STATE CORONER'S COURT

OF NEW SOUTH WALES

Inquest:	Inquest into the death of Benjamin Woodhouse
Hearing dates:	14,15,16,17 November 2022
Date of findings:	26 May 2023
Place of findings:	Coroner's Court of New South Wales
Findings of:	Magistrate David O'Neil, Deputy State Coroner
Catchwords:	CORONIAL LAW – mental health, involuntary patient, escorted leave, conditions of leave
File number:	2020/21513
Representation:	Counsel Assisting: Simeon Beckett SC, instructed by Valentina Markovina of the Department of Communities and Justice (Legal) AFEA Care Services Pty Ltd and Raffi Yacoubian: Michael Dalla-Pozza, instructed by Helen Sims of Norton Rose Fulbright North Sydney Local Health District: Patrick Rooney, instructed byKate Hinchcliffe, Makinson D'Apice Lawyers Primary Care and Community Services: Jeunesse Chapman, instructed by Tracy Dunford of Lander and Rodgers
Findings:	I make the following findings in relation to the death of Mr Woodhouse, pursuant to section 81(1) of the *Coroners Act 2009* NSW: **Identity**: Benjamin Woodhouse **Date**: 21 January 2020 between 11am and 5 pm **Place**: Parramatta River, Gladesville **Cause**: Drowning **Manner**: Misadventure

Introduction

1. On 21 January 2020, Mr Benjamin Woodhouse (**Ben**) was on day leave from Tarban House, Macquarie Hospital, where he was an involuntary patient. Ben was in Gladesville, being escorted by his carer, Raffi Yacoubian (**Raffi)**, when he exited the car Raffi was driving and commenced walking towards the Parramatta River. Raffi was unable to find Ben, having lost sight of him shortly after he exited the vehicle.

2. Ben was found approximately five hours later floating in the Parramatta River, deceased.

3. An inquest was held into Ben's death over 14-17 November 2022.

The Coroner's Role

4. An inquest is a public examination of the circumstances of death. It provides an opportunity to closely consider what led to the death. The process of holding an inquest does not imply that anyone is guilty of wrongdoing.

5. The primary function of an inquest is to identify the circumstances in which the death occurred, and to make the formal findings required under section 81(1) of the *Coroners Act 2009* NSW (**the Act**); namely:

    - the person's identity;
    - the date and place of the person's death; and
    - the manner and cause of the person's death.

6. Another purpose of an inquest is to consider whether it is necessary or desirable to make recommendations in relation to any matter connected with the death. This involves identifying any lessons that can be learned from the death, and whether anything should or could be done differently in the future to prevent deaths from happening in similar circumstances.

7. Prior to holding the inquest a detailed coronial investigation was undertaken. Investigating Police compiled a brief of evidence and relevant documents were

obtained, including a report by a forensic pathologist as to the cause of death. The Police also interviewed various witnesses including Ben's brother, John.

8. All the documents and witness statements obtained during the investigation formed part of the brief of evidence tendered at inquest. All of that material, and the evidence at the inquest, has been considered in making the findings detailed below.

Participants in the Inquest

9. At the time of his death Ben was a recipient of National Disability Insurance Scheme (**NDIS**) funding and an involuntary patient at Tarban House in Macquarie Hospital. Macquarie Hospital is administered by Northern Sydney Local Health District (**LHD**).

10. Primary Care and Community Services (**PCCS**) co-ordinated the delivery of NDIS funded services to Ben and were the primary contact with the LHD. AFEA Care Services (**AFEA**) provided care services to Ben, including escorting Ben on day leave. In December 2019 and January 2020 the escort services were directly provided by Raffi. Both PCCS and AFEA had been involved in the provision of NDIS funded services to Ben from 2017 onwards.

11. The provision of escorting services by AFEA in late 2019 in circumstances where Ben was an involuntary patient was a substantial change to AFEA's role. Previously, AFEA had delivered services to Ben whilst Ben was living in the community.

Early Background

12. Ben was born on the eleventh of August 1960. He was one of two boys, who grew up together in Oatley, NSW. Ben's brother, John, provided a statement and attended the inquest. Ben was a prolific reader when young and loved words and philosophical language. He was also strong and athletic. He was, however, not trusting of friendliness.

13. Ben completed high school at Hurstville Boys High and enrolled in tertiary study but, it seems, did not ever commence those studies.

14. Ben suffered from schizophrenia all his adult life.

15. From 19 years of age Ben had a history of inpatient admissions due to poor medication compliance, psychosis, suicidality and self-neglect.

16. Despite his health problems, Ben had worked on the railways in his twenties and later in the Commonwealth public service for a period. Following a redundancy he was not subsequently substantially employed.

