the circumstances at the TAC that night, I do not attribute responsibility for Mitchell absconding to Ms Maurer or the fact of her not reviewing the paramedic record.

155. However, I do find that it would be beneficial for the TAC to review its practices and procedures surrounding how paramedic electronic medical records are considered on receipt in light of the circumstances that arose on 4 May 2017.

156. I make a recommendation to this effect below. It is deliberately framed in non-prescriptive terms, recognising that information management is a nuanced matter. Mandating that staff review specific materials may prove unworkable, result in practitioners being overwhelmed with information, and/or ultimately be

counterproductive to the outcome sought to be achieved. The manner in which information is managed and presented requires careful consideration.

Notification to police that Mitchell had absconded

157. Penrith Police Station was notified by phone at about 9:30pm about Mitchell's departure. By that point, Mitchell had been gone about 30 minutes. An immediate phone call to the police shortly after Mitchell left might have increased the chances of a nearby patrolling vehicle quickly and finding Mitchell nearby Nepean Hospital. The facsimile notification was sent at about 9:36pm, and did not mention Mitchell's report to Ms Tulk that he had thought about standing on rail tracks.

158. It cannot be known whether an immediate report to police by phone, and the provision of information that Mitchell had mentioned railway tracks, might have materially improved the prospects of police locating Mitchell before he self-harmed.

159. Furthermore, there is no doubting that the TAC would be a busy place. Staff may be managing numerous responsibilities. It is unrealistic to expect a phone call to police could always be made within a short time of a patient leaving. The reasonableness of the timing of the notification and the information provided will also depend on the circumstances of the patient.

160. However, it would be beneficial for the TAC to review its practices and procedures about how notifications are made to police when a patient involuntarily detained under the MH Act absconds. I also make a recommendation to this effect below.

The TAC

161. I heard evidence from Ms Bethany Pade, the Manager of Community and Partnerships in Mental Health at Nepean Hospital, about the establishment of the TAC in early 2017, its setup, and the policies and procedures applicable at the TAC both as at 4 May 2017 and now.

162. As I have set out above, before the commencement of TAC, patients detained under the MH Act were typically admitted and assessed through the Nepean Hospital's Emergency Department. Creating a less stressful environment that specifically catered for persons requiring mental health assessment and treatment was the principal aim of the TAC's establishment, so as to better care for persons in mental distress.

163. Having presided over many inquests that have touched upon the issue of people being admitted to emergency departments for mental health treatment, I accept unreservedly the benefits the TAC provides for mentally ill persons. Emergency departments are typically busy environments that cater to patients with a myriad of health issues. Even those not suffering mental distress can find an emergency department a stressful place.

164. The NBM LHD is to be commended for establishing a specialised facility for this purpose. The observations and findings I make below in no way detract from my view on this.

Securing of involuntarily admitted patients

165. When Mitchell left the TAC at about 9pm on 4 May 2017, he was already an admitted patient under the MH Act who was brought back to the TAC by police utilising their powers of involuntarily detention under the MH Act.

166. It is understandable that Mitchell's family, the NSW Police Force and the community in general would expect that once Mitchell was taken to the TAC under the involuntary powers of the MH Act, he would be kept in a secure environment and unable to leave before being properly assessed by a qualified mental health practitioner.

167. LSC Scott said in evidence he believed the TAC to be a secure facility. That is not surprising, given the secure roller door garage that ambulance or police enter when bringing involuntarily detained patients to that unit.

168. Police officers would understandably be frustrated at a situation whereby they locate a missing person displaying mental instability and exercise statutory

powers to involuntarily transport that person to hospital for assessment, only to be requested to again locate that person after he or she has absconded from hospital. It also increases the risk of police coming into adverse contact with a person who does not want to be admitted for treatment.

169. Ms Pade in her evidence noted the tension between creating a welcoming environment for persons attending the TAC and maintaining a secure space for persons detained under the MH Act. The persons presenting to the TAC reception include those voluntarily attending for assessment, family members attending with loved ones awaiting assessment and those involuntarily detained under the MH Act. The TAC reception area is designed to enable persons to leave without restraint.

