STATE CORONER'S COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of AX (a pseudonym)
Hearing dates:	3 – 6 June 2024
Date of findings:	11 October 2024
Place of findings:	State Coroners Court of New South Wales at Lidcombe
Findings of:	Magistrate Joan Baptie, Deputy State Coroner
Catchwords:	CORONIAL LAW – death as a result of fall from height – Queen Victoria Building – acute psychotic illness – adequacy of care and treatment provided by Prince of Wales Hospital – appropriateness of police response to missing person's report
File number:	2020/00228990
Representation:	Ms E Sullivan, Counsel Assisting instructed by Ms A Boatman of the Crown Solicitor's Office Mr K Connor SC, instructed by Mr C Stanford of Stanford Lawyers for the family of AX Mr P Rooney, instructed by Ms R Cooke of Hicksons Lawyers for the South Eastern Sydney Local Health District Mr S De Brennan, instructed by Mr S Davis of the Office of General Counsel for the Commissioner of Police
Non-publication order:	Non-publication orders have been made pursuant to section 75(1) and (2) of the *Coroners Act 2009* (NSW) in relation to the non-publication of the identity of the deceased and the identity of the family members of the deceased. A copy of these orders can be found on the Registry file.

Findings:

The identity of the deceased
The person who died was AX

Date of Death
AX died on 5 August 2020

Place of Death
AX died at the Queen Victoria Building, Sydney, New South Wales

Cause of Death
Multiple blunt force injuries

Manner of Death
Falling over a stair-case railing from a height, whilst suffering from acute psychotic illness

Recommendations: **To the South Eastern Sydney Local Health District (SESLHD)**

1. That as a matter of priority, a review be undertaken by executive staff in relation to establishing a clear process and procedure for the mental health consumers/patients who attend the Emergency Department (ED) at Prince of Wales Hospital (POWH) but leave prior to completion of treatment, (namely, "unmanaged departures"). The review should include:

    a. clarification of applicable policy for unmanaged departures, including operative 'flow charts' (such as that in Tab 35, Annexure B) and the *Mental Health Clinical Nurse Consultant, Emergency Department, Prince of Wales Hospital Practice Guide* (October 2023) and consideration of appropriate staff training as to such policies and procedures;

    b. consideration as to implementing appropriate clinical audits of available data regarding:

        i. the Mental Health Clinical Nurse Consultant "Referral Board" data;

        ii. data in the form of notifications on IMS+ regarding incidents of unmanaged departure;

2. That as a matter of priority, steps be taken to ensure that mental health clinical staff in the ED of Prince of Wales Hospital have a clear understanding of the circumstances in which consumers/patients can be scheduled under the *Mental Health Act 2007* (including as to the constraints on a clinician who has not personally examined a consumer/patient).

Introduction

1 This inquest concerns the death of AX.

2 AX was born on 20 March 1975 at Bega. She died on 5 August 2020 at the Queen Victoria Building, Sydney in the state of New South Wales at the age of 45 years.

3 AX died from injuries sustained as a result of falling from a height in the Queen Victoria building.

4 The identity, date and place of AX's death are not in dispute. Similarly, AX's cause of death is not in dispute. This inquest has focused on the manner of AX's death and the relevant contributing circumstances.

5 AX's family have been constant advocates for her and have been unwavering in their determination to ascertain whether there were any shortcomings in her care and treatment. AX's mother, has provided extensive assistance to the investigating police. Various family members and friends have participated and contributed every day during these proceedings, and I acknowledge the profound loss and anguish felt and experienced by her family and friends. I would like to express my sincere condolences for their loss of the woman they knew as their loving daughter, mother, sister, niece and friend. I hope that AX's memory had been honoured by the careful examination of the circumstances surrounding her death and the lessons that have been learned from the circumstances of her passing.

The role of the Coroner and the scope of the inquest

6 A coroner is required to investigate all reportable deaths and to make findings as to the person's identity; as well as when and how the person died. A coroner is also required to identify the manner and cause of the person's death. In addition, a coroner may make recommendations, based on the evidence deduced during the inquest, which may improve public health and safety.

7 During these proceedings, evidence has been received in the form of statements and other documentation, which was tendered in court and admitted into evidence. In addition, oral evidence was received from numerous witnesses. Expert evidence was received from Dr Kerri Eagle, Forensic Psychiatrist and Dr Richard Furst, Forensic Psychiatrist, by way of expert reports, as well as oral evidence which was given concurrently by both experts.

8 All the material placed before the Court has been thoroughly reviewed and considered. I have been greatly assisted by the written submissions prepared by counsel assisting, Ms Emma Sullivan, Mr Kevin O'Connor,

SC, Mr De Brennan, and Mr Rooney. At times, I have embraced their descriptions in these findings.

9 Non-publication orders have been made pursuant section 75(1) and (2) of the *Coroners Act 2009* (NSW). There is to be no publication of the identity of AX or the identity of her relatives, including immediate and extended family members.

10 In these findings I have referred to the deceased as AX. This is not meant as any disrespect to AX or her family. Rather, it is to acknowledge the nature of the person who has been described during these proceedings as a person who saw the best in humanity from a young age and continued seeing the best in people throughout her life.

A Brief Overview of AX's Life

11 AX was born on 20 March 1975 in Bega. AX was the first child of RS and BS. MS is her younger brother.

12 AX's father was a police officer and was transferred to Warilla police station and the family moved to Shellharbour in 1978.

13 After her parents separated, AX commenced attending a new school at Dapto.

14 AX excelled in her schoolwork, particularly in her favourite subject English. She loved to write and continued with her writing for many years. She was a very popular student, who made friendships which endured long after she completed her schooling.

15 After completing her HSC 1992, AX travelled abroad in Europe and eventually returned to Australia. In 1999, AX completed a degree in Nursing from Wollongong University.

16 Shortly after finishing her degree, AX travelled to South Korea, where she taught English for about two years. Her co-workers were full of praise for her patience and understanding of the children's needs.

17 AX returned to Australia and met GH. Their relationship blossomed and in 2008, their first child was born. In 2011, their second child was born.

18 In 2013, AX and GH separated, however, their relationship remained amicable. AX and her children moved to Port Macquarie where AX was an active member of the community. AX studied art at Wauchope and Port Macquarie TAFE and would turn up to gatherings of her fellow students and friends with surprises from her garden. She was very popular amongst her friends.

19 In 2019, AX commenced working for a nursing agency, where she worked as an aged care support worker.

20 AX's death has had a devastating impact on her family and her friends who all regarded her as having enriched and brightened their lives.

List of Issues considered during the inquest

21 The following list of issues were prepared before the proceedings commenced and were central to the issues considered, as well as providing focus during the inquest:

i. Determination of the statutory findings required under section 81of the *Coroners Act* 2009 (NSW), namely, the identity of the deceased, and the date, place, manner and cause of death.

ii. Whether the care and treatment provided to AX by clinicians at the Prince of Wales Hospital on 4 August 2020 was adequate and appropriate having regard to her presentation, including whether:

a. further steps should have been taken after AX unexpectedly departed the ED around 4pm that day, and if so, the nature of those steps;
b. relatedly, whether AX ought to have been scheduled pursuant to the *Mental Health Act* 2007 (NSW).

iii. Whether the response of the NSW Police Force to the missing person's report concerning AX was adequate, including whether further steps should have been undertaken to locate AX.

iv. Whether it is necessary or desirable to make any recommendations in relation to any matter connected to AX's death.

22 During these proceedings, the NSW Police Force provided supplementary statements which clarified a number of issues of concern. These statements made appropriate concessions and confirmed areas of reform, additional resources and ongoing training of officers. As such, a number of police witnesses were not required to provide oral evidence.

23 The inquest then primarily focused on the adequacy of the care and treatment that AX received in the ED at the Prince of Wales Hospital ("POWH") on 4 August 2020.

Mental Health History

24 AX had a history of mental health issues dating back to 2004.

25 AX was admitted to the Emergency Department at Shellharbour Hospital from 11 August to 18 August 2004, following a 'depressive episode'. She

was referred by the community mental health team, noting a history of depression. The notes suggested that AX had taken an overdose of paracetamol and Normison, one week prior to her admission. An initial diagnosis of a "moderate depressive episode with psychotic symptoms" was posited. On her discharge, AX was recorded as having suffered a "major depressive episode." She was described as having suicidal ideations, thoughts of self-harm and suffering from paranoid thinking.

26 In 2008, AX was admitted to Shellharbour Hospital for an emergency caesarean. Hospital records referred to AX as having a diagnosis of bipolar disorder and prior to her pregnancy, she had been prescribed Epilim.

27 There is no notation in any clinical records of AX having any history of substance abuse.

Physical Health

28 AX had a medical history which was significant for uterine fibroids, iron deficiency, hypercholesterolaemia, irregular menses, pyuria, smoking, migraine, LSCS, haematuria, renal colic, abdominal pain, otitis external, gastroenteritis and tiredness.

Events leading up to 4 August 2020

29 On 31 July 2020, AX unexpectedly took her two children to stay with their father in Newcastle. She then drove alone to Forster and stayed the night in a hotel.

30 On 1 August 2020, AX made a phone call to her brother, MS. During the phone call, she told MS of her concern that she was being stalked. AX then drove from Forster to her aunt PA's home in Paddington, Sydney.

TUESDAY, 4 AUGUST 2020

AX's attendance at Waverley Police Station

31 At around 1pm on Tuesday, 4 August 2020, AX drove her car to Waverley Police Station. She parked her car outside the police station, on the wrong side of the road and in a 'police only' designated parking zone. She told police, "I have come down from Port Macquarie and there is nothing you can do but I am not safe". Police noted that AX appeared agitated and proceeded to ask her what her concerns were. She was unable to provide any answers to police, other than, "They are all trying to kill me, I am unsafe".

32 Police were suitably concerned with her presentation and contacted the NSW Ambulance. At 1.13pm, paramedics attended the police station and conducted a mental health assessment on AX.

33 AX agreed to voluntarily accompany the paramedics to the Prince of Wales Hospital (POWH) and was transported by ambulance. The ambulance arrived at the hospital at 1.36pm.

34 The paramedics in attendance made the following written notations:

> CT: 45YOF FOR MHA AT WAVERLEY POLICE STATION. OA: MET O/S BY OFFICER WHO STATES PT PARKED ON WRONG SIDE OF THE ROAD THEN WALKED INTO POLICE STATION AND SAT DOWN WITHOUT SPEAKING TO ANYONE. OFFICER STATES PT APPEARS PARANOID AND THAT PT STATES "SOMEONE IS FOLLOWING HER". PT ALERT, APPEARS WELL PERFUSED WITH NO INCREASED WOB. PT DOES NOT APPEAR DRUG OR ALCOHOL AFFECTED. OE: PT GCS 15. PT STATES "KNOWS SOMEONE HAS BEEN FOLLOWING HER FOR THE LAST 7 YEARS." PT DENIES ANY VISUAL OR AUDITORY HALLUCINATIONS AND STATEDS IT IS "JUST A FEELING". PT UNWILLING TO ANSWER ANY MORE QUESTIONS SURROUNDING INCIDENT. PT STATE NIL MENTAL HEALTH HX OR ANY PRIOR MHA AT ANY HOSPITAL. PT STATES NO THOUGHTS OF SELF HARM WITH NO PREVIOUS ATTEMPTS OF SELF-HARM. PT DENIES ANY DRUG OR ALCOHOL USE IN LAST 24 HRS. PT TRANSPORTED VOLUNTARILY TO POWH FOR MHA. PT STABLE ON ROUTE WITH NIL ACUTE CHANGES.

Attendance at the Prince of Wales Hospital and Assessment by Mental Health Clinical Nurse Consultant, Mr Toby Clark

35 At the POWH, AX was observed by the Mental Health Clinical Nurse Consultant, Toby Clark (CNC Clark) in the ambulance bay who noted that she appeared "guarded and suspicious". At 1.56pm, the triage nurse, RN Columbres referred AX for a mental health assessment and provided CNC Clark with the known information that AX had presented to a police station and that there were concerns that she was paranoid.

36 CNC Clark requested AX's medical records from Port Macquarie Hospital. He could not recall that these records contained anything of note. These records were unable to be located for this inquest.

37 At 2pm, CNC Clark commenced a mental health assessment of AX, which lasted for around 30 minutes. CNC Clark spoke with AX on three further occasions to obtain further information, including contact details for AX's mother, Ms RS.