17. In adult life Ben spent some time living in Tasmania with a woman with whom he had formed a friendship, however ultimately Ben returned to live in Sydney.

Ben's Mental Health Treatment, 2017-2019

18. Ben had been in and out of a number of mental health facilities in Goulburn and Bega in the period 2014 to 2016. In 2016, Ben was transferred to Sydney from the South Coast of NSW as part of a housing accommodation support initiative.

19. Between August 2017 and July 2019 Ben was a patient of the Ryde Community Mental Health Assertive Outreach Team whilst subject to a Community Treatment Order (**CTO**).

20. In that period of time there were a number of reports of Ben being a "missing person" and a pattern of Ben telling police he had committed very serious criminal offences during the 1990s.

21. On a number of occasions Police, upon locating Ben, took him to Royal North Shore Hospital, where he stayed for short periods.

22. At Oatley Park in June 2019 there was an incident where Ben said he heard voices telling him to drown himself and entered the water to waist deep.

23. In July 2019 Ben became an involuntary patient at Macquarie Hospital following a determination by the Mental Health Review Tribunal that Ben was a mentally ill person.

24. Throughout the balance of 2019 there were further assessments by the Mental Health Review Tribunal in August, September, and November 2019. In each of these assessments Ben was found to remain a mentally ill person and as such remained an involuntary patient. A further review date was planned for February 2020.

25. In 2019-20 Dr Chan was a medical officer practising in psychiatry at Macquarie Hospital, an area in which he had worked for about 19 years. Dr Chan was aware of Ben's history of absconding as he had treated Ben some years before at Goulburn.

26. Ben's leave was approved from time to time by the hospital's treating consultant psychiatrist. During his time as an involuntary patient Ben had periods of day leave inside the grounds of the hospital. There were occasions when Ben went AWOL during leave inside the grounds, however, on these occasions he was safely located.

27. At various times in September 2019 Ben successfully went on escorted leave with staff.

28. By November 2019 it was determined that Ben could go on escorted leave away from the hospital.

Arrangements for Leave

29. As previously noted, PCCS and AFEA had been involved in the provision of NDIS services to Ben since 2017 from time to time. Both had responsibilities to ensure the services were provided safely and in order to do this were required to undertake risk assessments.

30. The PCCS Support Co-ordinator conducted a risk assessment together with her predecessor in approximately September 2019. That risk assessment was not ever uploaded on to the PCCS system and its full content is not known. When the risk assessment was completed PCCS was not aware of Ben's attraction to water or Ben's ongoing expressions of self-harm.

31. In November 2019 AFEA were re engaged by PCCS.

32. AFEA did not have a functioning risk assessment process in the period October 2019 to January 2020.

33. AFEA did, however, prepare a NDIS client assessment and review form which was referred to as the "care plan".

34. The AFEA care plan prepared in relation to escorting Ben provided for weekly outings, fortnightly visits to see Ben's mother and noted "while in the car keep the doors locked". The care plan made no mention of Ben's propensity to go into water nor his regular talk of self-harm.

35. On the evidence in the inquest, as at the time when the escort services were to be provided, neither service provider had been advised by the LHD of Ben's regular talk of self-harm nor of his propensity to go into water and, in particular, the LHD had not informed either service provider of the June 2019 Oatley Park incident.

Escorted Leave Commences

36. On 3 December 2019 Raffi went to Macquarie Hospital to take Ben out on escorted leave for the first time. Raffi had a Certificate III TAFE qualification in Individual Support, Ageing, Home and Community Care but had done no training in relation to clients with mental health issues either with AFEA or elsewhere. He had limited experience as a support worker in an aged care facility prior to commencing casual work as a casual support worker with AFEA.

37. Raffi and Ben went to Gladesville and visited a friend near Ben's old flat. Ben immediately escaped and could not be located by Raffi. Ben was found the next day at a nearby café where Raffi thought he might go. Police were called and Ben was returned to hospital. Dr Chan cancelled leave for the following days.

38. Leave was restored on 6 December 2019 and Ben went on leave with Raffi on 6, 9, 10, 16, 17 and 20 December without incident.

39. On 27 December 2019 Ben went out with Raffi again. Ben became angry when he discovered he had no money in his account. He jumped out of the car that he had been in with Raffi and ran down to the river at Meadowbank which he walked into until he was waist deep. Police were called and made Ben come out of the water. Ben made a threat to hurt himself which was recorded by police. He was taken to Concord Hospital for re-assessment and then back to Macquarie Hospital. In Dr Chan's progress note of that day he recorded:

> *"Ongoing issue*
> 1. *can be impulsive*
> 2. *although his mental state is at baseline - and as well as he can be*
> 3. *AWOL risk – chronic and unchanged"*

40. Ben's leave was again cancelled.

41. AFEA had an app for carers to report to management what occurred during service delivery, however on the evidence, Raffi did not ever use the AFEA App but rather provided verbal reports to his immediate manager from time to time.

