CORONERS COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of IE
Hearing dates:	11-14 November 2024
Date of findings:	17 February 2025
Place of findings:	NSW Coroners Court - Lidcombe
Findings of:	Magistrate Rebecca Hosking, Deputy State Coroner
Catchwords:	CORONIAL LAW- Cause and manner of death, intentional self-harm, policies and procedures for transfer of involuntary patients between hospital/mental health facilities and absconded patient, police procedures in respect of missing involuntary patients in mental health facilities
File number:	2021/00011393
Representation	Counsel Assisting the Inquest: Jake Harris instructed by Clara Potocki, NSW Crown Solicitor NSW Commissioner of Police: Jillian Caldwell instructed by Detective Sergeant Stephen Davis, Office of General Counsel NSWPF Sydney Local Health District: Patrick Rooney instructed by Sarah Henry of Makinson D'Apice

Findings	**Identity:** The person who has died is IE **Place of death:** Approximately 300m South of the Monash Avenue entrance into the Dee Why to North Curl Curl bush track, off Oaks Avenue, Dee Why NSW 2099 **Date of death:** 13 January 2021 **Cause of death:** Multiple blunt force injuries **Manner of death:** Intentional self-harm following absconding from a patient vehicle whilst detained as involuntary patient under the Mental Health Act 2007, travelling to Dee Why and jumping from a cliff.
Non-publication orders	Non-publication and pseudonym orders apply to the evidence in this inquest. A copy of the orders made by Deputy State Coroner Hosking is available upon request from the Court Registry.

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INTRODUCTION

1. Section 81(1) of the *Coroners Act 2009* (NSW) **(the Act)** requires that when an inquest is held, the coroner must record in writing their findings as to various aspects of the death.

2. In accordance with s 75(5) of the Act, and subject to non-publication and pseudonym orders, I make an order permitting the publication of a report of the proceedings as I find it is desirable in the public interest to do so.

3. IE's death was initially identified as one with respect to which an inquest was mandatory pursuant to ss 23(1)(c) and 27(1)(b) of the Act because he died 'as a result of police operations'. Having heard the evidence, I have determined the inquest was not mandatory for the reasons I outline below at [172]-[178].

4. These are the findings of an inquest into the circumstances of the death of IE. IE was a much loved son, brother, friend and member of his community. His premature death at aged 27 followed the death of his brother also in tragic circumstances. I wish to acknowledge the pain and suffering of IE's family for the loss of two of their sons.

5. IE was a successful soccer player. He was the Vice Captain off his semi-professional soccer team. He was interested in health and natural therapies and pursued this interest by working and studying in the fitness and wellbeing industry. His family described IE as a beacon of light in his community, always putting others before himself.

6. In May 2019 he suffered a decline in his mental health. This decline continued and at the time of his death, IE was detained at Concord Centre for Mental Health **(CCMH)** within Concord Repatriation General Hospital **(Concord Hospital)** under the *Mental Health Act* 2007 (NSW) **(MHA).** On 13 January 2021, IE was being transferred from CCMH to Banks House at Bankstown-Liverpool Hospital. During the transfer, he absconded, and we now know that he made his way from Homebush to the headland at Dee Why where he jumped to his death at about 3.15pm.

THE ROLE OF THE CORONER

7. Pursuant to s 81 of the Act, a coroner holding an inquest concerning the suspected death of a person must make findings as to whether the person has died and if so, the date and place of the person's death, and the cause and manner of their death.

8. In addition, the coroner may make recommendations in relation to matters which have the capacity to improve public health and safety in the future, arising out of the death in question.

THE ISSUES EXAMINED AT THE INQUEST

9. An inquest into the circumstances of IE's death was held on 11-14 November 2024.

10. The issues examined at the inquest follow.

    a. What was the nature and duration of IE's mental health condition, including any diagnosis.

    b. Was the care and treatment provided to IE during his admission to Concord Hospital from 8 - 13 January 2021 reasonable and appropriate?

        i. Was it appropriate to detain IE on an involuntary basis?

        ii. Was IE prescribed appropriate medications, at an appropriate dose?

    c. Was the decision to transfer IE to Banks House on 13 January 2021 reasonable and appropriate?

        i. Was there an adequate risk assessment?

        ii. Was it adequate to transfer IE with one nurse and a driver?

        iii. Should the vehicle have activated child locks?

    d. Was information provided to the NSW Police Force **(NSWPF)** about IE absconding provided promptly and was their response reasonable and appropriate?

        i. Should IE have been identified as a missing person at the time of the first report, and prior to the report made by his brother at about 4.52pm?

        ii. Should the incident have been escalated to a higher priority?

        iii. Which Police Area Command was required to respond to the reports?

        iv. Should there have been earlier attempts made by police to locate IE?

    e. The statutory findings: Was IE's death intentionally self inflicted?

    f. Is it necessary or desirable to make any recommendations in relation to any matter connected with the death?

THE EVIDENCE

11. Tendered to the court was a 4 volume brief of evidence compiled by the Officer in Charge of the coronial investigation, Sergeant Kyle Christian.

