CORONERS COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of GP
Hearing dates:	3-6 March 2025
Date of Findings:	31 March 2025
Place of Findings:	Coroners Court of New South Wales, Lidcombe
Findings of:	Magistrate David O'Neil, Deputy State Coroner of NSW
Catchwords:	CORONIAL LAW – mental health – abscondment from mental health facility – hospital care and treatment – police response to abscondment – ADHD – Vyvanse – manner of death
File number:	2023/265561

Representation	Counsel Assisting, Mr Jake Harris, instructed by Ms Francesca Lilly of the NSW Crown Solicitor's Office Mr Craig Norman of Office of the General Counsel, for the Commissioner of NSW Police Force Mr Cameron Jackson, instructed by Mr John Kamaras of Avant Law, for Dr Artin Jebejian and Dr Virk Mr Patrick Rooney, instructed by Mr Matthew Renwick of McCabes, for Northern Sydney Local Health District and South Western Sydney Local Health District
Non-publication orders	Non-publication orders made pursuant to s 74 of the *Coroners Act 2009* and/or the incidental powers of the Court apply in this matter and are available on the Court file. Copies are also annexed to these findings.
Findings:	**The identity of the deceased** The person who died was GP. **Date of Death** GP died on 20 August 2023. **Place of Death** GP died at Burragula Lookout, North Head, Manly. **Cause of death** The cause of GP 's death was multiple traumatic injuries. **Manner of Death** Deliberate self-harm

Recommendations

I make the following recommendation pursuant to s 82 of the Coroners Act 2009 (NSW)

To Northern Sydney Local Health District (SWSLHD):

(1) That it consider introducing a consistent form for use in all of the LHD's mental health units and PECCs, for staff to record a patient's belongings, including mobile phones and the location of those belongings.

(2) that it provide further training and guidance to mental health service staff on the use of property forms in mental health units and PECCs, to ensure these are completed consistently and how they may be referred to in the event that a patient absconds.

To the Commissioner of Police and NSW Health,

(3) that they consider amending the absconding patient form when it is published with the next version of the Memorandum of Understanding, or sooner if practicable, to include a question "Does the patient have access to a mobile phone or other electronic device?" (with options YES, NO, UNCERTAIN) together with the mobile phone number.

Introduction

1 GP died on 20 August 2023, following a fall from height at the Burragula Lookout, at North Head, Manly.

2 In the months prior to his death, GP had a significant decline in his mental health, in the context of the breakdown of his relationship. He had 3 brief involuntary admissions to mental health facilities in the fortnight prior to his death.

3 On 7 August, he was admitted to Campbelltown Hospital. He absconded from the emergency department but was quickly located by police and returned. On discharge from that hospital on 9 August, he drove to Fitzroy Falls lookout and threatened to jump. Police attended and negotiated with him to return to safety. He was scheduled and taken to the Mirrabrook Unit at Shellharbour hospital, where he was detained until 11 August.

4 He then sought an admission to Gordon Private Hospital, where he was to be admitted on 18 August. However, he absconded from that hospital, too. He returned voluntarily a few hours later. He was scheduled and taken to Hornsby hospital and detained.

5 At about 4.30am on 20 August 2023, GP stole a swipe card from a nurse, and left the hospital. He took an Uber to North Head and walked to the Baragulla Lookout. He called his wife, and in the course of a call, fell to his death.

Inquest

6 An inquest was held between 3 and 6 March 2025.

7 An inquest is a public examination of the circumstances of a death. It provides an opportunity to closely consider what led to the death. It is not the primary purpose of an inquest to blame or punish anyone for the death. The process of

holding an inquest does not imply that anyone is guilty of wrongdoing. Despite this there may nevertheless be factual findings which necessitate an adverse comment or criticism to be made.

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

(a) the person's identity;

(b) the date and place of the person's death; and

(c) the manner and cause of death.

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

Coronial Investigation

10 Prior to holding the inquest, a detailed coronial investigation was undertaken. Investigating Police compiled an initial brief of evidence, and a number of documents were obtained, including a report by a forensic pathologist as to the cause of death.

11 The following agencies and individuals were identified as having a sufficient interest in the proceedings and received notification:

(1) GP's wife;

(2) GP's mother;

(3) Northern Sydney Local Health District;

(4) South Western Sydney Local Health District;

(5) The Commissioner of the NSW Police Force; and

(6) Dr Artin Jebejian.

12 All the documents including witness statements and expert reports obtained during the coronial investigation formed part of the five-volume brief of evidence that was tendered at the commencement of the inquest. All of that material, and the oral evidence at the inquest, have been considered in making the findings detailed below.

Witnesses

13 The following witnesses gave oral evidence in the inquest.

(1) Constable Carl Edwards (Officer in Charge);

(2) Dr Artin Jebejian (Gordon Private Hospital);

(3) Chief Inspector Jason Harrison (Radio Operations Group – State Coordination Unit, NSWPF);

(4) Dr Abdul Virk (Campbelltown Hospital);

(5) Dr Harsh Chalana (Shellharbour Hospital);

(6) Dr Gurubhaskar Shivakumar (Hornsby Hospital);

(7) Registered Nurse Sujan Kunwar (Hornsby Hospital);

(8) Sergeant Katrina Bond (Hornsby Police Station); and

(9) Leanne Frizzel (Service Director – Hornsby Ku-ring-gai Mental Health Service).

Expert Witnesses

14 The following expert witnesses gave oral evidence, in addition to providing written reports, which were tendered as part of the brief of evidence:

(1) Dr Andrew Ellis

(2) Dr Danny Sullivan.

Issues considered in the Inquest

15 A list of issues was prepared and circulated to the interested parties before the inquest commenced. These issues guided the coronial investigation and were considered at inquest. The issues examined included:

(1) What was the nature of GP's mental health condition?

(2) Did GP receive reasonable and adequate care and treatment in the community?

(3) Regarding the prescription of Vyvanse (lisdexamfetamine):

(a) Was the decision to prescribe that drug reasonable and appropriate?

(b) Should it have been ceased in July 2023?

(c) Did it have an impact on GP's mental condition, or the events that led to his death?

(4) Did GP receive adequate care and treatment at:

(a) Campbelltown Hospital, and

(b) Shellharbour Hospital?

(5) Did GP receive adequate care and treatment at Hornsby Hospital? In particular:

(a) Was it appropriate to detain GP as an involuntary patient?

(b) Was his placement in the PECC appropriate?

(c) Should GP have been provided access to his mobile phone?

(d) Were adequate steps taken in response to his agitation at approximately 4:00am on 20 August 2023?

(6) Was the response by Hornsby Hospital to GP absconding reasonable and appropriate, and in accordance with relevant policy?