42. AFEA also had an incident reporting system and whilst neither Raffi nor his support manager completed a report for the incident on 3 December 2019, they did report the 27 December 2019 incident.

43. Raffi's report included the following:

> *"What lessons can be learned: To lock my car so that he will not open the door of my car while I'm driving and sit him at the back."*

44. The incident report was sent to PCCS on 30 December 2019 with the AFEA care co-ordinator saying, “Requested carer Raffi to sit Benjamin in the back seat so he can put the child lock on and make sure he will not open the door and jump again.”

14 January 2020 Meeting

45. A case plan meeting was held at Macquarie Hospital on 14 January 2020, following the cancellation of leave on 27 December. It was attended by representatives of the LHD (Dr Chan and Social Worker Beth Davis), PCCS (Ms Filmer), AFEA (Ms Depasse) and Raffi.

46. Ms Filmer made detailed notes of the meeting. Ms Filmer noted the purpose of the meeting was to “discuss options, safety, risks about Ben being allowed escorted leave with support worker after incident”. The details of the events of 27 December 2019 were discussed including that Ben had jumped out of a moving car and run away from Raffi. Raffi told the meeting he found Ben floating in the river on that occasion. Raffi also informed the meeting that Ben had said “he wants to kill himself”. The meeting was also informed that not having money could be a “trigger” for Ben absconding.

47. Ms Filmer recorded that “all acknowledged” that it would be difficult for Raffi to create more boundaries for Ben but “suggested child lock to be on in the car”. Those present also discussed the use of a second carer to assist with leave. Raffi did not agree with that proposal and neither did Dr Chan who was recorded as saying he “doesn't think it would matter because when he is in that state, you cannot catch him”. Dr Chan was aware that Ben had promised he would not abscond but then had gone ahead and done so.

48. Dr Chan, the only person at the meeting with authority to grant leave under section 47(1) of the *Mental Health Act 2007*, restored Ben’s leave for up to 3 times a week.

49. Dr Chan recorded that Ben was a “chronic” risk of being AWOL but a “low risk of self-harm and aggression”.

50. Leave was to resume. Ben went on leave with Raffi on the day of the meeting, 14 January, and then on 17 January. On each occasion Ben rode in the front of the vehicle and according to Raffi was very happy.

21 January 2020

51. At about 10.00am on 21 January 2020 Raffi picked Ben up to take him on leave. The plan was to have breakfast at a café in Gladesville and then drive to Ben's mother's nursing care home for a visit.

52. After attending the café at 175A Victoria Rd Gladesville Ben and Raffi walked back to Raffi's car parked near Gladesville RSL at about 11.00am.

53. Raffi let Ben sit in the front seat of the car.

54. At an intersection in Gladesville Ben got out of the car and walked in the opposite direction to that of the car. Raffi followed him but had to turn the car around. This meant that Ben was able to move quickly away from Raffi.

55. Raffi caught up with Ben and tried to encourage Ben to come back into the car but Ben kept walking.

56. Raffi lost sight of Ben. He last saw Ben walking on the footpath in the direction of the Parramatta River.

57. Raffi drove down to the end of a cul-de-sac, did a u-turn and parked the car. He walked down the stairs at the end of the road through some parkland to the water to look for Ben but was unable to see him.

58. Raffi returned to the car and drove around the area looking for Ben, without success.

59. Raffi called his supervisor and told her Ben had run away. He did not mention to her that Ben was near water when he disappeared.

60. At 11.18am the AFEA supervisor emailed Ms Filmer (PCCS) with the news as per the protocol established between AFEA and PCCS. The supervisor then logged the disappearance on AFEA's App notifying her superior.

61. No one from AFEA called the police.

62. At 11.23am Ms Filmer emailed the social worker at Macquarie Hospital and Michael Troy, Case Manager at Ryde Community Mental Health Assertive Outreach Team.

63. At about that time Ms Filmer also called Tarban House at Macquarie Hospital and spoke with a registered nurse. Ms Filmer provided the mobile numbers of herself and Raffi.

64. At about 12.00pm an "absconded patient report" was faxed to the police.

65. The report provided an "assessed risk level" of "low", and a risk to self (and others) of "low". The report lacked the following information:

- there was no "last seen at" address provided;
- Raffi's involvement and contact details were not included;
- the contact details of Ms Filmer were not included;
- there was no indication that Ben was a risk of entering the water.