170. Ms Pade highlighted that the TAC was developed to "*create a consumer friendly and accessible environment that people would be willing to present to in a mental health crisis*".[91] Placing a patient in a secure area can adversely affect that person's willingness to engage with treating staff or to seek help in future. At the same time priority would be given to preventing a person from harming themselves if he or she is considered at imminent risk of doing so.

171. Placing patients in secure rooms before assessment also involves the use of not insignificant resources. Policy requires two staff be placed with patient be they security or clinical staff. The decision to place a patient in a secure room deprives the Team Leader at TAC of two staff members to assist with the other workload in the unit.

172. The TAC assigned security officer sits close by to the reception area's sliding entrance doors. If an involuntarily detained patient attempted to leave, the officer would stand in the doorway and dissuade that person from leaving.

173. When Mitchell absconded, the officer assigned to the reception area had left to assist escorting a patient to the High Dependency Unit. The glass sliding doors had been locked, but the override button was situated close by the doors in an area accessible to the public. Mitchell may have known of that

[91] Exhibit 1, Vol 2, Tab 60 at [13].

button from his prior attendance there.

174. Without any criticism intended of Mr Latu, Mitchell is unlikely to have absconded had Mr Latu been seated in his usual position next to the TAC entrance. Mr Latu gave evidence that following this incident, he is now directly informed of the patients under a schedule.

175. Counsel Assisting submitted the potential for involuntarily detained patients to leave the TAC (while awaiting assessment in the reception area) remains a concern.

176. Counsel for the NBM LHD submitted on behalf of the LHD that some steps have been taken to improve the practices at the TAC and that recommendations were therefore unnecessary. He referred to the evidence of Ms Pade that a review had been undertaken of the management of Mitchell and relevant changes had been made since his death including:[92]

- Actions were identified around formalising processes when people return from leave and no bed is available, as well as consideration to be given to patients waiting for beds in the inpatient unit (and not in the TAC);

- The policy regarding inpatient therapeutic leave was updated to provide clear direction regarding management and where to accommodate patients on leave when there is no bed available on their return. The policy was also updated to reflect that managers are responsible for compliance with the procedures around notification of the designated carer/family member before leave was granted and if a patient fails to return to leave; and

- The updated policy now sets out steps for staff to take where a patient presents after external leave and a bed is not available, including:
    - Review of the patient's mental state;
    - Consideration of whether leave can be extended, and
    - Triage of the bed demand.

[92] Exhibit 1, Vol 2, Tab 60.

177. I have carefully considered the evidence of the circumstances of Mitchell's departure, the evidence of Ms Pade and the submissions of the parties.

178. I accept that no arrangement could ever be foolproof. While there might be little risk of an involuntarily patient absconding if all such persons were placed in a secured area, I accept the means of securing a patient is a nuanced issue. It requires balancing several countervailing factors. It also requires consideration of the resources to be applied.

179. However, the circumstances in which Mitchell came to leave the TAC show how readily gaps can arise in the security arrangements for the reception area. In his evidence, Mr Latu said he may have to attend various places within the TAC on a shift. That includes accompanying patients to other units and even accompanying patients brought in by police or ambulance through the roller door bay. Clearly he cannot be in all places at one time. This enhances the risk of a patient absconding when a security officer is away from that position.

180. It would be beneficial for the NBM LHD and the TAC to review its practices and procedures for securing persons involuntarily detained under the MH Act pending psychiatric assessment (the focus of that review being on how to prevent their absconding before assessment).

Alerts for the risk of absconding

181. Ms Pade also gave evidence about the alerts embedded on a patient's electronic medical record. She stated that a risk of absconding was not a static risk, and that a prior history of absconding did not necessarily indicate the patient would likely abscond again. Another consideration is avoiding 'alert fatigue' whereby too many alerts or flags arise resulting in practitioners paying less attention to them in the time available.

182. I also note Ms Maurer's evidence that, had she known Mitchell had absconded from an inpatient unit (not reception area) previously, she expects she would have moved Mitchell to a secure room.