(7) Was the police response to the report that GP had absconded reasonable and appropriate, and in accordance with NSW Police Force policy? In particular, should a triangulation have been performed earlier?

(8) Is it necessary or desirable to make any recommendations in relation to any matter connected with the death?

Background

16 I shall now set out a general background before turning to the issues.

17 GP was born in 1982. He grew up on Sydney's Lower North Shore and was educated in that area. GP's parents separated when he was eight. In 2001, when he was 18, he met a young woman at a barbecue through friends. They formed a relationship and married in 2010. They had three children. In 2011, GP and a business partner started their own business. In 2017, GP's father was diagnosed with Lewy body dementia. He passed away in 2019.

18 During 2020, GP's business partner dissolved his interest in their business. GP took this very personally and lost motivation in the business. In 2021 the family

moved houses looking for a fresh start, however by this time GP had suffered a deterioration in his mood and he withdrew from social life. His behaviour towards his wife became controlling.

19 In June 2023, GP's wife told him she was not happy in their relationship, and she suggested a trial separation. On 8 July 2023, GP moved out of the family home to an Airbnb. GP obtained a rental property for himself in late July. The rental property was closer to the family home. He continued to see the children and take them to activities up until near the time of his death.

20 GP had been referred to psychologists in August 2019, and again in early 2020. GP attended upon at least two psychologists and completed the number of consultations allowed under his care plan. In August 2020, GP's General Practitioner referred him to a private psychiatrist, Dr Artin Jebejian. Dr Jebejian reviewed GP on 14 September 2020 via Zoom. All subsequent appointments on March 1, 2021, 8 October 2021, 21 July 2022, 8 February 2023, 17 July 2023, and 8 August 2023 were by telephone.

21 After GP moved out of the family home to an Airbnb in July 2023, his mental health deteriorated. He told his wife and a friend that he had met a man at a local men's group who had also been through a separation, who spoke about jumping off a cliff at Fitzroy Falls. That was the first known reference GP made to self-harm. On review on 17 July 2023, GP told Dr Jebejian that he had separated from his wife. He was feeling social anxiety, more panic, had intrusive thoughts and he felt down, nervous and short-tempered. Dr Jebejian considered GP had bipolar II disorder. He recommended GP continue the Vyvanse which had been previously prescribed, but added fluoxetine, an antidepressant.

22 On 25 July 2023, GP and his wife attended a financial mediator to discuss their relationship breakdown. However, GP left after 15 minutes, saying it was not going to be helpful. On 5 August 2023, GP attended the family home. He took his wife to the bedroom and locked the door. They had a discussion about their

relationship. He made an implied threat during the conversation to harm himself and his wife.

23 A couple of days later, on 7 August 2023, GP asked his wife to come to his unit. He was in an emotional state, pacing around. He began to read out something he had written on his phone, which appeared to be a goodbye note. His wife made an excuse to go to the bathroom, where she called a friend for help. GP overheard this and left the home. When his wife called him, he told her he was driving to Fitzroy Falls, which she interpreted as a suicide threat.

24 She persuaded him to return and then took him to Campbelltown Hospital. GP presented to Campbelltown emergency department (ED) at about 12.25pm on 7 August. At triage, he was withdrawn, and disclosed plans to jump off a cliff. He was given diazepam. He was reviewed by a nurse practitioner. His wife left the hospital in the afternoon to pick up the children. At about 5.10pm, GP absconded from the ED through a fire escape. Staff attempted to call Campbelltown Police but were unable to get through.

25 Staff informed a police officer who was already at the hospital in relation to another patient. Police made a broadcast about GP at 5.21pm. His wife received a call from GP who told her he had left the ED and was running down the road. GP's wife called the hospital. Police attended promptly and located GP a short distance from the hospital. He was returned to the hospital. He was given diazepam and transferred to the High Dependency Unit at 6.20pm. GP was observed in the High Dependency Unit on care level 2, which involved observation every 15 minutes.

26 GP had access to his phone and made a large number of calls and texts to his wife. The next morning, 8 August 2023, GP asked for his phone at about 7.30am. He was asked to wait but became agitated, claiming he had a business meeting at 9.30am. He was given more diazepam.

27 Dr Aseem Atul spoke with GP's wife who described the background. She was concerned about GP. She said GP had called her 60 times since admission.

Dr Atul suggested it would be better if she did not see GP at this time. GP was observed in the High Dependency Unit for the rest of the day.

28 At some stage that day, GP spoke to Dr Jebejian by phone. GP reportedly told him he was still taking 60mg of Vyvanse and 20mg of Prozac (fluoxetine).

29 On 9 August 2023, GP was reviewed by psychiatrists Dr Abdul Virk and Dr Atul. GP indicated he was not coping well with being in the hospital environment, and in particular the High Dependency Unit. He indicated that being in that unit would negatively impact his recovery and increase his distress. In his oral evidence, Dr Virk confirmed that the High Dependency Unit can be quite confronting in terms of both its austerity and the other patients.

30 GP was seeking discharge and had completed an application for discharge which was required to be considered by appropriate treaters. The plan at the hospital had been to transfer GP to a lower acuity ward. However, at the time there were issues within the Campbelltown Mental Health Unit about step-downs due to bed block, that is, the unavailability of a bed due to all the beds being occupied. In his oral evidence, Dr Virk confirmed that bed block was a chronic problem at Campbelltown Hospital.

31 On examination, GP indicated that he was motivated to resume a normal life by returning to work, which he found therapeutic and necessary for his wellbeing. He indicated he no longer thought suicide was an option for dealing with his situation, in particular indicating that he was mindful of the impact that his suicide might have on his children. He further indicated he thought it was better to be treated in the community by Dr Jebejian rather than being an inpatient. He said he had well-established community supports, including a number of friends who could assist him upon discharge.

32 Dr Virk was of the view that whilst GP's mood was still reflective, he was now in a normal, balanced, stable emotional state. In determining the appropriate approach, Dr Virk was also mindful that GP could be referred to community mental health services, additional to his private psychiatrist. Given GP's

progress during his admission and his expressed views, Dr Virk made the decision to discharge GP with some confidence that he was not at acute risk of harm to himself or others.

33 GP was discharged about 11:00am that same day. He was given a cab charge for transfer to Campbelltown station. GP sent his wife a text saying he would call a private mental health clinic, however he took his ute and drove to Fitzroy Falls. At 1:30pm he called his wife saying he was at the falls and was going to commit suicide. His wife asked her sister to call triple-0 and called GP while she drove to Fitzroy Falls herself.