66. Constable Matthews received the absconded patient report at Eastwood Police Station at about 12.00pm. He completed a Missing Person Risk Assessment form and determined Ben was a "medium risk" and, as a result, did not escalate the report to the Police Missing Person Unit.

67. The Missing Person Risk Assessment form did not include important information such as the circumstances of the incident on 27 December 2019 which was available on COPS.

68. Constable Matthews set out Ben's risk of self-harm as "N/A", no doubt based on the information conveyed from the hospital.

69. At 2.41pm Constable Lum attended Ben's home address and did not find Ben there. At 3.38pm Constable Matthews called Macquarie Hospital and spoke to a registered nurse who told him that Ben was not a self-harm risk.

70. Constable Matthews was not provided with Raffi's details and did not call him on 21 January 2020. This meant that the police who were looking for Ben did not have access to the person who had last seen Ben and who was best placed to advise on Ben's latest known movements.

71. The Officer in Charge (**OIC**) agreed in evidence that it would have assisted the police search to have the details of both Raffi and where he last saw Ben. The NSW Police missing person form used by the LHD did not ask for such information to be included.

72. The OIC said that Water Police and PolAir were available to provide services, subject to other work commitments. Neither was requested on 21 January 2020 prior to Ben's body being found.

73. At 5.10pm a person residing at Shackel Avenue, Gladesville called police to alert them to a body found floating in the river. The body floating in the river was that of Ben.

74. Police responded to the CAD job within about five minutes of the job being dispatched. Water Police also responded.

75. A limited search of the immediate area, including a canvas of nearby residents, did not reveal anything suggestive of the intervention of a third party in the apparent drowning.

76. Two days later the OIC spoke with Raffi who informed her that he thought Ben had gone down to the river at the bottom of Ross Street when he last saw Ben. The OIC went to the area to conduct a further search of the foreshore and a canvas of local residents. No further information about Ben's movements on 21 January 2020 was obtained.

Issues arising at the conclusion of the evidence.

77. The evidence revealed a number of areas for consideration and for possible recommendation. They are:

    a. the decision to grant leave at the 14 January meeting;

    b. the deficiencies in the risk assessment processes of the service providers; and

    c. could the search for Ben have been better.

The decision to grant leave at the 14 January 2020 meeting

78. As set out above, the purpose of the 14 January 2020 case plan meeting was to discuss the risks involved in Ben's escorted leave with a support worker. It follows from this that it had to be decided whether leave would continue, and if so on what conditions.

79. The only person at the January 14 meeting who could legally approve Ben's leave was Dr Chan.

80. It is fundamental to the management of involuntary patients that assessments be made on an ongoing basis with a view to facilitating the patient returning to the community when they are well enough to do so.

81. Dr Chan was well placed to consider Ben's situation given his long-term dealings with Ben.

82. The main question arising from the evidence about the meeting is: "Did Dr Chan make it a condition of Ben's leave that he must sit in the back seat of the vehicle and that the child lock must be applied?" A relevant aspect of the evidence touching on this question is whether Raffi, as he claims, told the meeting that Ben refused to sit in the back seat of the car.

83. In relation to the meeting, I found that it was difficult to rely on any of the witnesses' recollection given the trauma that followed just 7 days later, with Ben's passing,

and the amount of time between the meeting taking place and the witnesses being required to give oral evidence.

84. Centuries of courts giving consideration to evidence of conversations has made clear the difficulty of witnesses accurately recalling old conversations.

85. It has already been noted that Ms Filmer made a quite extensive note of the meeting. There were also notes made in the LHD electronic records by both Dr Chan and the social worker who attended the meeting, Ms Davies. These notes, which were relatively contemporaneous, together with Ms Filmer's note, have been decisive in my determination of the two evidentiary questions which arose in relation to the meeting.

86. Whether or not Dr Chan wanted to attach conditions to Ben's escorted leave, he did not do so. I am satisfied that the meeting discussed whether or not Ben should sit in the back seat and whether the child lock should be applied and that it was suggested that Raffi try that approach with Ben, but that suggestion never got to the level of being a condition.

87. I have come to that view for the following reasons.

88. Firstly, Ms Filmer's note reads: "<u>suggested</u> child lock to be on in the car" (emphasis added). It was agreed in the proceedings that application of the child lock was relevant only to the back seat thus the note about the child lock necessarily indicates that Ben being in the back seat was part of the discussion.

89. Secondly, neither Dr Chan's note nor Ms Davies' note in relation to 14 January make any mention of the child lock, the back seat or any conditions.