38 CNC Clark made various notations in the clinical notes on numerous occasions.

39 Under the heading, "History of the Presenting Problem", CNC Clark entered the following detail at 4.03pm:

> Pt tells me that around 2 days ago she dropped her children at her ex-partner's address and decided to travel down to Paddington to stay with her aunt as she felt that she was being followed. Admits that she has had this feeling for around the past 7 years however for the past week the feeling has intensified. [AX] was not able to tell me whom she thinks is following her. Cannot identify if it's many people of 1 person. Was also not able to state if these is a link to a wider organised system such as the government. [AX] state she has an "intense feeling" and ultimately thinks that she will "die" – "I just know it…its important for you to know that I am unsafe.
> Concedes that today she decided to drive around Sydney to avoid the people who are after her. Then went into the police station to ask for help. Was not sure how the police could help as she is not sure who is following her.
> Denied TOSH
> Denied TOHTO

Denied SI

40 CNC Clark recalled speaking with Ms RS by telephone, however, he could not recall the duration of the phone call. He recorded the following details in the clinical notes under the heading, 'Formulation and Diagnosis:

> Presentation of a 45yo female to POWED via ambulance transferred form (sic) Waverley police station due to concern regarding paranoid ideas. Unknown MH or medical history. Mother has advised that [AX] has had episodes of paranoia in the past and was admitted to Shell Harbour Hospital around 15 years ago for 10 days. Has never been given a MH diagnosis and does not think that she was prescribed medications for her MH. Was however seen by a psychiatrist in the community however unable to give name. On review [AX] presents as paranoid and guarded describing paranoid persecutory delusions feeling that she is being followed and watched fearing for her life. Over the past week has decided to drop her children off at her ex-partners and travel to Sydney spontaneously. Her family are concerned about her mental health. Nil stated risks to self or others however appears highly vulnerable and acting on delusional beliefs.
>
> Possible relapse of psychosis however requires organic workup.

41 CNC Clark provided a statement in which he confirmed that AX denied ever having a mental health diagnosis or taking any mental health medications. He recalled that she became noticeably more guarded when talking about her 'developmental' history. He recalled that AX "was not behaviourally disturbed or overtly anxious. She had no significant thought disorder and could communicate effectively, guardedness notwithstanding."

42 CNC Clark recalled that "Once I had concluded my conversation with AX, I formed the impression of a voluntary patient with atypical paranoid symptoms. Given that she was 45 years of age and had no apparent background of mental health issues, I considered it necessary to exclude an organic cause for her presentation. I sought out her collateral history and arranged for her to be medically investigated as the question still remained as to the origin of her illness".

43 CNC Clark prepared an "Immediate Action Plan" which listed the following:

1. Requires full organic workup including bloods, UA, UDS, CTB
2. Possible neuro review
3. If the above are clear then predict MH admission

44 CNC Clark confirmed that AX had willingly participated in the mental health assessment and was co-operative. He had not perceived any behavioural disturbance and no acute risk was evident during his assessment of her. He noted that she had not indicated that she wished to leave the hospital, nor had she made any attempt to leave. Furthermore, she had not stated any thoughts of self-harm or harm to others.

45 CNC Clark stated that he was not authorised to schedule patients under the *Mental Health Act*, if, in his assessment, a patient required an involuntary mental health admission. He confirmed that if he formed the view that a patient required an involuntary admission, he would approach another clinician and request that they review the patient with a view to scheduling the patient. He indicated in AX's case, "I had no concerns to

justify an involuntary admission, [AX] was voluntarily cooperating with medical investigations and had not exhibited any ideas or behaviour to justify a more restrictive avenue of care".

46 CNC Clark then approached the Emergency Department's Consultant Physician, Dr Marion requesting a full organic workup including a neurology review to exclude any underlying organic pathology. Dr Marion was in the company of Dr Hugo Reynolds, a Junior Medical Officer, who then conducted a medical assessment sometime after 2.30pm.

Medical Assessment by Dr Hugo Reynolds, Junior Medical Officer

47 CNC Clark provided Dr Reynolds with a brief handover of the known facts and history. Dr Reynolds confirmed in evidence that he was told that AX had no known history of mental health issues, according to the Port Macquarie Hospital records, as well as AX's own denials of past admissions. He indicated that the fact that AX had attended a police station and told them that she was being followed, was suggestive of her acting on her paranoia.

48 Dr Reynolds went directly from the handover with CNC Clark to assess AX. He indicated that he did not conduct a mental state examination as that had already been conducted by CNC Clark. Dr Reynolds conducted a general screen of AX, assessing her for medical symptoms and conducting a neurological examination. He could not detect any abnormalities in her physical observations.

49 At 2.39pm, urine was collected for analysis and drug screening, with the results indicating no abnormality.

50 Dr Reynolds conducted his assessment of AX for at least half an hour. During this assessment, Dr Reynolds' progress notes confirmed that AX provided a very similar description of her symptoms of paranoia given by her to CNC Clark. Dr Reynolds noted that AX was "very cooperative with all investigations and compliant with questioning" and "happy with the plan to speak to neurology and have a brain scan." Dr Reynolds did note however, that AX's presentation included "avoidant eye contact, blunted affect, mild paranoia" and "a little bit guarded or blunted", as well as giving "shortish answers."

51 Dr Reynolds agreed with CNC Clark's impression of AX, confirming that "she was guarded with paranoid thoughts that appeared delusional."

52 At the conclusion of his assessment, Dr Reynolds left AX alone in her bed and spoke with the neurology registrar, providing him with a brief history. At 3.28pm, a CT scan of the brain was ordered.

53 Dr Reynolds prepared a detailed progress note in the hospital records between 3.16pm and 3.33pm. He recorded his diagnosis as:

Paranoia ? paranoid delusions – atypical –
?Organic cause
-?first presentation of though (sic) disorder. He recorded his treatment plan as:
1. Bloods
2. CTB
3. Neuro consult

Neurological Review conducted by Dr Chathupa Wickremaarachchi

54 At around 3.30pm, Dr Wickremaarachchi was contacted by telephone by Dr Reynolds, seeking a neurological assessment to determine if AX's symptoms reflected an organic neurological disorder.

55 Dr Wickremaarachchi recalled spending 5- 10 minutes assessing AX, prior to her leaving the examination to attend the toilet. He noted that as she was a voluntary patient, he believed that he had no grounds on which to stop her from leaving her bedside. He waited for approximately 15 minutes for her to return from the bathroom before contacting Dr Reynolds and the Nursing Unit Manager (NUM) Kathryn Power and advising them that she had not returned.

56 Dr Wickremaarachchi recalled that there was no indication during the examination which suggested to him that AX was uncomfortable with the assessment or that she was seeking to leave the ED.

57 Dr Wickremaarachchi and Dr Reynolds discussed their impressions of AX. Dr Wickremaarachchi noted that she was "orientated, attentive and not encephalopathic", although he also observed that although she appeared to be speaking normally, her speech was paranoid, and she was making minimal eye contact and had a blunted affect. Dr Reynolds understood that Dr Wickremaarachchi did not believe that she had a "primary organic neurological disorder" and that it was more likely to be a mental health condition, such as a psychotic disorder.

58 At 4.31pm, Dr Wickremaarachchi recorded his impressions in his clinical notes in the hospital records. His impression is recorded as:

> "Given the presentation is of paranoid ideation and negative symptoms – consistent with a primary psychotic disorder, and lacking features consistent with an encephalopathy or well formed visual hallucinations that would be in keeping with an organic disorder I think the cause of her psychosis is unlikely to be a primary brain disorder. In addition, she lacks 7/8 of the domains of limbic encephalitis i.e. although she exhibits features of psychosis, she meets none of the other diagnostic domains for limbic encephalitis (disorder of speech, movement, seizures, dysautonomia, LOC, central hypoventilation."

Handover between CNC Clark and CNC Doyle – conflicting accounts

59 Mr John Doyle was rostered to work from 2pm until 10.30pm on 4 August 2020.

60 CNC Clark and CNC Doyle have different recollections about the events relating to their 'handover', as well as other related events.

61 CNC Clark could not recall specific details, however recalled giving CNC Doyle a clinical verbal handover in the PECC office, including giving CNC Doyle a summary of what had transpired with AX to date. In his statement dated 14 September 2021, CNC Clark recalled telling CNC Doyle during the handover, that once AX was medically cleared, "she would likely need a psychiatric admission". He also recalled saying that because she had been cooperative during her assessments in the ED, it was anticipated that she would continue to present as a voluntary patient.

62 CNC Doyle recalled being informed by CNC Clark at around 4pm that AX had driven to Sydney from the north coast, that she had family in Paddington and had presented to POWH via the Waverley police station. He confirmed that CNC Clark told him that he had completed a mental health assessment and that she was currently undergoing a neurological examination to determine if there was an organic basis for her behaviour. CNC Doyle stated:

> "I asked whether AX had been scheduled under the *Mental Health Act* and was advised that she had not. I asked why she had not been scheduled and was advised that there was no reason to schedule her. I offered to schedule her if it was required. I asked these questions and made this offer because I was the only accredited person as a staff member in the department who could schedule a patient at that time".

63 CNC Clark recalled that both he and CNC Doyle went to locate AX at around 4pm. When they arrived, AX was not in her bed. CNC Clark recalled that Dr Wickremaarachchi was at the bedside and he advised them both that AX had gone to the bathroom and had not returned. CNC Clark recalled Dr Wickremaarachchi indicating that "It's probably more of a mental health condition" and gave him the impression that it was not a neurological condition. CNC Clark did not recall having a conversation with Dr Wickremaarachchi about whether AX should be scheduled under the *Mental Health Act* or whether she was outside smoking.

64 CNC Doyle recalled arriving at AX's bedside and being advised that she was not there. He stated that the neurological registrar, (Dr Wickremaarachchi), was sitting by her bed and told them that she was outside smoking. CNC Doyle recalled that he asked at this time whether she had been scheduled under the *Mental Health Act*, "because if she was, she should not be outside smoking unaccompanied." He was advised that she had not been scheduled.

65 CNC Doyle indicated, “At this stage, it was unclear whether AX was going to return to the ED. I understand that staff were attempting to reach her on her mobile. I again offered to schedule her under *the Mental Health Act* so that the police could be engaged to look for her. However, there was no reason provided to me to justifiably schedule her”.

66 CNC Doyle spoke with the ‘communications clerk’ and asked if Waverley police had scheduled AX earlier that day. He was advised that the police had not scheduled her.

67 Dr Wickremaarachchi recalled both CNC Clark and CNC Doyle arriving at AX’s beside after she had left to go to the toilet. He was unable to recall the details of their verbal interactions, in particular, he did not recall saying that AX was outside smoking. It is noted that Dr Wickremaarachchi’s clinical notes do not mention her leaving to have a cigarette, rather that she was going to the bathroom. He was unable to specifically recall discussing AX’s legal status and/or whether she should be scheduled, nor whether he had given the impression that her presentation was more consistent with a psychotic disorder, rather than a primary brain disorder. In evidence, he accepted that he had documented his conclusion and shared it with Dr Reynolds and that it was likely, in those circumstances, that he had shared his conclusions with the CNCs.

68 CNC Clark finished his shift at around 4pm. At that time, he was unaware that AX had left the ED altogether.

69 It became clear from the evidence that CNC Doyle did not review any of AX’s clinical notes or records and relied solely on the verbal handover from CNC Clark.

70 Ms Kathryn Power, the Nursing Unit Manager (NUM) was advised that AX had not returned from the bathroom and commenced searching for her in the waiting room area and the smoking area. Dr Reynolds also searched for AX, without success. NUM Power confirmed that she had called AX’s mobile phone twice and the phone was either engaged or rang out, and as such, there was no opportunity to leave a voice message.

71 NUM Power recalled advising Dr Wickremaarachchi, Dr Reynolds and CNC Doyle that AX was missing from the ED. NUM Power recalled speaking with Dr Wickremaarachchi first, followed by Dr Reynolds in person, and then speaking with CNC Doyle over the phone. She recalled that her conversation with CNC Doyle lasted for about one minute and that CNC Doyle had reassured her that AX was not scheduled under the ‘Act’ and that there was no need to implement the absconding protocol.

72 NUM Power made a progress note at 4.23pm, indicating that she had become aware that “Neuro reg came to review pt but pt not in bed. I have checked with the nurses in her care and they are unsure where she is, I checked the WR and smoking area, she is not there. I have attempted to

ring her phone x2 but the phone is engaged? I have informed the ED RMO Hugo and the neor (sic) reg I have also informed the MHCNC John, John reitertaes (sic) he (sic) is not under the MH AACT."

73 Again, CNC Doyle did not enter any clinical notations relating to his conversations with NUM Power.

74 At 4.26pm, Dr Reynolds made a notation in the clinical records that:

> "Patient appears to have absconded. Voluntary, not currently holdable under the act, no high-risk features, no SI, TOSH or TOHO (above discussed w/ MH CNC John) No medical issues currently identified Neuro AT opinion – likely psychotic disorder Impression: Likely psychotic disorder – no high risk features. Dr Reynolds proposed a plan being – "for ongoing investigation if returns".