34 His wife arrived at the falls when police were arriving. GP was standing at a cliff edge at a lookout. Police attended, as did paramedics and a Police, Ambulance, Clinical, Early Response team, known as PACER. Police conducted an informal negotiation with GP to persuade him to return to safety. At one point, his wife was asked to move away because police were concerned GP wanted her to witness his death.

35 At about 2.45pm, GP agreed to return to the safe side of the barrier. He was seen by paramedics who issued a request under s 20 of the *Mental Health Act 2007* for police to assist conveying him to hospital. He was taken by ambulance to Shoalhaven Hospital. His wife was asked not to go with him. GP was reviewed in the emergency department where members of PACER flagged the fact that GP was at high risk of absconding. At about 11:00pm GP, was transferred to the Mirrabook Unit at Shellharbour Hospital.

36 At the Mirrabook Unit, Dr Thazhathaveetil scheduled GP under the *Mental Health Act* as a mentally disordered person. A mentally disordered person can be detained for no more than three continuous days, not including weekends, after examination by two authorised medical officers.

37 GP was viewed by psychiatrist Dr Harsh Chalana on 10 and 11 August. As a result of the first consultation on 10 August, Dr Chalana made the determination

that GP remained a mentally disordered person. The doctor was of the view GP needed further observation and assessment.

38 Dr Chalana was aware of the incident at Fitzroy Falls the day before, and of the admission to Campbelltown Hospital. On direct questioning, GP denied any thoughts of self-harm or suicidal ideations. He said he felt better than he did the previous day, and that he didn't like being in a public hospital. When Doctor examined GP the next day, GP appeared settled, engaging, and he reported that he felt a lot better and wanted to go home. He referred to his friends and his mother, and indicated he had already made an appointment with his GP and he was planning to see his psychiatrist within a week. He again denied any suicidal ideations or plans. He appeared future focused, and wrote up his own safety plan which referred to his mother, his friends, wanting to be there for his kids, the need to walk and exercise, and the availability of professional support in his GP and his psychiatrist.

39 Dr Chalana was aware that members of the medical team had spoken with GP's mother, and that she would pick him up from hospital. He also understood that GP's wife had concerns, but he was of the view that GP was no longer detainable under the *Mental Health Act* which required the least restrictive available care be provided rather than a more restrictive approach. Dr Chalana was also of the view that continued involuntary care in a public hospital was likely not going to be helpful for GP. GP was discharged that afternoon with the aspects of the plan referred to above put in place, as well as referral to the acute care team for community follow-up.

40 He returned home that night, and the next day arranged to stay with a friend. He remained with that friend for about a week. The friend helped GP to update his health insurance so as to assist fund a private psychiatric admission. GP was followed up by Community Mental Health over the next few days. On 16 August 2023, GP made arrangements to execute a power of attorney and a Will. On 17 August 2023, GP went to dinner with two friends. Unbeknown to one of the friends, GP disclosed to the other that he had been looking for places to suicide.

41 During this period GP was trying to obtain admission to the Northside Clinic, however it was unable to give him an admission date. He became frustrated about this and he contacted Dr Jebejian to assist with an admission to the Gordon Private Hospital. GP completed admission documents on 17 August.

42 On the morning of Friday, 18 August, a friend drove GP to Gordon Private Hospital. He was admitted at 10.30am. While waiting to be seen, he called and texted his wife relentlessly. At about 1pm, while waiting to be seen by the psychiatrist, GP left the hospital. He texted his wife saying he had left the hospital but did not plan to harm himself. He took an Uber to a friend's home, where he took his ute and drove off. His wife was concerned he would drive back to Fitzroy Falls.

43 His wife called the hospital and then called Hornsby Police Station. A concern for welfare broadcast was made at 2.18pm. Leading Senior Constable Bond and Constable Wilson responded. They contacted the hospital to obtain CCTV footage and a photo. They also spoke with GP's wife. His wife called GP back and spoke with him for about an hour. She eventually persuaded him to return to hospital. He dropped his ute back at a friend's home and took an Uber back to hospital, arriving about 4pm.

44 Dr Jebejian was at the hospital and he reviewed GP. He noted GP had a three-week history of severe depression and was feeling suicidal all the time. He considered GP to be at high risk to himself. Dr Jebejian spoke by phone to GP's wife who expressed concern for GP's safety. Dr Jebejian considered GP to be a flight risk and at high risk to his life. He considered GP had features of borderline personality disorder and narcissistic personality disorder. He made a diagnosis of adult ADHD with hyperactivity, panic disorder, with non-melancholic depressive episodes.

45 Dr Jebejian scheduled GP to a public mental health facility. GP was triaged at Hornsby Hospital Emergency Department at 8.13pm. A mental health assessment was performed at 2.18am on Saturday 19 August. A psychiatric

registrar reviewed GP at 2.50am. That registrar, Dr Ahmed Gomaa, found GP to be calm and engaging.

46 GP wanted to be discharged to a friend's care, but he could not speak to the friend at that time. Dr Gomaa discussed the plan with the on-call psychiatrist, Dr Hannah Choi, who did not agree to GP being released without a safety plan. Dr Ahmed Gomaa scheduled GP under the *Mental Health Act* as a mentally disordered person.

47 About 4am, GP was then transferred to the Psychiatric Emergency Care Centre or PECC. Registered Nurse Sujan Kunwar was working a night shift. He completed some of the PECC admission documents. This was challenging as GP wanted to sleep. These documents included a patient clothing and property checklist.

48 That document had a space for a mobile phone, although nothing was recorded. The medical notes did record elsewhere that GP had his phone with him, and GP's phone was recorded in the PECC "money and valuables book". GP was observed every 15 minutes while he was in the PECC.

49 During the day of 19 August, GP told staff repeatedly that he wanted to go back to the private hospital. He became frustrated because he wanted to be reviewed by a doctor. His wife visited GP that day. He was very emotional, continually crying. At one stage he told her, "If they say I can't get out tonight, I will escape". In the evening, GP was reviewed by a psychiatric registrar. At about 8pm, GP was given temazepam for anxiety. He was reviewed by a nurse and he appeared to accept that he would remain admitted at Hornsby until Monday.

50 Nurse Kunwar commenced his shift at 9.30pm. By that time, GP was asleep in his room. He remained asleep during all checks until about 4am. Just prior to 4am, GP awoke and went onto the ward. During a conversation, GP moved toward Nurse Kunwar and snatched his swipe card. He then ran to the fire exit

and went through, shutting the door behind him. This was captured on CCTV footage.