183. After the conclusion of evidence, I received written submissions from the NSW Ministry of Health (**the Ministry**) about a possible recommendation on this issue. The Ministry advised that a "risk of absconding" currently forms part of the options available to add to a patient's electronic medical record.[93]

184. Notwithstanding that submission, given the other evidence referred to above, I intend on making the recommendation on this issue. I consider that it would be beneficial for the NBM LHD to examine the potential advantages and disadvantages of introducing a standardised alert for absconding. That review should include consideration of the criteria for determining when to enter such an alert, and consideration of how predictive prior instances of absconding are of a persons' future risk of absconding.

185. With respect to this recommendation, the Ministry proposed the recommendation be made in the following terms:

> "*Consideration be given to completing a review of clinical practice guidelines for the assessment and management of a patient's risk of absconding, complemented by education and training of clinical staff".*

186. Although I have adopted a different formulation to that of the Ministry, I was assisted by its response.

FINDINGS REQUIRED BY S. 81(1) OF THE CORONERS ACT 2009

187. Having considered the documentary evidence and the oral evidence heard at the inquest, I can confirm that the death occurred and make these findings in relation to it:

Identity of the Deceased

The deceased person was Mitchell Flood-Smith.

Date of Death

Mitchell died on 4 May 2017.

[93] Submissions dated 11 October 2019

Place of Death

Mitchell died at Kingswood Railway Station, Kingswood NSW 2747.

Cause of Death

Mitchell died instantly due to multiple injuries sustained on impact.

Manner of death

Mitchell Flood-Smith died after absconding from Nepean Hospital Triage Access Centre and standing in front of a train with the intention of ending his life. The resultant collision caused Mitchell to suffer multiple blunt force injuries that were not survivable.

RECOMMENDATIONS UNDER S. 82 OF THE CORONERS ACT 2009

188. As set out above, at the close of the inquest, Counsel Assisting invited me to make several recommendations and the parties were provided an opportunity to be heard on those. After careful reflection of the evidence, issues and submissions, I make the following recommendations pursuant to s. 82 of the Act:

I recommend to the Ministry of Health and the Nepean Blue Mountains Local Health District that each reviews these findings and reviews:

i. the arrangements of the Nepean Hospital's Triage Assessment Centre (**the TAC**) regarding the review by nurses and staff of electronic records submitted by paramedics involved in the admission of patients to the TAC under the *Mental Health Act 2007* (**MH Act**);

ii. the practice and procedures as to the timing of making notifications made to the NSW Police Force about involuntarily admitted patients who have absconded and the information to be provided as part of that notification;

iii. the arrangements for securing persons involuntarily detained under the MH Act pending psychiatric assessment (the focus of that review being on how to prevent patients absconding before assessment); and

iv. the clinical practice guidelines for the assessment and management and documentation of a patient's risk of absconding, including the criteria for determining such risk, the predictive value of past instances of absconding and the education and training of clinical staff about those guidelines.

CONCLUDING REMARKS

189. I was informed that the NBM LHD is taking steps to improve the quality of communication with family members, carers and/or key members of a consumer's social network. The NBM LHD has arranged to meet with Ms Flood-Smith to discuss her concerns and to develop a practical guide for family members supporting loved ones struggling with mental illness. I commend the NBM LHD for its willingness to do this.

190. I commend the officer-in-charge, Detective Sergeant Steven Peroni, for his comprehensive investigation.

191. I thank the parties and those who gave evidence or helped to prepare the evidence. That includes Ms Pade who provided a lengthy statement and facilitated a viewing of the TAC by those assisting me.

192. I thank my Counsel Assisting, Mr Chris McGorey and his instructing solicitor, Mr William Nash from the NSW Crown Solicitor's Office who put so much effort and thoughtfulness into assisting me.

193. Mitchell was a young man with much promise who bore the difficult burden of mental illness. He was dearly loved. His passing is a terrible loss for his loved ones and the community. I express my heartfelt condolences to Mitchell's family for their loss.

194. I close this inquest.

Magistrate Teresa O'Sullivan
State Coroner
NSW State Coroner's Court
Lidcombe

DATED: 4 DECEMBER 2019