Interaction between CNC Doyle, Dr Reynolds and Psychiatry Registrar – conflicting accounts

75 CNC Doyle made reference for the first time during his sworn evidence before the Court, to a conversation he stated had occurred in the PECC office between himself, Dr Reynolds and the Psychiatry Registrar. His evidence indicated the following:

> "Dr Reynolds came into the PECC unit. I was sitting in the PECC office, with the registrar. Came in and told us that the patient had left – had not returned. Had left the department. I asked him, did you have any concerns? I first asked him, is she under schedule and have you done as schedule under the *Mental Health* Act? He said no. I said, do you have any concerns? Would you like – do you feel that I scheduled her? Would you like me to complete that for you? He said, no. He didn't have concerns enough to enact a schedule. I can't remember the exact detail of the conversation but that was the essence of it".

76 CNC Doyle recalled that his conversation with Dr Reynolds took about 5 - 10 minutes. During this conversation, CNC Doyle stated that he had interrogated Dr Reynolds as to whether there was any basis for him to schedule AX, as this was his usual practice.

77 CNC Doyle later indicated that Dr Dori Rakusin, a psychiatric registrar was also present in the PECC unit during the conversation about AX's legal status. CNC Doyle recollected that, "She was there. I distinctly remember that. We were working there, close together all evening."

78 He went on to state that Dr Rakusin was definitely involved in the discussion and that "I can't remember the words of the conversation. But my feeling is that we reached a consensus that we couldn't write a schedule on that basis of what we were told". In addition, he stated, "I can't remember the conversation, but I do feel that she asked questions. We were all talking together. It was a three-way conversation and the outcome

of that that a schedule wasn't written. Yes". CNC Doyle further stated that "we caucused it and reached – both reached the same decision".

79 Dr Reynolds recalled having a five minute conversation with CNC Doyle in the PECC office sometime prior to 5.02pm. Dr Reynolds did not recall a psychiatry registrar (Dr Rakusin) being present. Dr Reynolds recalled telling CNC Doyle that AX had left the ED, was not currently scheduled and had not expressed any suicidal ideation or thoughts of self-harm to him. Dr Reynolds recalled asking CNC Doyle "Do we have any course of action to call the police to – you know, possibly bring her back in? or is there anything else – you know, we should do in this instance? I think he's kind of stated because she wasn't under the Act – she wasn't scheduled, we weren't able to call the police to bring her back in…".

80 Dr Dori Rakusin provided a statement dated 30 July 2024. Dr Rakusin confirmed that she was working an evening shift as the psychiatric registrar in the PECC unit from 5pm to 10pm on 4 August 2020. In her statement, Dr Rakusin indicated that she had no recollection of meeting with or assessing AX. Furthermore, she had no recollection of discussing AX's presentation to the POWH with CNC Doyle or any other staff member at any time on 4 August 2020. She also confirmed that she made no entries in the progress notes referrable to AX.

Ms PA attends POWH ED.

81 Ms PA (Aunt of AX) provided a statement dated 20 November 2023. Ms PA confirmed that AX had arrived at her home at approximately 9pm on 2 August 2020. Ms PA was surprised that AX had arrived without her children.

82 On 4 August 2020, Ms PA left her home in the morning to attend a course. AX remained at her home. Ms PA recalled receiving a phone call from Ms RS (AX's mother) advising her that AX had been taken by ambulance to the POWH. Ms PA rang the POWH and spoke with a nurse who confirmed that AX was at the hospital. Ms PA then arranged for a friend to drive her to POWH about 30 minutes later.

83 On her arrival at the hospital, Ms PA was told by nursing staff that AX was not a patient. Ms PA insisted that she speak with the nurse she had originally spoken with and recalls speaking with the triage nurse who confirmed that AX had left the hospital.

84 Ms PA then spoke with Dr Reynolds, who she indicated "Did not seem to know what was going on".

85 Dr Reynolds confirmed that he had spoken with Ms PA sometime between 4.26pm and 5.02pm. His clinical progress notes recorded Ms PA's concerns at 5.02pm, stating:

> "She is concerned given patient past history;

Has long-standing history of psychotic illness;
States has attempted self-harm in the past;
Explained assessment and reasoning behind not holding patient involuntarily;
Can bring back patient for MH work-up when found if ongoing concern"

86 Dr Reynolds recalled telling Ms PA,

> "I explained that, even in retrospect, she was so cooperative that under the framework of 'least restrictive care' there was no imperative to schedule her at her presentation. Importantly, we did not have any history of previous mental illness or any high-risk features that would suggest increased risk of self-harm (e.g. suicidal ideation) that would increase the need to schedule a patient."

87 Dr Reynolds confirmed that he did not approach CNC Doyle and discuss the additional information provided by Ms PA.

AX returns to Ms PA's home in Paddington

88 Ms PA left the hospital and returned home. AX was not at her home and Ms PA then attempted to contact her by phone, without success.

89 At around 7pm, AX arrived at Ms PA's home. Ms PA recalls AX immediately raised her hands and said, "I don't want to talk about it".

90 Ms RS had driven to Sydney and had arrived at Ms PA's home. The three women ate dinner, watched television and AX and Ms PA practised their skiing exercises. Ms PA recalled that at that time, AX "seemed to be herself".

WEDNESDAY, 5 AUGUST 2020

Follow-up by CNC Clark at POWH

91 At 7.30am, CNC Clark commenced his shift. He reviewed AX's progress notes to see the outcome of her presentation. It was at this time that he became aware that AX had left the hospital the day before and that no referral to the Acute Care Services (ACS) team had been made.

92 At 10.41am, Ms RS received a text message containing the number for the Acute Care Team.

93 At 10.48am, Ms RS contacted the Mental Health Line Acute Care Team. The call lasted 8 minutes.

94 Shortly before 11.04am, CNC Clark contacted Ms RS. Ms RS stated that AX was worse and was very paranoid. CNC Clark advised Ms RS that he

was referring AX to the ACS team and that she should call triple zero if she had any urgent concerns regarding AX.

95 At 11.04am, CNC Clark sent Ms RS a text message stating: “Hi [RS]. We will make a referral to the St Vincent’s Hospital Acute Care Service [number given]. Hopefully they will call you this afternoon to discuss a plan.”

96 CNC Clark indicated that he then called the State Mental Health Telephone Access Line (SMHTAL) to refer AX to the ACS team.

97 The SMHTAL is a state-wide, 24 hour single access point for persons seeking information and support for mental health issues; it is operated by mental health clinicians who facilitate referrals to local mental health services, provide telephone triage and/or relevant information about appropriate persons. The SMTHAL confirmed with CNC Clark that they would refer AX to St Vincent’s ACS. CNC Clark had no further involvement with AX’s care.

Mr Gary Samuels, Mental Health Nurse, Acute Care Team

98 On 5 August 2020, Mr Gary Samuels was working in the Acute Care Team, where his “duties included answering calls that came through on the State Mental Health Telephone Access Line (SMHTAL).”

99 Mr Samuels recalled that he first became aware of AX’s case when he received a phone call from Ms RS on 5 August, sometime between 10 and 11am.

100 Mr Samuels understood that by that time, Ms RS had contacted the Emergency Department at the POWH and had been advised that the hospital was in the process of referring AX to the community mental health team at St Vincent’s Hospital, as AX was staying at Paddington and came within their catchment area, rather than the POWH. As the referral had not yet been completed, Ms RS was provided with the SMHTAL number.

101 During the phone call with Ms RS, she provided Mr Samuels with the details of her presentation at the POWH the previous day. She indicated that AX had left the hospital unexpectedly and returned to her Aunt PA’s home and that Ms RS wanted the referral to the St Vincent’s Hospital to be completed as AX was “perplexed and anxious”.

102 Mr Samuels reviewed AX’s medical records while he was on the phone to Ms RS. He asked to speak with AX, who was in Ms RS’s company during the phone call. AX declined the opportunity to speak with him. Mr Samuels concluded that AX was likely to be acutely mentally ill.

103 Mr Samuels then contacted CNC Clark by phone, which appears to be at odds with CNC Clark's recollection. Mr Samuels said that he expressed his concerns about AX's mental health condition with CNC Clark.

104 Mr Samuels then completed a full triage and faxed it to St Vincent's Hospital, as well as contacting the O'Brien Centre, the mental health service within St Vincent's Hospital and requested the Acute Care Service contact him about AX's referral.

105 Mr Samuels recalled receiving a phone call from Ms RS at 12.15pm, telling him that AX had suddenly jumped out of Ms RS's car at some traffic lights and had then run away. Mr Samuels recalls advising Ms RS to call the police.

106 Mr Samuels stated that it was around this time that he received a phone call from St Vincent's ACS. He advised them that AX was likely acutely unwell and needed to be assessed urgently. He handed over AX's case to them at 12.30pm.

Ms RS's recollection

107 Ms RS recalled receiving a text message from CNC Clark at 11.04am, indicating that AX's case would be referred to St Vincent's Hospital Acute Care Service. Ms RS stated that she received a further text message from CNC Clark asking her to call him to confirm Ms PA's home address for the purpose of the referral to St Vincent's Hospital. Ms RS called CNC Clark who told her that she should not leave AX alone and that he was concerned for her safety.

108 At around midday, AX told her mother that she was taking her dog for a walk. Ms RS accompanied AX. They had only walked a few houses down from Ms PA's home, when AX asked to use Ms RS's mobile phone. Ms RS indicated that her phone was at Aunt PA's place and they both returned home.

109 Ms RS recalled that AX then used her phone to call her brother, Mr MS. AX and MS spoke for about one minute. AX then called Mr Gary Hardy and spoke with her children for about four minutes. AX told each of them that she loved them. Ms RS became more alarmed that this was a sign of her intention to self-harm.

110 After these phone calls, Ms RS suggested to AX that they walk to a café nearby and have lunch. Ms RS recalled AX walking very fast and was not talking to her. Ms RS struggled to keep up with AX, who was now saying "go home Mum". Ms RS begged AX to go home to Ms PA's house, however, AX told her she was going for a walk by herself and would return in one hour. AX then continued walking along Oxford Street towards the city.

111 Ms RS contacted both CNC Clark, as well as the Acute Care Team at St Vincent's Hospital (Mr Samuels). Mr Samuels recorded a progress note confirming Ms RS's phone call at 12.20 hours, noting "AX absconded while they were driving along Oxford Street in Paddington".

Ms RS contacts police at Paddington Police Station

112 At that time, Paddington Police Station was a one-person station that was open to the public with a front counter service area which was staffed by one constable whose duties included answering the phone, dealing with walk-in enquiries and placing jobs on the police CAD system. At that time, the Eastern Suburbs Command had three General Duties vehicles in operation. The command covered an area from Watson's Bay in the north, to Clovelly in the south and Paddington to the west.

113 Ms RS contacted Paddington Police Station at 1.23pm and spoke with Constable David Kallo for almost 12 minutes. Ms RS recalled being told by Constable Kallo that she would need to attend in person to lodge a missing person's report. Ms RS says she attended Paddington Police Station shortly afterwards.

114 Constable Kallo recalled Ms RS telling him that "AX is experiencing a psychotic break and suffering from delusions" and that "…AX was admitted into the Prince of Wales Hospital the day before and that she left without any treatment. The staff told [RS] that if AX was to leave her side, to call police and ambulance as she may be at risk of harm". RS provided Constable Kallo with a description of AX, her last seen location and the direction she walked in.

115 Constable Kallo stated that at the time Ms RS attended at the police station, she provided him with photographs of AX located in her phone. He loaded these photos onto his personal phone and forwarded the photos to the Eastern Suburbs Supervisor's phone. Constable Kallo sent the photo to his supervisor who would then provide the photos to the "crews to actively patrol and look for AX. This was requested to be sent to neighbouring radio channels in the city as that was her last known direction."

116 Constable Kallo's supervisor, Sergeant Stuckey recalled "It was at some time after this (12.45) that I received a phone call from Senior Constable Kallo who provided me with the sequence of events and advice on the matter. At this time, it was deemed a concern for welfare and with immediate action taken. It is not known the exact time that Constable Kallo received this call from the NOK. I advised Senior Constable Kallo to place a job on CAD for a Keep a Lookout For (KALOF) and also assign a General Duties vehicle to conduct patrols of the area AX was last seen."

117 At 1.45pm the job was broadcast on police radio channels covering the Eastern Suburbs. Further channels were added at 1.46pm, 1.48pm and at 2.03pm.

118 At 2.03pm, Senior Constable Tamieka Archibald acknowledged the job. Senior Constable Archibald stated that she commenced patrolling the Bondi Junction Central Business District, Oxford Street up to Hyde Park, College Street, William Street, Crown Street and back onto Oxford Street. She continued the same route several times, as well as travelling the back streets of Paddington near Ms PA's home. Senior Constable Archibald "remained acknowledged" to this job until 4.30pm and indicated that she continued to monitor the broadcast for the duration of her shift.

AX attends the Queen Victoria Building, Sydney CBD

119 At 2.18pm on 5 August 2020, AX was seen at the Queen Victoria Building (the QVB), a commercial shopping complex located at 17 Market Street, Sydney.