51 Nurse Kunwar was not able to follow GP and he called for an "aggressive RT response". It is not known precisely where GP went after leaving the hospital. He had his phone with him. At 4.53am he used his phone to book an Uber which collected him about 20 minutes' walk from Hornsby Hospital. GP initially booked the Uber to be dropped at an Italian restaurant in Manly, however he changed the drop-off to North Head Scenic Drive, Manly. He was dropped there at 5.35am.

52 GP then walked about 1.8km to the Burragula Lookout at North Head. That walk takes about twenty minutes. On arriving at North Head, GP made a number of calls to his wife and also sent her a text at 6.02am. That text was in the nature of a goodbye message. When GP's wife awoke at about 6am, she saw missed calls from an unknown number and called Hornsby Hospital. She spoke to Nurse Kunwar and found out GP had absconded. GP was calling her at that time.

53 At 6.02am his wife called GP back. They spoke for about five minutes. There was a further call. During the call GP asked his wife to Facetime. He showed her where he was, saying, "Look how beautiful this is. I can see the view and the amazing sunrise". He told her he was at "The Gap". He also mentioned seeing the city, which cannot be seen from The Gap, which faces east.

54 He then put the phone down and said he was going to "roll off the cliff", which was followed by a scream. GP's wife called triple-0. She said that her husband was at The Gap and "had just called me from The Gap to say that he's jumping off the cliff".

55 GP's wife provided his phone number and her own. She said she did not have any tracking on GP's phone. She also believed he had got there in an Uber or possibly had used an Uber to get to his ute and then driven to The Gap. GP's wife then started driving to Sydney. At 9.31am, PolAir 5 searched the cliff line

around North Head. GP's body was located at about 10am on a rock ledge at the base of a 75m cliff beneath the Burragula Lookout. When GP's body was later recovered, Nurse Kunwar's swipe card was found in his pocket.

56 I will now turn to consideration of the issues as set out in the issues list.

Issue 1. What was the nature of GP's mental health condition?

57 Ms Friedman, the second psychologist who dealt with GP pursuant to his mental health plan, diagnosed GP as suffering from *mixed depression and anxiety in the context of grief* in correspondence dated 31 March 2020.

58 In his second written statement, Dr Jebejian somewhat guardedly indicated his "diagnosis or impression" of GP as at the time he prescribed lisdexamfetamine (Vyvanse) in January 2021. The "diagnosis or impression" was that GP had *features of adult attention deficit disorder / hyperactivity disorder*.

59 Whilst Dr Jebejian described the diagnosis as "features of", it must be accepted that in prescribing medication to treat adult ADHD, that was indeed his diagnosis as at January 2021.

60 Once GP commenced treatment with Dr Jebejian, he did not see a psychologist. His next engagement with a medical professional other than Dr Jebejian was at Campbelltown Hospital, where he was diagnosed as suffering from an *adjustment disorder upon the breakdown of his marriage*.

61 The recorded impression at Campbelltown Hospital was that the *suicide attempt had occurred in the context of psychosocial stressors.* Whilst he was viewed to be detainable on 9 and 10 August, his improvement was such that by 11 August, it was considered that he was no longer detainable under the *Mental Health Act*.

62 On discharge, it was noted that there was *no evidence of any psychotic symptoms and there was no evidence of pervasive mood disturbance*. It was

noted that there were *personality vulnerabilities, these being mainly narcissistic personality traits.*

63 Dr Ellis, who gave evidence as an expert, was of the view that GP suffered from a *major depressive disorder with significant functional impairment*. Dr Ellis was of the view that the disorder had started in about 2017 and was consistently present from 2021.

64 Dr Sullivan, who also gave evidence as an expert, was of the view that GP suffered an *adjustment disorder with mixed anxiety and depressed mood*.

65 Neither expert thought there was enough evidence to diagnose adult ADHD.

66 In oral evidence, both experts pointed out that their diagnoses were fundamentally similar, with Dr Sullivan indicating that his diagnosis was slightly more conservative than that of Dr Ellis.

67 The experts were critical of Dr Jebejian's approach in arriving at his diagnosis. They noted a number of deficiencies. Significantly, there was no information based on reliable or validated rating scales, informant interviews or review of school records. The structured questionnaire which had been completed, a diagnostic tool called the "Mood Assessment Program", identified that GP had probable Bipolar II Disorder and identified various symptoms of depression and anxiety. And as such, did not match the diagnosis of adult ADHD.

68 The need to gather collateral information was considered fundamental to both experts. This had not occurred. There was no investigation as to whether GP experienced any symptoms in childhood which would support an ADHD finding. Collateral information could have been gathered from GP's mother.

69 Another recognised source of collateral information is school reports. Dr Jebejian took no steps to gather such information.

70 In oral evidence, Dr Jebejian sought to support his diagnosis by indicating that during consultations GP said that Vyvanse had helped him concentrate at work.

When raised with the experts, they rejected this as a basis for supporting the diagnosis, indicating that the nature of Vyvanse, being an amphetamine, is that it would help most of the population concentrate to some degree, and as such this could not be relied upon to validate the original diagnosis.

71 Counsel for Dr Jebejian submitted that, there is support for the contention that Vyvanse assisted GP, in his wife's statement. I accept that in that statement GP's wife indicated an initial improvement not only in concentration but also in mood and demeanour. But this seemed to be short-lived in that during 2021, the year of prescription of Vyvanse, GP was not socially engaging and became more withdrawn from society as the year went on. It is also to be noted that in August 2023, GP complained when hospitalised that the Vyvanse had increased his anxiety and had not been working.

72 I reject the suggestion that GP's accounts to Dr Jebejian of better concentration at work supports the diagnosis of adult ADHD.

73 I am satisfied on the evidence that there was not sufficient evidence for a diagnosis of adult ADHD.

74 Taking a conservative approach, bearing in mind the restriction which the experts referred to in acknowledging they did not have the opportunity to see GP, I am satisfied on balance that GP was suffering an adjustment disorder with mixed anxiety and depressed mood.

Issue 2. Did GP receive reasonable and adequate care and treatment in the community?

Issue 3. Regarding the prescription of Vyvanse;

a), was the decision to prescribe that drug reasonable and appropriate;

b), should it have been ceased in July 2023;

c) did it have an impact on GP's mental condition or the events that led to his death.

75 It is convenient to deal with issues two and three together, as the prescription of Vyvanse was an integral part of the care and treatment provided to GP. Having considered GP's diagnosis in dealing with issue 1, it is appropriate to turn first to issue 3, as the prescribing of Vyvanse followed Dr Jebejian diagnosis of adult ADHD.

76 As I have concluded that Dr Jebejian did not have sufficient evidence to support the diagnosis of ADHD, it follows that Vyvanse should not have been prescribed.