90. Thirdly, the electronic records allowed for conditions of leave to be entered. For example, the "condition of leave" for 6 December 2019 read: "Do exactly as case manager directs". The electronic record for 14 January does not refer to "conditions of leave". The record for 17 January notes the "conditions of leave" as: "Escorted, to return to the unit at required time. Nil absconding from carer".

91. In circumstances where I am satisfied the suggestion that Raffi try to have Ben travel in the back seat was not elevated to a condition, I have come to the view that it is not necessary to decide whether Raffi explicitly told the meeting of any past refusal by Ben to sit in the back seat.

92. Another important aspect of the task undertaken at the meeting was that neither PCCS nor AFEA had updated their assessment of risk following the 3 December or 27 December incidents. This undermined their capacity to contribute in a meaningful way to the task being undertaken.

93. By the time of the 14 January meeting both PCCS and AFEA had a clear note of what happened on 27 December including Raffi's suggestion that Ben sit in the back seat. It was not the sole responsibility of Raffi to make sure the events of 27 December were adequately considered and ventilated. The failure of both PCCS and AFEA to reassess risk, in particular after the 27 December incident, reduced the ability of the 14 January meeting to make an appropriate decision about future leave.

94. I find that when Raffi left the 14 January meeting there was no condition in place requiring Ben to be in the back seat of the car during leave.

95. What is clear is that the uncertainty around what was decided at the meeting and the competing views as to whether any conditions were in place was completely unsatisfactory.

96. Recording conditions of leave in writing can minimise the risk of any similar uncertainty in the future.

97. I do not conclude that the decision to resume leave was wrong. Dr Chan's note of the 14 January meeting, upon which I rely, in preference to his oral evidence, indicates he assessed the risk of self-harm as low. In oral evidence Dr Chan indicated he assessed the risk of misadventure as medium and agreed it would have been preferable if he had recorded this in his notes.

98. It is not possible to determine what course the meeting would have taken if PCCS and or AFEA had reassessed risk. It should be noted however that Ms Filmer indicated in evidence that if Ben's risk had been properly assessed when she did her risk assessment it would have measured as "high" which would have led to the development of an "emergency plan".

99. Even if there had been a reassessment of risk by the agencies the meeting still would have had to consider Ben's need for leave, including to see his mother and to work towards returning to the community, Ben's strong desire to have leave, the many occasions of uneventful leave and Dr Chan's assessment of Ben's low risk of self-harm. The factors in favour of leave being restored were strong. It is not possible to know if a different conclusion would have been reached. Further I am not able to find that any different conclusion should have been reached. As such I am unable to find that the decision to restore leave was wrong.

The Deficiencies in the Agencies Risk Assessment Processes

100. Both PCCS and AFEA accepted the various deficiencies in their respective assessment systems.

101. Evidence was called on behalf of each of these entities addressing their deficiencies in some detail.

<u>Systemic issues at PCCS</u>

102. The Chief Capability Officer from PCCS, Mr Daniel d'Appio was called to give evidence.

103. Mr d'Appio indicated that PCCS policy in 2019 was to complete a Risk Assessment Form (F306) "When risk circumstances change or new risk information becomes available".

104. Daniel d'Appio accepted that it was a problem that Carly Filmer did not upload a new Risk Assessment Form in July 2019. The previous risk assessment form had been completed in 2017, when Ben was still living in the community.

105. Mr d'Appio also acknowledged that no risk assessments were completed after the incidents involving Ben on 3 December or 27 December and agreed that risk assessments should have been completed after both of those incidents.

Systemic issues at AFEA

106. The inquest heard from Ms Anna Lira, the Quality and Risk Manager at AFEA, who is a qualified accountant. She had been the Service Manager in 2019 under an earlier management structure.

107. Ms Lira accepted that Ben's care plan was deficient because it did not specifically mention Ben's history of absconding. She also agreed that the plan should have included facts such as Ben's history of entering water while he was absconding, his tendency to have suicidal thoughts or talk about suicide, and how to deal with those matters.

108. Ms Lira accepted that it was a problem with AFEA systems that incident reports were not being made available to the Care Manager, Ms Depasse, who was responsible for amending the care plan.

109. Ms Lira also accepted that the processes at AFEA in 2019 were deficient because there was no specific risk assessment process undertaken by the organisation, and that this was poor practice.

110. Ms Lira said that there were new risk assessment processes at AFEA.

111. There can be no doubt that thorough and accurate risk assessments were required so as to inform both the matters Raffi needed to be aware of and to inform what was to be done when Ben absconded. In addition to each of the service provider's systemic deficiencies two further issues emerged which had an impact upon the service providers' approach.