120 CCTV footage captured AX walking up the stairs on the northern side of the building. The footage depicts AX throwing numerous items from her bag onto the floor. These items appear to be a phone charger, a $10 note and an empty foil of Xanax tablets.

Mr Malik Muneer's interaction with AX

121 Shortly before 2.30pm, Mr Malik Abdul Muneer, a security rover employed within the QVB, responded to an alert provided by the building's security CCTV control room. He attended level 3 of the building and sighted AX at the northern stairwell area.

122 Mr Muneer approached AX and noted that she appeared "spaced out." He thought that she may have been under the influence of either drugs and/or alcohol as her speech was slurred and she appeared to be slow to respond to his questions.

123 In response to Mr Muneer asking her if she was okay, AX responded, "I'm leaving soon, don't worry officer I'm leaving soon. I need to be where I need to be." He recalled that her tone of voice was "very flat" and as if she was talking to herself. Mr Muneer then gestured to AX to come down from the stairs and requested that she go downstairs with him. AX did not respond.

124 AX then walked closer to the railing of the staircase and positioned herself so that she was leaning over the railing, looking down to the lower ground level. She did not respond to any requests to move away from the railing and continued to lean over the railing. At 2.28pm, AX pressed herself forward over the railing. Mr Muneer attempted to catch her, without success.

125 Police arrived at the scene at 2.35pm and commenced CPR. At 2.40pm, paramedics declared AX deceased.

Missing Person Risk Assessment

126 Constable Kallo stated that at around 3pm, Ms RS attended the Paddington Police Station and formally made a written 'missing person' report to Constable Kallo.

127 At 4.31pm, a message was broadcast by ES35 to VKG stating "ES35/M/DON'T NEED TO ATTD – THE PERSON HAS BEEN REPORTED MP AND WE ARE JUST KLO4.

AUTOPSY REPORT

128 On 10 August 2020, Dr Jennifer Pokorny, Staff Specialist Forensic Pathologist conducted a postmortem examination, limited to an external examination and toxicological analysis. Dr Pokorny confirmed that in her opinion, the cause of death was determined to be multiple blunt force injuries. The toxicological analysis "detected low levels of alcohol and ibuprofen in the blood, along with paracetamol at a level similar to that which may be seen with therapeutic use".

ISSUE 1: Determination of the statutory finding required under section 81 of the Coroners Act 2009, (NSW), namely, the identity of the deceased, and the date, place, manner and cause of death

129 As referred to above, Dr Pokorny was able to establish that the cause of death was as a result of "multiple blunt force injuries." As such, the cause of death, as well as AX's identity, date and place of her death are not in issue in this inquest.

130 The manner of AX's death has received considerable attention during these proceedings. The investigation of the manner of her death related to the circumstances in which AX died, and specifically whether she intended to cause her own death. In addition, consideration was also given to the care and treatment she received prior to her death and whether this contributed to her death, either directly or indirectly.

Evidence as to 'manner of death' and intent

131 Suicide has been defined as "voluntarily doing an act for the purpose of destroying one's own life while one is conscious of what one is doing", or similarly, "a suicidal act requires a voluntary and deliberate act by the deceased; and further, that the intent behind the action is for the deceased to end their own life, with the capacity at the relevant moment, to form that critical intention".

132 Evidence relating to AX's possible suicidal intention in the days leading up to and including 5 August 2020, included:

a) an apparent attempted suicide in August 2004, when she ingested and overdosed on prescribed medications, paracetamol and Normison.
b) A note located in AX's bag by Constable Sian Williams, stating "You will find me in everything. It's okay".
c) Ms RS's evidence that on 5 August 2020, AX called her brother and her children and told each of them that she loved them and goodbye.
d) AX's behaviour on the stairs of the QVB, including her slurred speech, slow responses, the tone in her voice and her appearance of talking to herself.

133 In relation to b) above, it is noted that there is no indication as to when this note was authored by AX. In addition, the meaning is somewhat ambiguous.

134 Dr Eagle provided two reports in these proceedings, dated 27 June 2022 and 10 May 2024. Dr Richard Furst provided one report dated 18 April 2024. Both Dr Eagle and Dr Furst gave oral evidence concurrently on 6 June 2024.

135 Both Dr Eagle and Dr Furst opined that AX was suffering from an acute psychosis at the time of her death.

136 Dr Eagle noted the symptoms described by Mr Muneer, the security guard at the QVB, were consistent with an acute mental health episode that might well be a psychotic episode.

137 Dr Eagle concluded that "on balance of all the information", AX's psychotic illness contributed to her actions on 5 August 2020.

138 In determining whether a person has intended to cause their own death, the Court must apply the '*Briginshaw'* standard or test. In particular, the Court must be satisfied on the balance of probabilities and have a reasonable satisfaction that there was a particular intention. It is noted that a "reasonable satisfaction is not a state of mind that is attained or established independently of the nature and consequence of the fact or facts to be proved. The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding are considerations which must affect the answer to the question whether the issue has been proved to the reasonable satisfaction of the tribunal. In such matters 'reasonable satisfaction' should not be produced by inexact proofs, indefinite testimony, or indirect inferences".

139 In *R v London Coroner; Ex parte Barber* [1975] 1 WLR 1310 at 1313, Lord Widgery CJ said: [P]erhaps one of the most important rules that coroners should bear in mind…[is] that suicide must never be presumed. If a person dies a violent death, the possibility of suicide may be there for all to see,

but it must not be presumed merely because it seems on the face of it to be a likely explanation. Suicide must be proved by the evidence, and if it is not proved by evidence, it is the duty of the coroner not to find suicide, but to find an open verdict…".

140 In accepting the uncontroverted expert evidence of both Dr Eagle and Dr Furst, the Court could not be satisfied on the balance of probabilities that on 5 August 2020, AX had the capacity to form the intention to commit an act with sufficient awareness as to the probable consequences of her actions, in this case, suicide.

141 The Court has concluded that the manner of death should be recorded as "falling over a stair-case railing from a height, whilst suffering from an acute psychotic illness".

ISSUE 2: Whether the care and treatment provided to AX by clinicians at the Prince of Wales Hospital on 4 August 2020 was adequate and appropriate having regards to her presentation, including whether:

a. further steps should have been taken after AX unexpectedly departed the ED around 4pm that day; and if so, the nature of those steps;

b. relatedly, whether AX ought to have been scheduled pursuant to the Mental Health Act 2007 (NSW).

142 As outlined above, AX received care from the following clinicians at the POWH on 4 August 2020:

a. CNC Toby Clark;
b. Dr Hugo Reynolds;
c. Dr Chathupa Wickremaarachchi;
d. CNC John Doyle; and
e. NUM Kathryn Power.

Dr Kerri Eagle

143 Dr Eagle's expert opinion was sought as to whether AX had received appropriate and adequate treatment considering her conclusions as to AX's presentation and diagnosis on 4 August 2020.

144 Dr Eagle noted that:

a. AX was suffering from a psychotic episode at the time of her death, which was characterised by a persecutory delusion that she was being followed;
b. Dr Eagle indicated that the aetiology of AX's psychosis was unclear as it may have been part of a chronic disorder or a primary mood disorder.

Dr Eagle noted the possibility of an organic basis, but viewed this as less likely;

c. Dr Eagle noted that AX presented with an episode of psychosis at the age of 45 years, without a clear history of experiencing a prior psychotic disorder which was unusual and warranted consideration of an organic basis for her disorder;
d. there were complexities with AX's presentation, given there was an unclear background or cause of her psychotic-like disorder.

145 Dr Eagle was of the opinion that:

a. there was an appropriate and timely assessment by an experienced mental health clinician (CNC Clark) following AX's presentation to the ED;
b. AX was appropriately identified as having a probable psychotic illness;
c. attempts were made to obtain collateral information from other hospitals and her mother;
d. AX was appropriately referred for further medical assessment to exclude an organic cause of her psychosis;
e. AX's unexpected departure from the ED was identified early by the clinicians.

146 The evidence suggested that although the Port Macquarie Hospital records were obtained, the Shellharbour Hospital records were not requested or reviewed. Dr Eagle referred to the "ongoing and frequent issue" of obtaining collateral information from other hospitals. Dr Eagle was of the opinion that it was unlikely that those records would have altered the diagnostic impression and further noted that "we are moving towards a single electronic medical record, which I think will resolve that issue completely".

147 In Dr Eagle's opinion, AX's case was too complex and her presentation too unusual for her case to have only been reviewed by a CNC, and that her case should have been discussed with a psychiatrist or a psychiatry registrar. Despite this shortcoming, Dr Eagle was of the view that AX received adequate care whilst in the ED of the POWH.

148 Dr Eagle was asked to provide her opinion as to whether AX should have been scheduled under the *Mental Health* Act, whilst in the ED. Dr Eagle stated:

> "You know, the issue turns on whether she could be safely managed in the list, you know, sore of the less restrictive way under the *Mental Health* Act. It is an individual clinical assessment. I think we all agree she could have been placed under the Act. That's, you know, quite clear, but she was cooperative and I don't think it was unreasonable to try and engage her on a voluntary basis at that stage of her treatment, but you know, you also need to be aware of those risks, that she was unpredictable, that she was psychotic, so she wasn't able, you know,

she wasn't operating within a reality context, and that would – and she had been acting on those delusions and there needed to be some monitoring around, you know, making sure she would, you know, stay safe and not do anything like she had been doing in response to those delusions that would jeopardise her wellbeing".

149 Dr Eagle also noted:

> "It's not should she have been scheduled, should she have not been scheduled. It was actually she was unwell. She was acting on delusions that were distorting her ability to determine what was real and what wasn't real. That made her unpredictable. That made – you know, that raised concerns that she wasn't going to necessarily remain cooperative. You know, because of her own illness, and so then there needed to be – if she wasn't going to be place under the *Mental Health* Act she still needed to have a level of support and observation and monitoring that was consistent with her mental illness or her mental state".

Dr Richard Furst

150 Dr Furst indicated that he was "broadly in agreement with Dr Eagle in terms of the formulation to the kind of psychotic episode". He noted the complexity and uncertainty the clinicians were faced with, given that different conditions can present in a similar fashion; as well as the incomplete information provided to them by AX when she attended the ED.

151 Dr Furst also noted that "it is unusual for a patient with recurrent psychotic episodes to maintain functional employment in the aged care sector and parent capacity and not have a definitive diagnosis".

152 Dr Furst was also of the opinion that AX had been provided with adequate care at the POWH ED. He noted that CNC Clark had obtained an adequate history from AX, as well as making adequate and appropriate enquiries as to her history, including sleep, appetite, mood, drug use, her background social history and collateral information from AX's mother.

153 Dr Furst commented that AX's presentation suggested that "clinically it's more likely to be a mental health issue or a mental health presentation heading towards the potential psychiatric admission and treatment episode, rather than like a strange symptom of multiple sclerosis or diabetes or something like that". Given his view, he indicated that AX could have been admitted to an acute psychiatric mental health inpatient unit while the tests were being conducted, given the low probability that her symptoms had an organic cause.

154 In relation to whether AX should have been scheduled pursuant to the *Mental Health* Act whilst in the ED, Dr Furst opined that it was an option available to the clinicians, given her presentation and her paranoia. As to whether AX should have been scheduled, Dr Furst stated, "I just don't

know ….I think I could justify both ways and I probably have done in my report, arguing both sides". Dr Furst noted that AX appeared to be cooperating with both ambulance officers and hospital staff, and in his opinion, it is preferable to continue to work with a patient that is agreeable to treatment, is competent to consent and is cooperative.

155 The expert evidence from both Dr Eagle and Dr Furst indicated that:

a. AX had received an appropriate and timely assessment by CNC Clark, resulting in him concluding that AX had a probable psychiatric illness;
b. CNC Clark made appropriate efforts to obtain collateral information from other hospitals and AX's mother;
c. AX received a timely and appropriate referral to Dr Reynolds and Dr Wickramarachchi; and
d. that AX's unexpected departure from the ED was actioned by the clinicians and a search for her was initiated promptly.

156 The evidence discloses that AX received adequate and appropriate care and treatment whilst in the ED, prior to her unexpected departure.