77 The decision to prescribe it was neither reasonable nor appropriate.

78 In relation to issue 3b, it is clear it would have been appropriate to cease Vyvanse in July 2023 given that it should never have been prescribed.

79 The weight of the evidence is that whilst the prescription by Dr Jebejian was still on foot in July and August 2023, GP stopped it altogether during August, at the latest.

80 On 17 July 2023, Dr Jebejian prescribed fluoxetine, an antidepressant. On his admission to Campbelltown Hospital, Vyvanse was noted as well as "*started antidepressant, three weeks ago*".

81 In the notes for 8 August, GP blamed his medication for his "*bad day yesterday"*, and he blamed Vyvanse in that it made him hyper-focused on work and more anxious. When he was discharged from Shoalhaven, only fluoxetine was noted on the discharge referral.

82 The final sub-issue is whether Vyvanse had an impact on GP's mental condition or the events that led to his death. It must first be observed that prescribing GP Vyvanse represented a missed opportunity to prescribe more appropriate medication, as was pointed out by both expert witnesses. It's clear GP was of

the view that Vyvanse increased his anxiety. Dr Ellis expressed the view that it also could have caused agitation and augmented GP's hypomania.

83 Despite this, I accept the evidence from both experts that as GP stopped taking Vyvanse at least a week prior to his death, and as no amphetamine was detected by toxicology at autopsy, it is unlikely that Vyvanse was impacting upon GP at the time of his death.

84 This finding cannot obscure the reality that it will never be known what path GP's treatment would have followed and how he would have reacted to that treatment, if a different diagnosis had been made when GP first attended upon Dr Jebejian.

85 Issue 2 is not wholly focused upon Dr Jebejian's treatment of GP, but more broadly asks about GP's care and treatment in the community.

86 Dr Ellis said that GP's, psychologists and the community mental health team provided adequate care.

87 Dr Sullivan gave evidence that there were no grounds to coerce GP. In Dr Sullivan's view it was not appropriate to impose a community treatment order, and appropriate efforts were made to deal with him on his own terms.

88 Dr Jebejian's care of GP cannot be similarly viewed. On the evidence before me, Dr Jebejian did not provide reasonable and adequate care to GP. That care was deficient in a number of ways. I will endeavour to deal with the deficiencies in some form of chronological order.

89 Dr Jebejian's note-taking was substantially deficient. He made handwritten notes only, despite indicating in evidence that his normal practise - even if he made such notes - was to then make typed notes. He could not provide an explanation as to why he did not do that in GP's case. The content of the notes should have been more detailed, including mental state examination and a diagnostic formulation.

90 I have above dealt with the deficiencies in Dr Jebejian's approach to diagnosing GP's condition including his failure to seek any collateral information.

91 In addition, Dr Jebejian didn't at any stage write to GP's referring general practitioner setting out his observations, diagnosis and medication.

92 It is trite to point out the importance of detailed and accurate note-taking, both for the general practitioner and to inform any other practitioner who may subsequently treat a patient.

93 The notes should have included a detailed care plan. That plan should have included psychotherapy or, at least some level of psychological support.

94 There was the recognition at inquest that in the closing days and weeks of his life GP was resistant to intervention. His involvement with psychologists prior to being referred to Dr Jebejian paints a slightly different picture. Dr Jebejian suggested that GP was at times hard to engage with. I accept that this is accurate to a degree. Nevertheless, I find that Dr Jebejian did not apply an appropriate level of rigour in encouraging GP to undertake further psychological assistance to supplement the treatment being provided by himself.

95 A further issue in relation to Dr Jebejian's care and treatment of GP related to the nature and frequency of the consultations. Dr Jebejian had one Zoom consultation with GP and all subsequent consultations were by phone. He did not consult with GP face-to-face until August 2023 at Gordon Private Hospital. Additionally, upon prescribing Vyvanse, guidelines indicated that Dr Jebejian should have seen GP at least every six months to assess how he was progressing on the medication. This is understandable in the context of Vyvanse being an amphetamine.

96 Dr Jebejian did not prescribe Vyvanse at the first consultation on 14 September 2020, but rather prescribed it following a phone consultation in January 2021. Dr Jebejian next saw GP on March 1, 2021, which would have provided the opportunity to make an early assessment of how GP was progressing on

Vyvanse, albeit a phone consultation. The only handwritten note which sheds any light on the issue arising from that consultation is “better mood”.

97 In oral evidence, Dr Jebejian indicated that GP told him that he was able to concentrate better at work whilst taking Vyvanse. As previously indicated the expert evidence was that Vyvanse was likely to have that effect on the majority of the population. Dr Jebejian next saw GP a little more than nine months later in October 2021, then July 22 (nine months) February 23 (eight months) and 17 July 23 (five months) prior to the consultation by phone on 8 August 23 when GP was in Campbelltown Hospital.

98 Neither the frequency nor the method of the consultations lent themselves to appropriate assessment of how GP was progressing. Whilst Zoom meetings grew in popularity during the pandemic years (2020, 2021) that was not the case in relation to consultations after 2021. In regard to these consultations, Dr Jebejian indicated that GP liked the phone consultations.

99 I am of the view Dr Jebejian should have been more persistent in seeking to consult face-to-face, at least on some occasions. As the expert witnesses pointed out, face to face consultations are an important aspect of diagnosis and treatment.

100 As an additional point, the experts were of the view that after speaking to GP at Campbelltown Hospital on 8 August, Dr Jebejian should have endeavoured to speak to the treating team.

101 To his credit, during oral evidence, Dr Jebejian made frank concessions in his evidence in relation to a number of the above issues.

Issue 4. Did GP receive adequate care and treatment at Campbelltown Hospital and Shellharbour Hospital?

102 In his evidence, Dr Sullivan pointed out that, with the benefit of hindsight, it was apparent that GP was avoiding meaningful engagement with clinicians in the

various consultations in August 2023. GP, an intelligent man, was presenting positive views about his mental health to clinicians in a way which hid his true feelings, intentions and mental state.

103 When GP presented to Campbelltown Emergency Department on 7 August, he was withdrawn and disclosed plans to jump off a cliff. By 9 August, after GP had spent some time in the High Dependency Unit with observations every 15 minutes, he told clinicians that he was not coping well with being in the hospital environment, was motivated to resume a normal life by returning to work, no longer thought suicide was an option, was mindful of the impact that might have on his children, thought it was better to be treated in the community by Dr Jebejian and had well-established community supports. Despite all these representations, shortly after release on 9 August, GP contacted his wife and headed directly to Fitzroy Falls.