112. Firstly, both PCCS and AFEA suggested they were awaiting a Behavioural Support Plan to be provided and they were of the view that the LHD would be the source of that plan. By the completion of the evidence, it was clear that it

is for the NDIS providers to provide such a plan and that the plan is to be prepared by accredited experts.

113. AFEA indicated that it now proactively seeks Behavioural Support Plans for relevant clients.

114. Secondly, the service providers not having access to the most current information relating to Ben when the escorting services commenced effectively meant any risk assessment undertaken without that information would be flawed.

115. It is unclear on the evidence why the most up to date information did not become known to PCCS and AFEA at the commencement of the provision of escorting services.

116. Ms Manning, who gave evidence on behalf of the LHD, indicated that staff kept the service providers up to date at meetings and provided information verbally.

117. The evidence did not go beyond that representation. No evidence was called to specifically assert that either AFEA or PCCS had been told of the incident in Oatley Park in June 2019, of Ben's expressions of wanting to self-harm or take his own life or of Ben's general propensity to go into the water.

118. This situation is to be avoided in the future.

The Search for Ben

119. It is clear from the information set out above in relation to events on 21 January 2020 that there were delays in calling the police once Ben went missing, there was no "last seen at" address provided to the police, there was no indication of Raffi's involvement, and/or provision of his contact details to police and there was no indication as to the risk of Ben entering water. All of these matters were unsatisfactory aspects of the search.

120. There is no doubt each of the individuals involved sought to do what they saw as appropriate, however, the lack of guidance as to the appropriate steps to take and the insufficiencies in some of the documentation relied upon led to inadequacies in the search.

121. Mr d'Appio saw benefit in PCCS informing the police "as soon as possible" once an involuntary patient went AWOL rather than relying on the LHD or another agency to do so.

122. Ms Lira accepted that it would have been prudent to call the police straight away when Raffi notified AFEA that Ben had run away in light of "what happened in December" 2019. She agreed that AFEA policies should be changed so that police are notified straightaway.

123. Ms Lira also agreed that in the case of an AFEA client who had absconded it would assist if there was a specific form containing relevant details, such as contacts at AFEA, to advise police or the LHD.

Recommendations

124. Counsel Assisting made a number of recommendations. I shall deal with them in order.

Recommendation 1

125. Recommendation 1 was originally in two parts. The LHD has met the first part of the recommendation by changes made to its documentation since Ben's passing.

126. The second part of recommendation 1 reads as follows:

> *That the LHD amend its leave form to be provided to the patient, family and any third party carer to record the conditions of leave which must be complied with.*

127. The LHD opposes the recommendation, arguing that the document “Inpatient Leave for Consumers, Families and Carers” is available to families and carers and noting that “it is intended for leave conditions to be discussed with the patient and/or carer prior to going on leave”.

128. The inpatient leave form provides no space for the recording of conditions and yet includes the following:

> *“While on leave”* as a header and thereafter,
>
> *“If leave is not going as planned you can return to the unit at any time. If you need to speak to a staff member call.”*
>
> Space is then provided for a phone number to be inserted.

129. In my view, things “not going as planned” would include a circumstance where a condition of leave was not being met. The conditions should be recorded somewhere on the inpatient leave form. This removes the possibility of the consumer, family or carer not being clear as to the precise conditions of leave. The conditions of leave should not be a matter that carers are required to commit to memory.

130. The provision of the conditions of leave in writing removes the possibility of communication breakdown and or misunderstandings between the staff of the LHD and the consumer, family or carer.

131. Additionally, the need for the conditions of leave to be in writing means they must be noted by the medical officer approving the leave. I propose to make the amended recommendation 1.

Recommendation 2

132. Proposed recommendation 2 reads as follows:

> *“Where it is proposed to send an involuntary patient on leave the LHD provide a written summary to both support coordinators and care*

providers of a patient's history, diagnosis, trigger points, risk, behaviour management techniques and what to do in an emergency, e.g. if the patient absconds."

133. AFEA indicated that it would be of assistance if the LHD provided a written summary of relevant matters, such as history, diagnosis, trigger points to poor behaviour, risk and behaviour management. PCCS accepted that all of the foregoing matters were material to a proper risk assessment being completed.

134. The LHD opposes any recommendation being made as to a written summary being provided to coordinators and care providers. The LHD maintains that the relevant information "should be with the support agency" at the time of application for services. There is no explanation as to how the information would be with the support agency, and on the evidence before the inquest, highly relevant information was not known to the support agency at the commencement of escort services in 2019.

135. Whatever information was provided to PCCS and/or AFEA in 2017 the services provided were services whilst Ben was living in the community. The situation changed dramatically in 2019 when Ben became an involuntary patient. Events between 2017 and July 2019, known to the LHD were not, on the evidence, communicated to PCCS (as the primary point of contact), or directly to AFEA.