Adequacy of the steps taken following AX's unexpected departure

157 The evidence disclosed that:

a. Shortly after 3.30pm, Dr Wickremaarachchi formed the view that AX was not returning from the bathroom and notified NUM Power and Dr Reynolds. Dr Wickremaarachchi then discussed his clinical impressions with Dr Reynolds. He also made a detailed clinical note in the hospital records.

b. NUM Power searched for AX for about 5 minutes, including speaking with other nursing staff, searching the waiting room and smoking area. NUM Power also attempted to contact AX's mobile phone. Dr Reynolds also joined in to search for AX;

c. NUM Power contacted CNC Doyle to advise him that AX was missing. NUM Power stated that during this phone call, CNC Doyle reassured her that AX was not a scheduled mental health patient and there was therefore no need to implement the absconding protocol;

d. Dr Reynolds and CNC Doyle had a 5-10 minute conversation in the PECC office, although their recollections of this conversation vary dramatically;

e. CNC Doyle conceded that at no time did he review any of AX's clinical notes available on the hospital's electronic record system, nor did he make any clinical notes;

f. At sometime between 4.26 and 5.02 pm, Ms PA attended the hospital and had a conversation with Dr Reynolds. During this conversation, Ms PA provided vital collateral information to Dr Reynolds. Dr Reynolds did not provide any of this additional collateral information to CNC Doyle, although, it is noted that Dr Reynolds made a clinical notation on the hospital record system of his interaction with Ms PA;

g. No further action was instigated by the hospital;

h. at 7pm, AX arrived at her aunt's home (Ms PA) and indicated that she didn't want to talk about what had happened. Ms PA indicated that AX "seemed to be herself";

i. at 7.30am on 5 August 2020, CNC Clark commenced his shift and reviewed AX's case note. He then became aware that AX had suddenly left the hospital and that no referral had been actioned to the Acute Care Service (ACS) team;

j. CNC Clark contacted Ms RS shortly before 11.04am and was advised that AX's presentation was worse and she appeared very paranoid. CNC Clark suggested that AX should not be left alone and advised that he was making a referral to the ACS team;

k. at 11.04am, Ms RS received a text message from CNC Clark confirming the referral to the ACS team and that "Hopefully they will call you this afternoon to discuss a plan";

l. AX was referred to the St Vincent's ACS Team and Ms RS spoke with Mr Gary Samuels, who also made contact with CNC Clark.

158 At no time on either 4 August or 5 August were steps taken to schedule AX under the *Mental Health* Act.

Evidence of CNC Clark

159 CNC Clark confirmed that he recollected that his shift on 4 August 2020 was "very, very busy". He stated that the pandemic had significant impacts on staff, including the need to wear full PPE, and there was "heightened stress and nervousness".

160 CNC Clark described his role as a mental health CNC was "to provide (an) assessment for the mental health patients that come in that are triaged and referred to us. We assist in assessment, liaison and the admissions or discharge". He further noted that the MH CNCs "work as part of a multi-disciplinary team, together with consultants and registrars, and ED social workers and anyone that we need to".

161 CNC Clark confirmed that MH CNCs were assigned a registrar on a daily basis, although they were not always available. He stated that if the registrar was not available, he would be able to access a consultant or the on-call psychiatrist. CNC Clark was unable to recall if there was a psychiatry registrar in the ED during his assessment of AX.

162 CNC Clark indicated that when he commenced his shift it was his practice to access the Electronic Medical Records (eMR) and FirstNet to ascertain "how busy it is, who might be coming our way".

163 CNC Clark stated that when he was receiving a patient 'handover' from another CNC, he would also review the progress notes on the hospital medical record system, to determine "what's been happening and what's recorded so far."

164 CNC Clark confirmed that his usual practice was to make detailed notes on the computer located in the PECC office. He stated that he would often commence making notes and then experience an interruption and have to return to making the notes later. During his evidence, he was provided with copies of print-outs of medical records from the eMR system which were struck through with a line and appeared in varying colours. He clarified that the records on the system appear in black and white and a line striking out text indicated that the record had been changed. He further confirmed that each entry was time stamped.

165 CNC Clark recalled being very concerned for AX after he assessed her. He recorded in his notes that she had an intense feeling that she would die, was lacking insight and making poor judgments, was highly vulnerable and acting on delusional beliefs. He agreed that he believed her presentation indicated a possible relapse of psychosis, however, wanted an organic workup, although he ultimately predicted that she would require a mental health admission given her psychotic symptoms.

166 CNC Clark agreed that psychosis is an inherently dangerous condition if left untreated and that AX's behaviour was unpredictable given she was acting on delusional beliefs.

167 CNC Clark confirmed that although he was not accredited to schedule a patient under the *Mental Health* Act, his job required him to regularly consider the involuntary detention of patients. He understood the principle of least restrictive care and that scheduling a patient could have widespread and adverse ramifications for that patient's current treatment, as well as their preparedness to accept care in the future. In cases where he believed a patient's involuntary detention may be required, he would discuss his concerns with a psychiatry registrar or ED doctor.

168 CNC Clark was asked whether he should have sought the input of the psychiatry registrar at an earlier point in time, and he indicated:

> "Well, I suppose – would things have shifted or changed had I have spoken to a consultant prior to the, you know, the medical workup being done? I'm not necessarily sure that there would have been any other change in the – the criteria of her legal status. There may have been, but it's not 100%. It really depends on who you speak to because there's so many different consultant psychiatrists. People might have erred on the side of caution. Others may have not. But at the time, I don't – I don't think they – my experience at that point would have been, "Well, you need to call me back when the medical tests have come back. Yeah."

169 CNC Clark did not recall speaking with Dr Hugo Reynolds about potentially scheduling AX. Similarly, he did not recall having any discussion with CNC Doyle about the same.

170 At the time CNC Clark completed his shift at 4pm on 4 August 2020, he was unaware that AX had left the building. He indicated that had he been made aware that she had left during her neurological assessment, he would have "followed the, sort of, AWOL procedure of, you know, contacting next of kin, referring to the acute care team, considering – consider, possibly, a police welfare check. Yeah."

171 He was asked whether he would have considered scheduling AX after she left the hospital and he indicated that he would have called the consultant psychiatrist to obtain their advice and guidance.

172 CNC Clark reviewed AX's case notes the following morning, 5 August 2020 at 7.30am at the commencement of his shift. He became very concerned when he discovered that AX had not been admitted. He made a notation stating,

> "Follow up with case. Noted that patient left the department. Unclear why she was not referred on the ACT?!". He confirmed his note expressed his surprise, "because I think, if I had written earlier that she was for admission and she'd left than obviously the next stop would be to involve the acute care team. Because it doesn't go from, you know, admission to no care. It would go, you know, admission – but well, if she's left, then, you know, something needs to help."

173 He confirmed that in his view the acute care team should have been contacted the previous evening on 4 August 2020.

174 CNC Clark was unable to give an explanation for his delay in contacting Ms RS at 11am on 5 August 2020. He conceded that he should have acted differently, including initiating contact with the SMHTAL access line as soon as he became aware of AX's situation at the commencement of his shift.

175 He was unable to state with any certainty whether he had called Mr Gary Samuels or whether Mr Samuels had contacted him on 5 August 2020.

176 CNC Clark presented as a thorough, thoughtful and diligent clinician. He made comprehensive clinical notes and readily engaged with other clinicians. He was prepared to concede that his recollection of certain matters was impacted by the lapse of time since the events occurred and contrary to his own interests. He was clearly deeply affected by the event on 4 and 5 August 2020.

Evidence of Dr Hugo Reynolds

177 Dr Reynold was a junior medical officer in the ED at POWH. He provided a statement dated 21 October 2021 and gave oral evidence on 4 June 2024.

178 He indicated that the ED is “pretty much always busy” during the day shift. He confirmed that the impact of the pandemic had meant that things were “fairly chaotic in that year” and the advice was changing as new information became available about the nature of COVID-19.

179 Dr Reynolds was a self-confessed “over-noter” and as such, made comprehensive and detailed notes in the eMR.

180 Dr Reynolds indicated that he had not previously experienced a voluntary patient leaving the ED prior to the completion of an assessment of treatment for a likely psychotic disorder.

181 Dr Reynolds agreed that it could not be ruled out that AX had left the ED as a function of her psychotic disorder and that she was therefore at a risk of misadventure. He thought AX gave “very appropriate answers” during his assessment, however, he felt that her indication to him that someone was following her was the one thing that made him question her capacity.

182 Dr Reynolds stated that he had some understanding of the process of scheduling a patient pursuant to the *Mental Health Act*, however he had escalated the care of AX back to the mental health team, specifically to CNC Doyle.

183 Dr Reynolds indicated in doing so, he was seeking CNC Doyle’s view based on CNC Doyle’s experience and considered that by sending AX’s case back to the mental health team, it was a “re-referral or a re-consultation” to that team.

184 Dr Reynolds recalled the conversation he had with CNC Doyle in the PECC office as follows:

> “From memory, I just checked that he was aware of the patient and I think Toby had handed over to him that this patient was in the department and had been assessed to whatever degree. I explained that she had absconded. She wasn't currently scheduled. She-you know, didn't express this like suicidal ideation or thoughts of self-harm or things to me. Otherwise, from what Toby had handed over and I

what I had assessed seemed similar to what he had assessed. Do we have any course of action to call the police two-you know, possibly bring her back in? Or is there anything else-you know, we should do in this instance? I think he's kind of stated because she wasn't under the Act - she wasn't scheduled, we weren't able to call the police to bring her back in and then that was kind of the extent of what I remember from the conversation".

185 Dr Reynolds understood from CNC Doyle's comments during that conversation that the police could not be contacted for assistance if AX was not scheduled.

186 Dr Reynolds could not be certain whether he in fact told CNC Doyle that he believed that AX probably had a psychotic illness. Dr Reynolds believed that he would have provided his clinical impression to CNC Doyle, that in his opinion, AX was not suffering from any medical condition which would explain her presentation.

187 Dr Reynolds indicated that he could not be sure if he told CNC Doyle that he did not think that there were grounds to schedule AX, although he conceded that it was possible that he did. He did not think that there was any discussion with CNC Doyle about the potential that AX was at risk of misadventure, given that she was acting on her delusions.

188 Dr Reynolds did not recall CNC Doyle providing him with any additional information or advice beyond indicating that AX "was voluntary at that time, that we were unable to call the police and that if they were to return, then we could assess them further".

189 Dr Reynolds agreed that he was authorised to schedule patients pursuant to the *Mental Health Act*, although he indicated that "more often than not", he felt that it was the mental health team which would make the decision about scheduling a patient, although accepted that he could not devolve his responsibility in this matter.

190 Dr Reynolds agreed that he had not contacted his consultant, Dr Marian, after AX had left the ED, as he felt that it was a matter for the mental health team's further management. He further agreed that he had not sought to escalate AX's case to a psychiatry consultant, as it was his experience that the ED doctor would just consult the person who was there. He viewed the CNCs as being quite experienced and it was usual that the CNC would liaise directly with the psychiatry consultant.

191 Dr Reynolds had a clear recollection of conversing with CNC Doyle in the PECC office and was certain that at no time was a psychiatry registrar involved in the conversation between CNC Doyle and himself.

192 Dr Reynolds indicated that his conversation with Ms PA sometime prior to 5.02pm was brief. He accepted that the information that Ms PA provided was significant, particularly as it raised two additional high-risk features,

being a long-standing history of psychotic illness and past attempts at self-harm. Dr Reynolds accepted that Ms PA's information was particularly important given that she was very familiar with AX, and it "was something maybe I should've put more weight into".

193 Dr Reynolds conceded that he did not think to provide Ms PA with information relating to "a number you could call…if you have any kind of mental health issue" and was not aware of the acute care team existence at that time".

194 Dr Reynolds conceded that by 5pm on 4 August 2020, he was aware of the following six matters:

a. that AX had a longstanding history of psychotic illness,
b. That she had attempted self-harm in the past;
c. that she was acting on persecutory delusions;
d. that she had a likely psychotic disorder;
e. that the fact of her departure from the ED suggested that the principle of least restrictive care was no longer practical; and
f. that it could not be ruled out that AX's departure from ED was a response to her psychotic symptoms.

195 Dr Reynolds agreed that in those circumstances, AX was at risk of harm or misadventure, stating:

> "I know, I think, the features you discussed, it would've been possible that she may have been able to be scheduled but I wasn't sure that she met the risk with – you know, when you're look at the wording, it has to be high risk of harm to herself or to others. From the – like, limited information I was working with at the time, I wasn't sure that she met that threshold in order to involuntarily – kind of override her rights to – yeah".

196 Dr Reynolds was asked what he could or should have done differently given the circumstances of 4 August 2020, he responded:

> "I mean, obviously, it would've been reasonable, I think, to go back and speak to John (Doyle) and see if, in his opinion, that changed or not – she were now schedulable or not. Again, I'm not sure whether she would've met the threshold based on their opinion or not. But, I guess, in some areas it's quite nuanced as to whether someone can or not can be scheduled. There may be – like a more senior opinion would've been valuable in that instance. I, again, was acting under the impression that, obviously, John was experience[d] and – you know, his opinion was valuable in that situation. I had never previously called a psychiatry consultant. Or maybe I could – you know, bypass him or speak to a registrar if I was unhappy with his opinion on something but I think, usually – I don't' know, I wouldn't escalate thing to a consultant. It would be unusual if you'd been told by the team – who would usually liaise with the consultant, that that was appropriate. And obviously,

maybe, discussing with my own boss as to whether they had a different opinion to the mental health team. Whether that would be a reasonable thing to have done. And now knowing about the acute care team, I mean, it would've been reasonable to refer her to the acute care team at that time. Again, it wasn't a service I was – like, I was aware of, at that time, in order to make that referral but that would've been something – having then done mental health in the future and knowing more about the service of Prince of Wales, would've been something that would've been good to initiate at that time, rather than at a later date, which I think it was. Yeah". Dr Reynolds became upset during this reflection.