104 Another aspect of GP's approach to the clinicians related to his wife. At the time of GP's admission to Campbelltown, the major stressor in his life was the fact that his marriage was failing, and he and his wife were living in separate premises. He told clinicians that he wanted his wife excluded from his care and not to be provided with any information, yet he regularly contacted her, sometimes obsessively, and upon release from Campbelltown Hospital contacted her when he was heading to Fitzroy Falls.

105 Whilst GP's approach can be seen with the benefit of hindsight, clinicians at Campbelltown Hospital did not have that advantage. Self-evidently, dealing with patients with mental health issues is extremely complex. Importantly, doctors have to abide by the *Mental Health Act*'s principle, that the best possible care be provided in the least restrictive environment. Furthermore, once GP made application for discharge, that application had to be appropriately considered, with the opportunity for GP to appeal to the Mental Health Review Tribunal if he disagreed with the decision.

106 Another factor feeding into the assessment of the appropriate course is the need to work with the patient rather than to alienate the patient, either from the

individual practitioner, the specific hospital or the medical system. There was evidence from clinicians and experts that it's important to retain the trust of the patient.

107 All these factors feed into the determination to be made. I accept the evidence of the experts that there was no proper basis to detain GP at Campbelltown Hospital on 9 August 2023.

108 I also accept Dr Ellis's evidence that the discharge plan should have been more stringent. The plan as it existed was for GP to make his own way home via Campbelltown railway station. No precise support person was nominated despite the potential availability of numerous friends and his mother, and there should have been a specific plan for GP to re-engage with Dr Jebejian via the involvement of a GP.

109 I do note that the hospital had tried to contact Dr Jebejian. To his credit, Dr Virk accepted in his evidence that there were deficiencies in the care of GP in that the mental state examination was not recorded and there was no entry regarding medication. I accept from his evidence that he and his co-workers were extremely busy due to their very high workload. Dr Virk also accepted that the discharge plan could have been more sophisticated. Despite these areas where there could have been improvement, I am satisfied that a reasonable level of care was provided to GP at Campbelltown Hospital, including by Dr Virk.

110 In relation to Shoalhaven Hospital, I accept the view of the experts that the standard of care provided was appropriate. On this occasion, GP was remaining in the hospital on the basis of him being assessed as a mentally disordered rather than mentally ill person. Once again GP made an application to be discharged and that application had to be fully and properly considered. Whilst clinicians at Shoalhaven Hospital were aware that GP had left Campbelltown Hospital, and gone to Fitzroy Falls that same afternoon, within two days of his admission to Campbelltown, GP was denying any thoughts of

self-harm or suicidal ideations and indicated that he didn't like being in a public hospital.

111 At Shellharbour Hospital GP again referred to his friends and his mother, and indicated he had already made an appointment with his GP. Furthermore, he indicated he wanted to be there for his kids and understood the need to walk and exercise. On Dr Chalana's assessment, it was not appropriate to detain GP for any longer. The expert evidence was that this was an appropriate course. Regrettably, clinicians at Shellharbour Hospital did not have notes from Campbelltown Hospital. There is no single digital patient record for public patients yet available in New South Wales.

112 As raised at inquest, there is an ongoing programme in New South Wales to put the single digital patient record in place. There have been delays in this occurring. It was not the purpose of this inquest to explore the causes of those delays, nor examine how extensive they are. For the citizens of New South Wales, the sooner the single digital patient record is in place the better. Clinicians at Shellharbour Hospital had only GP's account of what occurred at Campbelltown. It would have been preferable for the record from Campbelltown to be available to Shellharbour Hospital.

113 An important aspect of the care for GP at Shellharbour Hospital and the appropriateness of his discharge was that there was an extensive discharge plan put in place. The plan included an appointment with his GP, agreement to seeing his treating psychiatrist within seven days, contact with his mother and engagement with the community mental health team.

114 An issue arose during the inquest as to Dr Chalana's expressed view that GP was being released into the care of his mother. Whilst Dr Chalana's evidence was that he did not expect GP's mother to have a significant level of obligations in relation to GP's care - such as ensuring that he took his medication - the fact was that GP's mother had no capacity to provide GP with accommodation and she understood that all she was doing was picking GP up upon his discharge.

115 Dr Chalana's mistaken understanding of the situation arose from the fact that he did not make the call to GP's mother, but rather one of his team did, and there was imperfect communication as to what had occurred in that conversation. I accept Dr Chalana's evidence that if he fully understood the mother's position, he would have made inquiries as to whether another person - most likely a friend - could have acted as a person into whose care GP could have been released.

116 In circumstances where GP was in fact provided housing with a friend shortly after his discharge, I am satisfied that the original plan was appropriate despite the misunderstanding and lack of full communication with GP's mother.

117 As previously observed, the experts were of the view the care provided by the community mental health team was appropriate. And I note that they made significant efforts to keep in contact with GP following his discharge from Shellharbour Hospital.

Issue 5. The sub-issues identify the questions to be addressed in relation to GP's care at Hornsby Hospital.

I propose to deal with the sub issues in order.

Issue 5a, was it appropriate to detain GP as an involuntary patient?

118 The expert witnesses agreed that it was appropriate to detain GP as an involuntary patient.

119 As earlier set out, it was Dr Jebejian who assessed GP at Gordon Private Hospital and determined he should be sent to Hornsby Hospital. He found GP had a *three-week history of severe depression, was feeling suicidal all the time and was a high risk to himself and a flight risk.*

Issue 5B, was his placement in the PECC appropriate?

120 Insofar as GP's detention in PECC, the Psychiatric Emergency Care Centre is concerned, the placement in PECC was appropriate only because of the circumstance that a bed was not available in the Acute Mental Health Unit. In those circumstances admission to PECC was considered to be more clinically appropriate than GP remaining in the emergency department.

121 The Acute Mental Health Unit clearly provided a more secure environment than the PECC. The PECC model of care documentation states that patients who are *unlikely to abscond* may be considered for PECC. GP was clearly a flight risk, as identified by Dr Jebejian, and as such, ideally, would not have been placed in PECC. Whilst no criticism can be made of anyone at Hornsby Hospital for a bed not being available, this further example of a lack of resources is deeply regrettable.

Issue 5C. Should GP have been provided access to his mobile phone?

122 The evidence at inquest was that there is a move *away* from taking phones from patients during mental health inpatient stays. Access to phones is considered to promote recovery, autonomy and well-being, and tends to normalise admissions. Phones are only removed from patients if there are clear indicators that assessed risks require that course to be followed. There was no evidence at inquest to suggest that GP should not have had access to his phone. If it had been known that GP had his phone when he absconded, the opportunity to find where he was going would have been enhanced.

Issue 5D. Were adequate steps taken in response to his, GP's, agitation at approximately 4am on 20 August 2023?