136. Ms Elizabeth Manning, the service director and psychiatric manager at Macquarie Hospital, gave evidence that it would be useful to formalise the relevant information into a short document that could be provided to other organisations. She agreed that this document could be provided to NDIS contractors at the start of the carer arrangement and updated as necessary to indicate changes such as new items of risk. She agreed that this could be incorporated safely into the process. Ms Manning indicated that the consumer should be included in the conversation about that information to ensure that their information is being shared consensually with the contractual agency.

137. Despite Ms Manning's evidence, the LHD opposes the recommendation being made.

138. The LHDs further expressed concern is that privacy issues arise in relation to the provision of the written information in circumstances where the information may inadvertently fall into the hands of associates of the care providers.

139. Firstly, in relation to this, AFEA pointed out that it has privacy obligations and responsibilities. There is no reason to think the situation would be any different in relation to PCCS.

140. The LHD suggests that as support agency staff utilise their personal vehicles, there is a high likelihood of this confidential and sensitive information being available to people who are not permitted access, thus creating a potential breach of privacy. The LHD raises the additional issue as to where the proposed record would be kept. Given the clear indication of AFEA as to their privacy responsibilities the concerns seem without foundation.

141. The primary purpose of the provision of up-to-date information is to assist the service providers in preparing accurate and effective risk assessments. The document would go to the agency in the first instance. There does not appear to be any proper basis for the concern as to the document being in the possession of the individual carer.

142. The recommendation is specifically directed at the circumstance of an involuntary patient being approved for leave. In the recommendation the support coordinator is the entity in the equivalent role to PCCS and the care provider is the entity in the equivalent role of AFEA.

143. Finally, the provision of information in writing avoids the uncertainty and error that can surround the provision of information verbally.

144. I propose to make recommendation 2 as drafted.

Recommendations 3 and 4

145. Recommendations 3 and 4 are both directed towards PCCS.

146. Recommendation 3:

> *The PCCS review current management of and compliance with its risk policy and procedures in light of this case and conduct risk assessments on intake as well as when significant events occur.*

There is no objection to recommendation 3.

147. Recommendation 4:

> *That PCCS require a support co-ordinator to contact police and/or ambulance as soon as it is notified that a client who is an involuntary patient absconds from a carer except where such contact with police and/or ambulance has already occurred.*

148. This recommendation is slightly amended from its original form.

149. PCCS objects to recommendation 4 being made on the basis that there may well be circumstances where PCCS is not in receipt of the relevant information due to it being the care provider who would have the day-to-day interactions with the carer.

150. The recommendation as originally drafted has now been amended to take into account the matters raised by PCCS. Appropriately, the primary obligation will remain with the agency providing the escort services but recommendation 4 allows for the circumstances where PCCS becomes aware of the involuntary patient absconding but the agency providing the escorting services has not contacted police and/or ambulance.

151. In Ben's case, it was indeed PCCS who contacted Macquarie Hospital and provided the information that was passed on to the police.

Recommendations 5 and 6

152. These recommendations are directed to AFEA:

153. Recommendation 5:

> *That AFEA institute a risk assessment process for each client (who is an involuntary patient) which includes a regular review of such risk assessments including when relevant circumstances change.*

154. There is no opposition to this recommendation being made.

155. Recommendation 6:

> *That AFEA make it plain to its support workers and care co-ordinators that they are expected to contact police and/or ambulance as soon as a client who is an involuntary patient absconds from a carer.*

156. This recommendation has been amended slightly from its initial form and there is no opposition to it being made.

Recommendation 7

157. This recommendation is directed to both PCCS and AFEA:

> *That PCCS and AFEA each develop a form based upon the NSW Police "absconded patient – report to police" form, containing relevant information to provide the police and any other relevant agency which sets out full information about the circumstances of the absconding.*

158. AFEA has no objection to the recommendation being made.

159. PCCS objects on the same basis as it objected to recommendation 4. For the same reasons as those expressed in relation to recommendation 4, recommendation 7 should be made.

Recommendation 8

> *That the Commissioner of Police consider amending the absconded patient report to police form in the light of these findings to include a*

requirement to specify where the patient was last seen, by whom and the contact details of the person who last saw the patient.

160. In evidence, the OIC agreed that it would have assisted the police search to have the contact details of Raffi and where he last saw Ben.

161. The Commissioner of Police was not represented in the proceedings thus the recommendations are expressed as a request to the Police Commissioner to consider amending the relevant document in the relevant way.