197 Dr Reynolds presented as a considerate and careful clinician, particularly in terms of his notetaking. He was prepared to concede matters, contrary to his own self-interest and appeared to have a reasonable recollection of AX's presentation.

Evidence of NUM Kathryn Power

198 Nurse Unit Manager, Ms Kathryn Power prepared a statement in these proceedings dated, 22 May 2024. Ms Power also gave oral evidence on 4 June 2024.

199 NUM Power indicated that the pandemic created extra work and took a lot more effort in the treatment of patients, given the need to don PPE and other associated procedures.

200 NUM Power indicated that it was common for voluntary patients in the mental health space, who had not completed treatment, to leave the ED due to a high volume of patients and long wait times.

201 NUM Power did not recall being advised by either CNC Doyle or Dr Reynolds that AX's tentative diagnosis was a likely psychotic disorder. She could not recall accessing AX's progress notes on the system.

202 NUM Power confirmed that she spoke with the CNC and ED doctor when she became aware that AX had left the building. NUM Power noted that she would put her trust in the risk assessment that both the CNC and ED doctor had undertaken and would be guided by their advice. In terms of considering if there was a risk to AX, she recalled that the CNC indicated to her that AX was not 'under the Act'. NUM Power understood from this comment that AX was free to leave as she was a voluntary patient.

203 NUM Power did not receive any advice that there was a risk associated with AX's departure. She indicated that if she understood that a patient was at a high clinical risk, she would have contacted a security officer, as well as engaging other nursing staff to assist with a search of the premises. She confirmed that there are CCTV cameras at various locations, and that these cameras can be accessed by security staff.

204 NUM Power confirmed that if a patient is assessed as being 'at risk' or "If there's concern regarding the patient's wellbeing and potential risk associated with the absence, contact the police. That's where(sic) we do in the instance where they abscond. We contact with the local Maroubra police. Then we send them a fax sheet of the patient description with a risk assessment and then they may contact us and get some more information". NUM Power agreed that this procedure was not specific to a patient that has been scheduled.

205 NUM Power confirmed that an entry is made in the incident management system (IIMS) when a patient absconds, however, there was no record in the IIMS system relating to AX's absence.

Evidence of CNC John Doyle

206 Mr John Doyle provided three statements dated 9 August 2021, 22 May 2024 and 17 July 2024. He also gave evidence on 4 and 5 June 2024.

207 Mr Doyle was a mental health clinical nurse clinician at POWH ED and had been employed in that capacity since 2009. Mr Doyle was in his 50th year of practice in 2020 and had been accredited to schedule patients for nine years.

208 CNC Doyle confirmed that he took no notes of anything that occurred on 4 August 2020.

209 He stated that a clinical 'handover' from one CNC to another was largely verbal, "we don't refer to electronic records. It's all verbal".

210 CNC Doyle gave evidence that: "There are two ways that I can institute a schedule under the *Mental Health* Act. It's on the basis of my own observations and assessment and interview and on the basis of those which are conveyed to me by others. Those others can be other clinicians or other persons".

211 CNC Doyle indicated that patient's clinical records were a "post-consideration", being an "examination and analysis of records …in terms of treatment options." In contrast, he indicated that a schedule was instituted on the basis of risk, as determined by what is observed or "what is told that other people have observed".

212 CNC Doyle conceded that clinical records may contain information relevant to the decision to schedule or not. He ultimately accepted that 'past history' would be relevant to the decision to schedule, although he described such records as "a secondary consideration. The principle is what is observed or what other people – or what I am told…. The information is historical".

213 CNC Doyle recalled that he first became aware of AX's presentation at around 4pm on 4 August 2020 when he was walking through the ED with CNC Clark. He recalled being told by CNC Clark that she was having a neuro exam' and he didn't recall CNC Clark telling him too much. CNC Doyle recalled that CNC Clark's diagnosis was "more likely organic in nature. That's all I can recall".

214 CNC Doyle recalled attending at AX's bedside after the handover with CNC Clark. He recalled seeing a gentleman sitting by the bed and assumed he must be the neuro registrar.

215 CNC Doyle recalled asking where the patient was, and the gentleman replied that "she'd gone out for a cigarette". He recalled asking the gentleman if she was "under the *Mental Health Act*? Because someone who is placed under the *Mental Health Act* can't leave the ward and he said, no. I said to him – I said, Do you think she should be under the Act or would you like me to look at executing a schedule. Have you any concerns to do that? and he said, no". He further indicated that he had a good recollection of the conversation "because I offered to enact a schedule".

216 CNC Doyle did not recall the registrar indicating that it wasn't a likely neurological issue, but likely a psychotic disorder. He stated "I don't think he said that because he didn't have a firm impression. I don't think he'd already conducted – I was still unclear what his judgment was on that". CNC Doyle indicated that if it had been said "I would've got the registrar and we would've reviewed the notes and patient", if the patient had gone, "we'd start to identify risks as to whether we should enact a schedule".

217 CNC Doyle indicated that at this stage he didn't have any concerns that AX was an untreated patient with psychotic symptoms. CNC Doyle stated that he relied on the accounts of CNC Clark, the neurology registrar, the ED doctor and the NUM, rather than any medical records, to determine that there was no justification to schedule AX on 4 August 2020.

218 CNC Doyle recalled speaking with Dr Reynolds in the PECC office on 4 August 2020. He remembered asking Dr Reynolds "did you have any concerns? I first asked him, is she under schedule and have you done a schedule under the *Mental Health* Act? He said, no. I said, do you have any concerns? Would you like – do you feel that I scheduled(sic) her? Would you like me to complete that for you? He said, no. He didn't have concerns enough to enact a schedule. I can't remember the exact detail of the conversation but that was the essence of it".

219 CNC Doyle could not recall speaking with Dr Reynolds and being told by him that he had made a diagnosis of a likely psychotic disorder nor of AX acting on persecutory delusions, nor her previous mental health history. He recalled that there was a discussion as to high risk features such as her suicidal ideation and thoughts of self-harm. He could not recall if they had discussed whether the police should be called, but did not dispute that this may have been discussed.

220 CNC Doyle recalled that Dr Reynolds was speaking with the psychiatry registrar but couldn't recall how long they had spoken.

221 CNC Doyle was asked why he had not previously mentioned the presence of the psychiatry registrar in the PECC office and why he had not included this detail in his earlier statements. CNC Doyle indicated that he didn't recall being asked about this detail previously and that he was more focussed on his own decisions and he had "overlooked to include it.". He stated, "She was there. I distinctly remember that. We were working there, close together all evening".

222 CNC Doyle denied that he was reconstructing his evidence as to the conversation with Dr Reynolds and the psychiatry registrar. CNC Doyle stated that he reached his own decision (about AX), but "[t]here may have been – I'm sure we caucused it and reached – both reached the same decision."

223 On the second day of his oral testimony, CNC Doyle identified the psychiatry registrar as Dr Dori Rakusin. He indicated that he had been able to identify her based on a roster from August 2020, which was "just among the stuff on my desk". He then produced the roster.

224 CNC Doyle was provided with a copy of Schedule 1 Medical Certificate and confirmed that in order to complete the section 19 Certificate he would have to personally observe or examine the patient. CNC Doyle was then asked whether he still believed that he could schedule a patient that he had no necessarily seen or observed and he stated, "You could – I – I did – no, it can be done on the basis of what I communicated; that's my understanding".

225 When examined by counsel appearing for the SESLHD, CNC Doyle confirmed his view that he could have scheduled AX without seeing her.

226 CNC Doyle was taken through AX's clinical records for her treatment on 4 August 2020. He was shown CNC Clark's diagnosis of "possible relapse of psychosis, however, require organic work-up". He agreed that that notation provided clear evidence of delusional ideation by AX.

227 CNC Doyle agreed that CNC Clark's entry at 3.21pm with the three-point plan, including "possible neuro review" and "if above is clear, then predict mental health admission" was contrary to his contention that CNC Clark had felt AX had a neurological issue, and that they were considering a neuro admission.

228 CNC Doyle agreed that had he read those notes after AX had left the ED, he "would have certainly taken that into consideration" but would also have sought validation from others within the department. CNC Doyle agreed that he could have contacted CNC Clark about his thinking and whether he

should schedule AX. He also conceded that he could have consulted with the duty psychiatry registrar about what steps should be taken.

229 CNC Doyle accepted that in retrospect, there was a clear possibility that AX left the ED because she was acting on her psychotic symptoms and that she would have been at a risk of misadventure or harm.

230 In his supplementary statement prepared after the conclusion of his evidence and dated 17 July 2024, CNC Doyle indicated that he regretted not reviewing the clinical records. He also regretted not making any note in the medical records regarding his actions and his thinking behind not taking any action after AX left the ED. He further indicated that he had provided incorrect evidence when he stated that a clinician could schedule a patient without examining or assessing a patient. He confirmed that "a patient cannot be scheduled in absentia".

231 CNC Doyle indicated that "During my evidence at the Inquest, I became perplexed with the repetition of the questions." He indicated that he would "welcome further professional development on this topic".

Evidence of Dr Dori Rakusin

232 Dr Dori Rakusin provided a statement dated 30 July 2024. In August 2020, Dr Rakusin was a psychiatric registrar at the POWH.

233 Dr Rakusin confirmed that she was rostered to work in the PECC unit at the hospital from 5-10pm on 4 August 2020.

234 Dr Rakusin had no recollection of meeting with AX on 4 August 2020. In addition, Dr Rakusin stated that she does not recall discussing AX's presentation with CNC Doyle or any other CNC. Dr Rakusin also indicated that she had no recollection of discussing AX's case with any ED doctor. She confirmed that she made no notations in the electronic medical records relating to AX.

235 Dr Rakusin noted that if a clinician in the ED requested an assessment of a patient, the general practice at that time was for both the psychiatric registrar and the CNC to conduct a mental health assessment jointly. Dr Rakusin noted that if the patient was under the *Mental Health Act*, the psychiatric registrar had to see the patient. Decisions as to the patient's care and management were then discussed with the consultant psychiatrist and recorded by the registrar in the patient's notes.

236 Dr Rakusin noted that a patient was "very rarely" scheduled by ED doctors. She noted that whilst an ED doctor was authorised to schedule a patient, it was the usual procedure that patients would be scheduled by psychiatric registrars, CNCs, police or ambulance officers.

EXPERT EVIDENCE

Dr Kerri Eagle

237 Dr Eagle noted the impact the pandemic was having on public hospitals in August 2020, when she commented:

> "I was working at RPA in Camperdown. It was just an appalling time for people with mental illness, actually, re-presenting to emergency departments. Care was compromised, unfortunately, in a number of ways due to the restrictions and the concern, and the, you know, diversion of resources away from areas. Having said that, there's no specific indication that this presentation was impacted specifically by a restriction associated with COVID...but it sounded like she was assessed; it was flagged she needed a mental health admission. Nothing in that pathway, you know, should have been impacted by the pandemic, from my perspective."

238 Dr Eagle was of the opinion that there were a number of steps available to the clinical staff to arrange for follow-up care for AX after she left the ED.

239 Dr Eagle stated that the first step was for the clinical staff to immediately notify the police of the patient's departure from the ED. Dr Eagle indicated that it is her practice to notify the police where she has held concerns for the patient's wellbeing. She acknowledged that the police are likely to conduct their own risk assessment and that their assessment would inform them as to whether they became involved or not.

240 Dr Eagle indicated that secondly, she would have expected the clinical staff to have liaised with the psychiatry registrar or consultant psychiatrist regarding an appropriated follow-up plan given AX's presentation, identifying potential risks of harm, as well as giving consideration to whether the patient should be placed under the provisions of the *Mental Health* Act.

241 Dr Eagle commented that psychiatrists should have been involved in determining the plan after AX had left the ED. She stated:

> "I think there are a number of benefits to a multidisciplinary team, regardless of what levels of expertise everybody has, and one of the most important benefits is that you get the opportunity to have a second opinion, and to have another set of eyes in a situation like this where something's gone wrong, as to what the most appropriate follow-up plan should be, so I do think they should have been involved; the psychiatry registrar, and the psychiatry registrar should have discussed it with the consultation psychiatrist on call."

242 Dr Eagle further expressed the view that the follow-up plan should have been documented in the clinical records at that time, including any discussion with the multidisciplinary team and any other party.