123 At about 4am on 20 August 2023, GP came from his bedroom unexpectedly. He was pacing around and appeared agitated. Nurse Kunwar was concerned by GP's demeanour, and prescribed lorazepam, an anti-anxiety medication. GP was initially resistant to taking the medication. GP asked to be discharged, and Nurse Kunwar told him he'd request a doctor to attend. GP then asked to go out into the courtyard, which was locked overnight. However, Nurse Kunwar

would not allow this. Nurse Kunwar was concerned enough by GP's state to contact the after-hours nurse manager and advise that there might be a need for the aggression response team to be asked for assistance.

124 Shortly after, when GP was talking with Nurse Kunwar in an open area of the ward, he snatched Nurse Kunwar's swipe card from Nurse Kunwar's waist and rushed to and through the fire exit. These actions of GP were, as the experts agreed, completely unpredictable. The experts were clear in their evidence that the conduct of Nurse Kunwar was at all stages appropriate.

Issue 6, Was the response by Hornsby Hospital to GP's absconding reasonable and appropriate and in accordance with relevant policy?

125 Following GP absconding, Nurse Kunwar appropriately called and informed the after-hours nurse manager of the situation and phoned police at approximately 4.36am, to advise them what had happened. He also called GP's nominated next-of-kin and attempted to call GP's wife and GP himself. Those steps are uncontroversial. However, two important issues emerged at inquest which are best considered simultaneously with Issue 7.

Issue 7. Was the police response to the report that GP had absconded reasonable and appropriate and in accordance with New South Wales Police Force policy? In particular, should a triangulation have been performed earlier?

126 The Memorandum of Understanding between the Commissioner of Police and New South Wales Health required that a fax be sent to police setting out relevant details, including the absconded patient's mobile phone number. At the time the hospital was not using the form attached to the Memorandum of Understanding, but was using a NSW Health Absent Without Leave (AWOL) document. A few issues arise.

127 Firstly, the AWOL form did not include the absconded patient's phone number and yet it prompts that the patient be called. Secondly, it allows for confirmation

that the document has been faxed to police. In this instance that box had not been “checked”. The box in relation to calling the patient had been “checked”.

128 Despite the box for indicating the fax had been sent to police not being “checked”, the AWOL form itself bears a timestamp of 5.10 indicating it had been faxed without indicating the number of the recipient. Inquiries by the officer-in-charge and the hospital could not determine whether the police received the fax, or the number it was sent to. The evidence does not allow me to determine to whom the AWOL form was faxed. However, whilst systemically it is unsatisfactory that there is no record available as to whom the fax was sent, that failing did not impact the efforts to locate GP, as police were verbally informed he had absconded and had a phone number for GP within their system following the efforts made by Hornsby Police when GP had left Gordon Private Hospital on the 18th of August. In addition, police had a photo of GP.

129 Appropriately, the LHD is to now use the form attached to the Memorandum of Understanding, which bears space for the telephone number to be recorded.

130 The second issue which arises is that police indicate they understood that GP did not have a phone on him when he left the hospital, whereas Nurse Kunwar’s position was that he was unsure as to whether GP did or did not have his phone with him. The issue took on a particular importance in light of the evidence of State Coordinator Chief Inspector Harrison, that he likely would have commenced triangulation earlier if he knew there was a possibility that GP had his phone with him.

131 Nurse Kunwar’s position in written and oral evidence was that he did not know whether GP had his phone on him. Contrastingly, up until GP’s wife made her triple-0 call at about 6.12am, police had proceeded on the basis that GP did not have his phone with him. Neither the statement of Sergeant Bond made 11 days after the incident, nor the statement of Constable Revae Swansbra made 17 days after the incident, make any mention of GP not having his phone with him. Of note, Constable Swansbra tried to call the phone number that was on the system for GP, noting it went straight to voicemail.

132 Furthermore, there is no suggestion in the early CAD messages that GP did not have his phone with him. The first written police document indicating GP did not have his phone with him is in the COPS entry made at 6.14am. The entry is timed just after GP's wife had made her triple-0 call, notifying, amongst other things, that she had had a FaceTime call with GP.

133 A later COPS entry, timed at 7.44am, wrongly indicates that the triple-0 call had been made at 6.27am. This error is repeated in at least one subsequent police statement. Whilst these errors are regrettable and should not have been made, it is clear that any steps by police after GP's wife's triple-0 call could not possibly have had any impact on the outcome.

134 The crucial time in relation to the police belief that GP did not have his phone with him was between 4.36am when the police were first contacted, and shortly after 6am when GP's phone call with his wife commenced. There was ample time for triangulation to have commenced in that period if it had been known that GP may have had his phone with him.

135 It will never be known what impact that would have had on the ultimate outcome, but triangulation could have occurred, but for the police belief GP did not have his phone with him.

136 Sergeant Bond pointed out that the circumstances were such that a triangulation would have been requested. And as indicated above, Chief Inspector Harrison likely would have commenced a triangulation.

137 It is clear that however the misunderstanding came about, it was in place by the time Sergeant Bond commenced searching the local area shortly after 5am. She attended addresses where GP had recently been living. Sergeant Bond had assisted in looking for GP on 18 August when his wife talked him into returning to Gordon Private Hospital and thus was familiar with relevant details.

138 There can be no doubt that Sergeant Bond was committed to taking every reasonable step to help locate GP on the morning of 20 August.

139 I am satisfied the hospital would not have deliberately indicated to police that GP did not have his phone. Not only did Nurse Kunwar try to ring GP, but the evidence is that PECC staff called his phone multiple times. I am similarly satisfied that police genuinely believed that they had been informed that GP did not have his phone on him.

140 It is not possible to determine how this misunderstanding occurred on the evidence available to me. I do not attribute any blame to any health staff member or police officer for the misunderstanding. Unquestionably, police took every step possible to help locate GP given the information they had, as they understood it, and the steps taken by hospital staff were appropriate.

141 Tragically, GP's call with his wife came too late for police to take any steps which could have impacted upon the outcome, however this was not known at the time. Following the triple-0 call Chief Inspector Harrison ordered triangulation and successfully identified GP was at North Head, rather than at The Gap as he had told his wife. This final aspect of GP's tragic passing makes clear both the capacity and competence of police in relation to triangulation and GP's approach, right up until the end, of misleading the agencies who would be able to assist him.

142 The final issue for consideration is *whether it is necessary or desirable to make any recommendations*. It should first be noted that following GP's death, the Northern Sydney Local Health District has introduced, as of March 2024, rubber watch/wristbands to facilitate access through locked doors. It is considered more discreet and more difficult for a patient to remove the wristbands, than it was for a patient to access the identification card as GP did on the morning of 20 August 2023. This would seem to be a positive improvement.