Findings under s 81(1) of the Coroner's Act

162. The identity, date, place and cause of Ben's death are well established on the evidence.

163. There is no evidence of any cause other than drowning and as the autopsy report of the forensic pathologist makes clear, Ben's passing is in keeping with drowning.

164. In my view, the overwhelming weight of the evidence is that despite repeated claims as to self-harm and suicide, Ben did not have the intention of taking his own life.

165. In that assessment I rely significantly on the observations of Dr Chan and Mr Michael Troy. Dr Chan and Mr Troy were the clinicians who best knew Ben.

166. Dr Chan had a detailed understanding of Ben's history.

167. Dr Chan's primary concern for Ben was of misadventure.

168. Dr Chan explained in his evidence that when Ben ran away, or absconded, he was always going to be at risk of misadventure because of his illness. Dr Chan noted that the specific risk may not be readily identified, but frequently people

in Ben's position end up getting into a situation where they might meet with accidents.

169. Dr Chan accepted that one of the risks of misadventure that he considered in August 2019 was Ben going into water.

170. In relation to Ben's expression of wanting to self-harm or die, Dr Chan noted that Ben would change his statements after incidents, providing an innocent explanation for what had occurred and indicating that he had no real intention of self-harm. An example of this was on one occasion when police had to urge Ben from the water his subsequent explanation was that he simply wanted to go for a swim.

171. Michael Troy from the Community Assertive Outreach team knew Ben well from dealing with him during Ben's time in the community. When Ben was admitted to Macquarie Hospital Mr Troy ceased to have responsibility for Ben's treatment, but Mr Troy kept in contact with Ben's progress, anticipating that Ben would one day return to the community. Mr Troy was familiar with Ben's history of absconding and his not infrequent expressions of wanting to self-harm or take his own life.

172. Mr Troy was aware of Ben's propensity to "tell shocking things to see what response that would bring". Mr Troy observed that whilst Ben was preoccupied with talking about death there had been nothing particularly adverse "like Ben hadn't attempted drowning or hadn't been found drowning or he hadn't hurt himself physically in any particular way."

173. I am satisfied that when Ben left the company of Raffi on 21 January 2020, he at some stage thereafter, entered the water and drowned through Pmisadventure.

Findings pursuant to s 81(1) of the *Coroners Act 2019*

174. For all the above reasons I make the following findings:

Identity: The person who died was Benjamin Woodhouse.

Date: Ben died on 21 January 2020 between 11am and 5pm.

Place: Ben died in the Parramatta River, Gladesville.

Cause: Ben died as a result of drowning.

Manner: The manner of Ben's death was by misadventure.

Recommendations pursuant to s 82 of the *Coroners Act 2019*

1) That the LHD amend its leave form to be provided to the patient, family and any third-party carer to record the conditions of leave which must be complied with.

2) Where it is proposed to send an involuntary patient on leave the LHD provide a written summary to both support coordinators and care providers of a patient's history, diagnosis, trigger points, risk, behaviour management techniques and what to do in an emergency, e.g., if the patient absconds.

3) The PCCS review current management of and compliance with its risk policy and procedures in light of this case and conduct risk assessments on intake as well as when significant events occur.

4) That PCCS require a support co-ordinator to contact police and/or ambulance as soon as it is notified that a client who is an involuntary patient absconds from a carer except where such contact with police and/or ambulance has already occurred.

5) That AFEA institute a risk assessment process for each client (who is an involuntary patient) which includes a regular review of such risk assessments including when relevant circumstances change.

6) That AFEA make it plain to its support workers and care co-ordinators that they are expected to contact police and/or ambulance as soon as a client who is an involuntary patient absconds from a carer.

7) That PCCS and AFEA each develop a form based upon the NSW Police "absconded patient – report to police" form, containing relevant information to provide to the police and any other relevant agency, which sets out full information about the circumstances of the absconding.

8) That the Commissioner of Police consider amending the absconded patient -report to police form in the light of these findings to include a requirement to specify where the patient was last seen, by whom and the contact details of the person who last saw the patient.

I direct that a copy of these findings be forwarded to the NDIS Quality and Safeguards Commission.

Closing

175. I acknowledge and express my gratitude to counsel assisting, Mr Simeon Beckett SC, and his instructing solicitor, Valentina Markovina, of the Department of Communities and Justice (Legal) for their assistance both before and during the Inquest. I also thank the Officer-in-Charge of the investigation, Senior Constable Isabella D'Angola, for her work in the police and coronial investigation.

176. On behalf of the Coroners Court of New South Wales, I offer my sincere and respectful condolences to the family, extended family, friends and associates of Ben.

177. I close this inquest.

Magistrate David O'Neil
Deputy State Coroner
Coroners Court of New South Wales
26 May 2023