243 Thirdly, Dr Eagle indicated that the clinical team should have liaised with AX's family and provided them with advice on how to access urgent medical care, as well as providing them with information including the risks associated with psychosis. Dr Eagle was of the view that in these circumstances, there would not have been any breach of AX's confidentiality for information to have been provided to her immediate family, who were clearly involved and concerned for her welfare.

244 Finally, Dr Eagle was of the view that an immediate referral should have been made to the SMHTAL to enable rapid access to acute mental health support for AX and her family.

245 Dr Eagle noted that it is unclear whether the acute care team would have been able to follow-up with her overnight. In addition, Dr Eagle agreed that in circumstances where AX returned to Ms PA's home and appeared unaffected, the acute care team may not have attended the home and assessed her.

246 Dr Eagle confirmed that AX "was in urgent need of psychiatric care and treatment" when she left the ED. Dr Eagle was asked about AX's decision-making capacity after leaving the ED. Dr Eagle confirmed that NSW does not have capacity based mental health legislation and there was not enough information available to determine why AX left and whether she had decision-making capacity, but clearly, there were risks associated with her leaving in the context of a psychotic illness.

247 Dr Eagle's opinion was sought as to the appropriateness of CNC Doyle not reviewing AX's clinical notes. Dr Eagle thought that it was "certainly" a step that ought to have been taken. She stated:

> "Yes, certainly, I think anyone in that situation where there's clear risks and concern, and someone's left, should have read through the notes, of course. That would be a very straightforward and easy thing to do, and important, so that you understood the context and all of the relevant information. There were some complexities around the situation……it probably reflects a lack of proper processes with CNCs, so Mr Clark, for instance, was not actually able to schedule AX, and so the extent to which that factored into his decision making, but then also in that situation, I think that made it more important that he involved the psychiatry team, because he wasn't actually able to even make that decision about whether she should be voluntary or involuntary…"

248 Dr Eagle's opinion was sought as to whether a clinician can schedule a person under the *Mental Health* Act without examining or assessing the patient. Dr Eagle stated:

> "…that's a legal question, and I'd love legal advice on that, but my understanding is no, we can't, cause I've been in that situation a lot, and I think you can't schedule a person without having had at least

> assessed them or examined them. You can, of course, having assessed them or examined them, and then the circumstances change, schedule them subsequently, so if I'd assessed somebody for, we'll give her a go. You know, voluntarily, to stay, but then she took off, I could schedule her once she'd left, and said (sic), well, now the risk has changed. This is no longer least restrictive… but I still have to have done an examination or assessment. That's my understanding of it, but I'm not here as a lawyer".

249 Dr Eagle continued, indicating that:

> "I think most psychiatrists and most clinicians believe that to be, that you can't schedule someone unless you've personally examined them, and I think, you know, I think it's a gap…..it would be nice if there was, you know, a – another option where you could bring them back in for assessment if they've absconded without being assessed, but yes, I – I think that's the understanding of most practitioners, in my experience, is that you need to have seen the person to have scheduled them – to then schedule them, then not subsequently".

Dr Richard Furst

250 Dr Furst commented that the impact of the COVID pandemic placed a lot of stress or strain on the emergency departments in August 2020. He noted however, that those pandemic pressures did not appear to have necessarily had any impact on AX's clinical care.

251 Dr Furst disagreed with Dr Eagle regarding the steps which could or should have been taken after AX left the ED. Dr Furst was of the view that once she had left the ED her episode of care had ended and unless there were concerns by the staff who had seen her warranting action under the *Mental Health* Act, "then I take the view that she left voluntarily" and there was not much that could be done.

252 Dr Furst disagreed that the police should have been contacted with a concern for welfare call, about a person who had left the ED voluntarily. He indicated that "if you're concerned with welfare you're scheduling. I don't see an option".

253 Dr Furst noted that in AX's circumstances, "looking retrospectively, it looks terrible but looking prospectively it looks fine". He further commented that "I think the expectations Dr Eagle's implying are unrealistic and unfair on the clinicians working in the hospital".

254 Dr Furst did accept that it would have been good clinical practice for there to have been a discussion with the psychiatric registrar or consultant to identify a follow-up plan and document that plan in the clinical records.

255 He also agreed that it would have been appropriate for AX's family to have been advised that she had left the ED unexpectedly.

256 Dr Furst also agreed that it would have been good clinical practice to have referred AX to the access line for appropriate clinical follow-up.

257 Dr Furst was asked about AX's capacity to engage in decision-making after she left the ED, and Dr Furst stated "…the fact that someone has left would tend to suggest that they're less rational or competent, because you would expect most people if they're rational and competent to remain and be discharge by the doctor".

258 Dr Furst was asked to provide his opinion as to whether a clinician could schedule a person they had not personally observed or examined. Dr Furst indicated that "I don't know the answer, actually".

CONSIDERATIONS

259 AX's presentation and treatment at the POWH ED has been reviewed in light of the COVID-19 pandemic. The evidence suggests that AX's treatment was not compromised because of the circumstances of the pandemic, however, it is noted that the clinical environment at the POWH at that time was a more stressful and challenging environment generally, for both clinical staff and patients.

260 CNC Clark had undertaken a thorough assessment of AX and recorded detailed notes in the eMR system. It was clear that AX was in urgent need of psychiatric care and treatment. AX appeared to be acting on persecutory delusions and was therefore likely to be highly vulnerable and at risk of misadventure.

261 Ms PA provided collateral information to Dr Reynolds sometime later, which underscored the true extent of AX's mental health history and associated issues.

262 It is accepted that Dr Reynolds spoke with CNC Doyle after AX had left the building. It is most concerning that an experienced CNC, such as CNC Doyle, at no time sought to review AX's clinical records. It is of further concern, that given the paucity of information he had gleaned, CNC Doyle felt that it was appropriate to give advice to Dr Reynolds that AX was a 'voluntary' patient, without having accessed any history, assessment, review or collateral medical information.

263 Indeed, CNC Doyle's evidence as to his understanding of the legal power to schedule a person under the *Mental Health Act* was both unsatisfactory and contradictory. It is further noted that CNC Doyle indicated to the Court that he has been a lecturer in mental health nursing, for 19 years.

264 CNC Doyle was emphatic in his evidence on 4 June 2024, that he believed that the *Mental Health Act* allowed an authorised clinician to schedule a person who he had not seen, interviewed or assessed.

265 In his third statement dated 22 August 2024, CNC Doyle indicated that he was “mistaken and confused” when he gave evidence that he believed that he could schedule a person who he had not seen, interviewed or assessed. He claimed that he had become confused as to his legal power to schedule a patient because “During my evidence at the Inquest, I became perplexed with the repetition of the questions”.

266 In CNC Doyle’s first statement dated 9 August 2021, he repeatedly makes reference to asking various clinicians if they required him to schedule AX after she had left the ED, despite never seeing her or assessing her. He also repeatedly gave the same evidence in Court on 4 June 2024, in what appeared to be unconstrained and free-flowing testimony.

267 The only times that CNC Doyle was asked questions repeatedly, coincided with his unresponsiveness to questioning.

268 CNC Doyle spent time during his evidence commenting about the importance of assessing a patient’s need for the least restrictive care in terms of considering whether to schedule a patient or not. His assertion that he could schedule a patient in absentia would appear to be contradictory with such considerations.

269 There were a number of factual disputes which arose during the evidence before the Court.

270 One area of dispute relates to who was in attendance and what was discussed after AX left her bed whilst Dr Wickremaarachchi was assessing her.

271 Having considered the evidence and the credibility of the witnesses, being Dr Wickremaarachchi, CNC Clark and CNC Doyle, the Court accepts the evidence given by both Dr Wickremaarachchi and CNC Clark on three related issues.

272 The first issue was whether both CNC Doyle and CNC Clark attended AX’s bedside after she had left, or CNC Doyle’s version that he attended alone and spoke with Dr Wickremaarachchi. The Court is satisfied that CNC Clark and Dr Wickremaarachchi’s versions are compatible and have been recorded in notes. CNC Doyle made no written notation of his account.

273 The second issue was whether Dr Wickremaarachchi said that AX had gone to the toilet and had not yet returned, as compared to CNC Doyle’s version, that he was told that AX had gone outside to have a cigarette. Again, the Court is satisfied that CNC Clark and Dr Wickremaarachchi’s versions are compatible and have been recorded. Again, CNC Doyle made no written notation of his account.

274 The third issue related to whether Dr Wickremaarachchi gave the clinical impression to CNC Clark and CNC Doyle that he was of the view that AX was presenting with a mental health condition rather than a neurological condition. Again, Dr Wickremaarachchi's version is accepted, again based on his recorded notes and the failure of CNC Doyle to provide any written confirmation of his account.

275 The Court further concluded that it would have been improbable for CNC Doyle to raise the issue of scheduling AX at this time, as he contended, given that it was not clear at that time that she had left the hospital and according to his version, was still the subject of a neurological assessment.

ISSUE 3: WHETHER THE RESPONSE OF THE NSW POLICE FORCE TO THE MISSING PERSON'S REPORT CONCERNING AX WAS ADEQUATE, INCLUDING WHETHER FURTHER STEPS SHOULD HAVE BEEN UNDERTAKEN TO LOCATE AX

276 A precis of the evidence of both Sergeant Stuckey and Constable Kallo is referred to above.

277 In addition to their evidence, a statement was prepared by Detective Acting Inspector Peter Folkes (DI Folkes) dated 27 March 2024. In his statement, DI Folkes provided a commentary on the perceived shortcomings of the police investigation on 5 August 2020, as well as improvements and revisions that have been undertaken by the NSW Police Force since 2020.

278 Police were unable to use phone triangulation technology as AX did not have her mobile phone with her. It is possible that she had discarded her phone the day before on 4 August 2020.

279 The Police Force was also dealing with the unprecedented demands of the COVID-19 pandemic from March 2020, including implementing mandatory isolation periods and border security which resulted in many police stations across the state being short-staffed.

280 The evidence indicates that from the time of Ms RS's call to Constable Kallo at Paddington police station at 1.23pm, until AX's fall at 2.28pm, there was a period of approximately 1 hour and 5 minutes available to police to successfully locate AX.

281 DI Folkes suggested, with the benefit of hindsight, that Sergeant Stuckey could have considered communicating with the Sydney City PAC Supervisors to ensure that they were aware that AX could possibly be heading into their PAC, at the same time he had communicated that information with the Eastern Beaches police vehicles at 1.50pm.

282 Constable Kallo's statement indicated that after speaking with Ms RS on the phone, he prepared the CAD entry and the pro-forma Missing Person template document. He did not make any further contemporaneous notes in his police notebook or elsewhere.

283 DI Folkes referred to the absence of any contemporaneous notes prepared by Constable Kallo, noting that the Missing Persons & Unidentified Bodies & Human Remains Standard Operating Procedures (MP & UBHR SOPS) require the following: "Record in official police notebook details including: - Establish the facts and keep accurate records of what was said and by whom".

284 DI Folkes further noted that "All Police are taught at the Police Academy in their basic training to record Time, Date, Place in that order, regarding information or records made. I believe that details such as the time of pertinent phone calls in a matter such as this are important details that should be noted contemporaneously, and if not in an official police notebook, then transcribed to one at the earliest opportunity".

285 DI Folkes noted that "This issue has been more specifically addressed within the 2024 MP & UBHR SOPS at various points".

286 Apart from preserving important operational and investigative information, the preparation of contemporaneous notes by Constable Kallo would no doubt have resolved the factual issue arising as to what time Ms RS physically attended Paddington Police Station. Constable Kallo indicated that she attended at around 3pm. Given Ms RS's significant concerns for her daughter, it seems somewhat unlikely that she would have delayed attending the police station close to Ms PA's home for almost 1.5 hours.

287 It is noted that Constable Kallo made appropriate concessions to this inquest, accepting the importance of contemporaneous notetaking.

288 The Court accepts that neither of these issues referred to by DI Folkes likely contributed to the outcome on 5 August 2020, in any respect.

289 A missing person is defined in the MP & UBHR SOPS (2024) as "anyone who is reported missing to police, whose whereabouts are unknown, and there are fears for the safety or concern for the welfare of that person. This includes anyone missing from any institution, excluding escapees. For missing person reports to be taken, there must be a genuine concern held for the safety or wellbeing of the person".

290 DI Folkes explained in his statement that missing person reports cannot be taken over the phone and requires the person reporting the missing person to attend in person. He explained that immediate concerns for the person could be addressed in the short term by a "commensurately urgent 'concern for welfare' response".

291 DI Folkes was of the view that Constable Kallo acted properly by taking the account from Ms RS, discussing the case with his supervisor and creating a CAD job. DI Folkes stated:

> "Although a formal report had not been taken, enough details were obtained by Constable Kallo to commence searching for [AX] in a manner consistent with a formal missing person report being made. The matter, at that stage, was equally a Concern For Welfare of someone whose current location was unknown and fears were held for their safety. Actions taken by police in response to the report by phone by [RS] were consistent with both types of reports as initial steps to be taken".