143 Counsel assisting has suggested three recommendations would be appropriate and there has been no resistance to any of the three.

144 As set out above it emerged during the evidence that in the PECC at Hornsby Hospital there were the following forms relevant to property --a patient clothing

and property checklist, a patient belongings checklist and a money and valuables book.

145 It was accepted by the Local Health District that it would be sensible to use a consistent form throughout the Local Health District and to provide guidance and training to mental health staff in relation to the use of that form. In that circumstance, the first two recommendations I make are to the Northern Sydney Local Health District.

(1) That it consider introducing a consistent form for use in all of the LHD's mental health units and PECCs, for staff to record a patient's belongings, including mobile phones and the location of those belongings.

Secondly,

(2) to provide further training and guidance to mental health service staff on the use of property forms in mental health units and PECCs, to ensure these are completed consistently and how they may be referred to in the event that a patient absconds.

146 The third recommendation arises from the misunderstanding that occurred in relation to whether GP did or did not have his phone with him when he absconded.

147 It was readily accepted by all parties that steps should be taken to endeavour to ensure the risk of such a misunderstanding occurring in the future is mitigated to the fullest extent practicable. In that regard, it is sensible to include on the Absconded Patient Form, which is to be faxed to police, an indication as to whether the patient has the phone with him. It is implicit in the recommendation that it is that form that will be used by the Local Health District.

148 I note that the Commissioner of Police gave a very clear indication at inquest, that it may be possible to amend the form in advance of completion of the current review of the Memorandum of Understanding. Whilst that was made

clear at inquest and Health NSW was given an opportunity to reply to the recommendation as drafted, it is not perfectly clear to me that Health NSW agree with the early publishing of the amended form. I would urge that early publishing occur if it is practicable, and have included wording in the recommendation to that end.

149 In the circumstances, the third recommendation is to the Commissioner of Police and NSW Health, that they

(1) consider amending the absconding patient form when it is published with the next version of the Memorandum of Understanding, or sooner if practicable, to include a question "Does the patient have access to a mobile phone or other electronic device? (with options YES, NO, UNCERTAIN)" together with the mobile phone number.

Ancillary issues

150 At inquest there was evidence that steps around GP's care and treatment at Campbelltown and Hornsby Hospitals were impacted upon by a lack of resources. At Campbelltown, the issue was referred to as bed block. At Hornsby Hospital the impact of a lack of a bed for GP in the acute mental health unit was potentially extremely significant. As observed, GP should not have been in the PECC, and would not have been there if there was a bed available in the acute mental health unit. During the expert evidence it was emphasised that mental health care is chronically underfunded.

151 Whilst the urgency of the need for appropriate care is fully recognised in other areas such as heart issues, for example, as referred to in the expert oral evidence, the same understanding of the urgency is not present in relation to mental health care and this is reflected in the deficiency in resourcing. The *Mental Health Act*, as already referred to, specifically refers to the principle that people with a mental illness or mental disorder should receive the best possible care. Whilst this is expressed within the Act in a particular context it is the aim of NSW Health that all patients in all settings receive the best possible care.

GP's circumstances make clear this did not occur due to resourcing issues at both Campbelltown and Hornsby hospitals.

152 No doubt those involved in appropriate positions will continue to agitate for more resources, and I can only encourage them to do so. I would note in regard to resourcing the evidence of Ms Leanne Frizzell, who gave evidence on behalf of the Local Health District in her role as Service Director, Hornsby Ku-ring-gai Mental Health Service. Ms Frizzell set out a number of steps Hornsby Hospital are taking so as to improve clinical practice, including extension of access to the current model of PECC care, initiatives specifically aimed at reducing suicides and further mandatory education for mental health and drug and alcohol staff. The hospital is to be commended for this application of available resources.

153 The final issue that arises is whether I should recommend Dr Jebejian be referred to the relevant medical authorities for consideration of disciplinary action in relation to the identified failings in his treatment of GP.

154 Referral may (relevantly) be made if the unsatisfactory conduct identified in the evidence at inquest indicates a complaint could be made, on the basis that the conduct revealed in the evidence falls significantly below the standard reasonably expected.

155 It must first be noted that referral is discretionary. In making an assessment as to whether Dr Jebejian's conduct fell significantly below the standard reasonably expected, I am of the view it is necessary to look at the conduct overall and so far as practicable, the circumstances in which the services were delivered.

156 The delivery of the services during the pandemic years was no doubt difficult. It is also my view that GP liked to keep control of his interactions with his treating practitioners. Whilst this aspect of GP's conduct was clear in the last weeks of his life it is ,however, difficult to discern, on the evidence, the extent of this conduct when GP was not so acutely unwell.

157 What persuades me in relation to Dr Jebejian's overall care is the detailed and thorough way he went about assessing GP and documenting his assessment at Gordon Private Hospital. That was persuasive of a more satisfactory level of competence and leads me to the view that the covid pandemic and GP's approach to his interactions with Dr Jebejian likely did impact on how Dr Jebejian delivered his services. When that is combined with the fact that it is not possible to point to any aspect of Dr Jebejian's care and treatment of GP as being causative of GP's ultimate demise, I am persuaded that no referral should be made.

158 For completeness, I should briefly refer to the autopsy.

159 Following an external post-mortem examination it was confirmed that GP had died from multiple traumatic injuries. Toxicological analysis revealed therapeutic levels of diazepam, lorazepam, doxylamine and fluoxetine. Alcohol was not detected.

160 Before turning to the formal findings I am required to make, I would like to acknowledge and express my gratitude to Mr Harris, counsel assisting and his instructing solicitor Ms Lilly. The assisting team has worked tirelessly to assist the smooth running of this inquest. I am grateful for their thoroughness and sensitivity during the coronial process. I also thank the other legal representatives for the manner in which they conducted the inquest. I also thank Constable Edwards for his role in the police investigation and for compiling the initial brief of evidence.

161 In this inquest the examination of GP's struggles with his mental health graphically reveals how challenging mental health difficulties are for family and clinicians. GP will be remembered as the man he was in health. He was a loving, involved, intelligent and humorous father and partner who will be sorely missed.

162 On behalf of the Coroners Court of New South Wales, I offer my sincere and respectful condolences to GP's mother, wife, children, extended family and friends.

163 The findings I make under section 81(1) of the Act are:

Identity: The person who died was GP

Date of death: 20 August 2023

Place of death: Burragula Lookout North Head, Manly.

Cause of Death: Multiple traumatic injuries

Manner: Deliberate self-harm.

164 I close this inquest.

Magistrate David O'Neil

Deputy State Coroner, Lidcombe

31 March 2025