292 DI Folkes stated that "I do not believe that accepting the Missing Person report over the phone would have improved the timing of that important first proactive tasking to locate [AX]". He further noted that the initial actions taken by the responding police were "consistent with a 'high-risk' missing person investigation for the short period of time that elapsed before [AX[was located."

293 DI Folkes advised that the MP & UBHR SOPS have undergone significant amendment and revision, together with additional resources and strategies available to police responding to missing person reports. These include:

a. Geographic Targeting of SMS Messaging using the Telstra Emergency Alert system to allow geographically targeted SMS messages to be sent to all mobile telecommunication devices within a defined area for high-risk missing person investigations, which was unavailable in 2020;
b. the potential involvement of a Missing Persons Coordinator, who can provide advice and guidance in missing person investigations; and
c. Constable Kallo's reference in his statement to additional resources being provided to general duties police, including personally issued MobiPols.

294 The Court is satisfied that apart from the two issues relating to contemporaneous notetaking and the communication of the CAD to the Sydney City PAC Supervisors, the response of the police was adequate. The review and revision of the MP SOPS is encouraging, and the allocation of additional resources is appropriate and appreciated.

295 The Court has been appreciative of the detailed review provided by DI Folkes. The concessions made by both DI Folkes, as well as Constable Kallo and Sergeant Stuckey, showed insight and reflection by the NSW Police Force.

ISSUE 4: RECOMMENDATIONS

Evidence of Mr Christopher Hay

296 Mr Christopher Hay, General Manager, Mental Health Services, SESLHD, provided a statement dated 8 September 2023. He also gave evidence on 5 June 2024. Mr Hay acknowledged AX's family and stated, "I just want to, on behalf of SES Mental Health Service and SES in general, just offer my condolences to [AX's] family. It's a tragic event and we're extremely sorry for our role in that process, and in her journey, and we are certainly hoping and looking to improve our services as a result of this coroner' inquiry".

297 Mr Hay confirmed that a number of changes had been implemented since AX's death, including a formalised framework outlining the expectations and requirements for a MH CNC within the ED to adopt a uniform approach to assessing patients and formulating plans with psychiatry registrars or consultants, track patients within ED and commence admission or discharge planning. This has led to the publication of the SESLHD "*Mental Health Clinical Nurse Consultant, Emergency Department, Prince of Wales Hospital Practice Guide*" (the Guide).

298 The Practice Guide addresses:

a. Admission and discharge planning;
b. requirements for involving psychiatry registrars and consultants for the formulation of care and treatment;
c. responsibilities and expectations for MH CNCs; and
d. processes to be followed should a patient deviate from their expected plan of care, such as leaving the ED unexpectedly.

299 The practice guide makes it clear that where a patient is referred to the mental health team for an assessment in the ED, the patient's planning and treatment is to be discussed with a Registrar or Consultant Psychiatrist at the earliest opportunity.

300 The AWOL procedure has been defined for dealing with an unmanaged departure, which is noted to include a "departure prior to the completion of care without sufficient assessment of capacity or safety."

301 The Guide states that where such a "departure occurs prior to the review above or where risk is unresolved, a joint plan should be undertaken and documented between ED and MH as soon as possible". A number of resulting actions are then listed, and include:

a. organising an immediate huddle with ED to discuss the issues and create a plan;
b. searching the ED and surrounding areas of the hospital grounds;
c. attempting to contact the patient by phone;

d. if phone contact is unsuccessful, notifying the patient's emergency contact, unless the risk is clearly outweighed by privacy or risk of violence;
e. initiating schedule under MHA, even if previously voluntary, the manner of their departure may now indicate that less restrictive care is no longer practical;
f. contact Maroubra police if MHA schedule or other significant welfare concern ; and
g. referral to Acute Care Team or other relevant clinician.

302 A new process for tracking a patient referred to the mental health team for review through the ED has been implemented and is managed via the MH CNC 'Referral Board'.

303 The SESLHD has implemented a process to ensure that all mental health patients who leave ED have follow up plans for management and referral.

304 Mr Hay became aware that CNC Clark had indicated in his evidence that he had only become aware of the Practice Guide until just prior to giving evidence. Mr Hay indicated that there were a number of other aspects of the Guide which required ongoing review and amendment and stated that in his view, "I don't think it's robust enough".

305 Similarly, Mr Hay noted that the mandatory MH CNC Referral Board process had only been subjected to one audit and that there was merit in introducing an ongoing clinical audit.

306 He further noted that there were improvements which were required to the 'unmanaged departure' procedures and that these would be reviewed and revised.

PROPOSED RECOMMENDATIONS

307 Section 82 of the *Coroners Act 2009*, permits a Coroner to make recommendations considered necessary or desirable in relation to any matter connected with a person's death which has been the subject of an inquest.

308 Two recommendations are proposed and are directed to the South Eastern Sydney Local Health District (SESLHD).

309 The first recommendation can be stated as follows:

> That as a matter of priority, a review be undertaken by executive staff in relation to establishing a clear process and procedure for the mental health consumers/patients who attend the Emergency Department (ED) at Prince of Wales Hospital (POWH) but leave prior to completion of treatment, (namely, "unmanaged departures"). The review should include:

a. clarification of applicable policy for unmanaged departures, including operative 'flow charts' (such as that in Tab 35, Annexure B) and the *Mental Health Clinical Nurse Consultant, Emergency Department, Prince of Wales Hospital Practice Guide* (October 2023) and consideration of appropriate staff training as to such policies and procedures;

b. consideration as to implementing appropriate clinical audits of available data regarding:

    i. the Mental Health Clinical Nurse Consultant "Referral Board" data;

    ii. data in the form of notifications on IMS+ regarding incidents of unmanaged departure;

310 The Court acknowledges that the SESLHD has identified shortcomings related to their response to "unmanaged departures", at POWH ED since 4 August 2020. In addition, it is noted that the SESLHD has assessed the risks and implemented a Practice Guide to provide clearer processes aimed at tracking patients through their assessment process, providing clear guidance and procedures relating to treatment and planning for patients, as well as the implementation of a "safety huddle" providing guidance from the psychiatry team.

311 It is further noted that the General Manager, Mental Health Services, Mr Hay, recognised that these processes require further revision and review. The Court commends these ongoing efforts and frank admissions by the SESLHD and notes that more beneficial options for clinical models could and should be trialled and implemented.

312 It is also noted, that the SESLHD is receptive to undertaking clinical audits to confirm whether these changes have been beneficial to patients and clinicians.

313 Mr Hay appeared prepared to critically analyse the role the SESLHD played on 4 August 2020, and to actively engage in meaningful improvements exposed by those shortcomings.

314 The second recommendation can be stated as follows:

> "That as a matter of priority, steps be taken to ensure that mental health clinical staff in the ED of Prince of Wales Hospital have a clear understanding of the circumstances in which consumers/patients can be scheduled under the *Mental Health Act* 2007 (including as to the constraints on a clinician who has not personally examined a consumer/patient)"

315 The evidence of CNC Doyle, both in statement form and oral evidence, indicated a concerning lack of understanding of the circumstances under which an accredited clinician can schedule a patient under the *Mental Health Act*.

316 CNC Doyle sought to ameliorate his earlier written and oral evidence by providing a further statement in which he confirmed that "a patient cannot be scheduled in absentia". CNC Doyle's assertions that he was both confused and became perplexed with the repetition of questions during his oral evidence belied his presentation in the witness box. He appeared very self-assured whilst giving evidence. In fact, his responses at times suggested that he was relishing his exchanges with counsel assisting.

317 The Court is of the view that CNC Doyle was an unreliable and most unsatisfactory witness. It is further noted that he sought to manufacture and rely on a recent invention when he introduced the notion that Dr Rakusin had been present in the PECC during his conversation with Dr Reynolds.

318 Immediately prior to his recollection of Dr Rakusin's involvement, CNC Doyle had been examined by counsel assisting about the compelling evidence gleaned by CNC Clark and Dr Reynolds that AX was very mentally unwell, vulnerable and at significant risk to herself. CNC Clark had recorded AX's history and his tentative diagnosis in her progress notes. CNC Doyle had admitted in evidence that he had not reviewed those notes.

319 An inference exists that as an experienced clinician, CNC Doyle must have realised while giving evidence that by asserting that a more senior clinician, a psychiatric registrar, had discussed AX's case with him, and had concurred with his assessment that AX didn't require scheduling, may have provided support to his assertion that AX was always a voluntary patient without any associated vulnerability or risk. Incredulously, prior to his recollection of Dr Rakusin's involvement, CNC Doyle had repeatedly offered to schedule AX in her absence and without recourse to any assessment, medical notes or history.

320 Despite the Court's assessment of CNC Doyle, the situation remains that CNC Doyle's continuing misapprehension of the scheduling provisions of the *Mental Health* Act, and the fact that his understanding was not detected at an earlier stage, is suggestive of a systemic issue within the SESLHD.

321 It is noted that both Dr Eagle and Dr Furst did not give emphatic opinions as to whether there is a professionally concluded position regarding this issue.

CORRESPONDENCE WITH HERITAGE COUNCIL OF NSW AND VICINITY CENTRES

322 The inquest did not examine the issue of the protection provided by the balustrade in the QVB stairwell.

323 The Heritage Council of NSW and Vicinity Centres were not identified as parties with a sufficient interest and were not parties to these proceedings and did not seek to make submissions.

324 Correspondence was sent to both Vicinity Centres and the Heritage Council of NSW prior to the commencement of the inquest, seeking their input as to whether improvements to the balustrades were being considered, particularly, in terms of public health and safety considerations. The correspondence was tendered in these proceedings.

CLOSING OBSERVATIONS

325 AX was a gregarious, fun-loving person who loved her children deeply. Similarly, she loved and was loved by her family and friends.

326 AX's death has devastated her family and friends. Her mother commented that "I can't describe the pain of living life without AX. My heart aches everyday for her and I light candles in my window most nights in her memory".

327 AX was remembered as "…a very loving and caring mother, and that her children were the most important part of her life. From the moment [her children] were born, AX's caring persona shone through and only grew stronger as the years went by. This is evident today, with both of [her children] growing into amazing young adults".

328 AX's brother, MS recalled "The day AX died, the moon was fuller and brighter that night than I had ever seen before and I'll never forget the drive into Paddington to be with mum the night we lost AX, and how big and bright the moon was in front of me as I drove towards it, trying to process the news that I had just received of AX's death. Every time I look up into the night sky and see the moon, I think of AX and sometimes they are happy memories, and other times it makes me sad".

329 I would like to record my gratitude to counsel assisting, Ms Emma Sullivan, and her instructing solicitor, Ms Amber Boatman for their assistance, their commitment and their untiring efforts to prepare and present this case.

330 I would also like to acknowledge and thank the Officer in Charge of the investigation, Detective Senior Constable Blair Joynson for his efforts and attendance at the inquest. I also thank the former Officer in Charge, Constable Sian Williams.

331 Finally, I would like to again record my most sincere condolences to AX's family.

Findings

I make the following finding pursuant to section 81 of the *Coroners* Act 2009 NSW:

The identity of the deceased

The person who died was AX

Date of Death

AX died on 5 August 2020

Place of Death

AX died at the Queen Victoria Building, Sydney, New South Wales

Cause of Death

Multiple blunt force injuries

Manner of Death

Falling over a stair-case railing from a height, whilst suffering from an acute psychotic illness

I make the following recommendations pursuant to section 82 of the *Coroners Act 2009* (NSW)

To the South Eastern Sydney Local Health District (SESLHD)

1. That as a matter of priority, a review be undertaken by executive staff in relation to establishing a clear process and procedure for the mental health consumers/patients who attend the Emergency Department (ED) at Prince of Wales Hospital (POWH) but leave prior to completion of treatment, (namely, “unmanaged departures”). The review should include:

    a. clarification of applicable policy for unmanaged departures, including operative ‘flow charts’ (such as that in Tab 35, Annexure B) and the *Mental Health Clinical Nurse Consultant, Emergency Department, Prince of Wales Hospital Practice Guide* (October 2023) and consideration of appropriate staff training as to such policies and procedures;

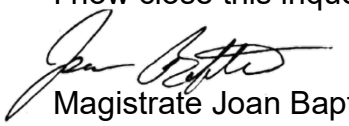
    b. consideration as to implementing appropriate clinical audits of available data regarding:

        i. the Mental Health Clinical Nurse Consultant “Referral Board” data;

ii. data in the form of notifications on IMS+ regarding incidents of unmanaged departure.

2. That as a matter of priority, steps be taken to ensure that mental health clinical staff in the ED of Prince of Wales Hospital have a clear understanding of the circumstances in which consumers/patients can be scheduled under the *Mental Health Act 2007* (including as to the constraints on a clinician who has not personally examined a consumer/patient).

I now close this inquest.



Magistrate Joan Baptie
Deputy State Coroner
11 October 2024