12. At the inquest the court received oral evidence from:

    a. Dr Andrew Ellis, Forensic Psychiatrist, expert

b. Sgt Christian, OIC

c. Dr Fiona McGregor, psychiatrist, Concord Hospital/CCMH

d. Dr Joanna Blades, psychiatric registrar, Concord Hospital/CCMH

e. Registered Nurse Rengie Adolfo, Concord Hospital/CCMH, accompanied IE when he was transferred

f. Registered Nurse Sina Lolomanaia, Nurse Unit Manager, Manning Unit, Concord Hospital/CCMH

g. Registered Nurse Nihiben Patel, Concord Hospital/CCMH

h. Dr Andrew McDonald, Clinical Director of Mental Health, Sydney Local Health District **(SLHD)**

i. Detective Sergeant Gareth Burton, NSWPF

j. Detective Inspector Ritchie Sim, Manager of the Missing Persons Register, NSWPF

FINDINGS

13. As will be seen, I have concluded that:

a. While the evidence was not conclusive, IE's most likely diagnosis was major depressive disorder which emerged in 2019.

b. The care and treatment provided by CCMH between 8 and 13 January 2021 was reasonable and appropriate including in respect to detaining him as an involuntary patient and his medication regime.

c. While it was appropriate to consider IE for transfer to Banks House, the process by which the transfer was attempted was inappropriate in the circumstances that follow.

i. There was no clinical assessment undertaken to determine if the transfer was appropriate. Given IE was transferred on the morning of his death from the high dependency unit to the acute unit, the psychiatrist that had treated and assessed him on the high dependency unit, Dr McGregor, should have been approached to undertake the assessment. Dr McGregor was available and would have undertaken the assessment if asked to do so.

ii. There was no discussion or consultation with IE or his mother (as his carer) in relation to the transfer. We know from his mother that IE did

not have confidence in Bankstown-Liverpool Hospital because of his prior attendances there. This should have been explored with him prior to the decision to transfer being made. Failing to consult IE in this way undermined his autonomy and failed to recognise his individuality. The care given to IE was substandard and failed to meet community expectations as to dignity of care.

iii. There was no risk assessment undertaken to inform the mode and method of transport in circumstances where IE was an involuntary patient at risk of self-harm.

d. The approach by Adolfo and Morgan to first try and locate IE before calling the NSWPF or the hospital was appropriate. The evidence indicates they looked for him for about 15 minutes before the CCMH was called. Then, within 15 minutes of the CCMH being notified, a call was placed to the NSWPF.

e. I find that the process of notifying the NSWPF and the information provided to them at first instance was inappropriate and inadequate in that:

i. The NSW Health - NSWPF Memorandum of Understanding 2018 **(MOU)** was not complied with in that: the Police Duty Officer or delegate at the Police Station nearest to the hospital was not called; as there had been no risk assessment undertaken, the request for NSWPF assistance could not be based on the risk IE posed to himself or the community; the Absconded Patient Form was not provided to the NSWPF until hours later; and, there was no discussion between Concord Hospital or the CCMH as to the role of each agency in the search for IE.

ii. There was an inappropriate emphasis on the 'theft' of Adolfo's phone. IE was a patient who had self-presented with suicidal ideation, and he had been deemed to be so unwell that he was deprived of his liberty and admitted to the CCMH involuntarily. The primary concern of his medical team and the NSWPF should have been on his safe return.

iii. The seriousness of the situation or the need for an urgent response given IE's risk of self-harm was not conveyed to the NSWPF.

iv. While inadequacies in the initial notification could be explained by the need to notify promptly and then gather more information, there was no follow up with the NSWPF when Adolfo and Morgan returned to the

CCMH to provide further information. The next contact with the NSWPF occurred more than 2 hours later and, as we now know, after IE had died.

f. The response of NSWPF was reasonable having regard to the information provided to them by the CCMH in the initial call.

g. As acknowledged by the NSWPF, when JE attended at Burwood Police Station, a missing person's report ought to have been taken by them and he should not have been sent to Auburn Police Station.

h. I am satisfied on the balance of probabilities that IE died from intentional self-harm in jumping of the cliff.[1]

BACKGROUND

14. I am grateful for submissions by counsel assisting from which I have drawn directly at times in relation to non-contentious issues.

Treatment sought 2020-2021

15. IE's family reported no prior mental health issues before his obvious decline in 2019. This was evidenced through being fussy about meals, appearing depressed and short tempered and later developing conspiracy theories about COVID-19.

16. He travelled to Europe in October 2019 and on his return his behaviour was different. He was using cannabis and expressed frustration with family members.

17. His deteriorating mental health continued in 2020 when he stopped being able to play soccer and ceased his studies.

18. On 11 September 2020, IE presented to Dr Sivaranjan with anxiety. He was referred to a psychologist.

19. On 1 October 2020 he was reviewed by Dr Prasad and reported that he was seeing a psychologist.

20. On 14 November 2020, IE presented to Concord Hospital Emergency Department **(ED)** with chest pains and anxiety. He told staff he had consumed mushrooms (psilocybin) and a marijuana brownie a week prior. He reported chronic feelings of depression and "social anxiety." He denied suicidal ideation. He was reassured about his chest pain. He was discharged for GP follow up, as he already had a mental health care plan and advised to see his psychologist.

[1] *Briginshaw v Briginshaw* 60 GLR 336.

21. In November and December 2020, IE attended a few different GPs and was prescribed an antidepressant, sertraline, as well as Circadin (melatonin) for sleep.

22. On 16 December 2020, IE presented to Bankstown-Lidcombe Hospital ED with anxiety and depression. He reported passive thoughts about suicide. He was discharged with a recommendation that his GP commence an antidepressant and advised to see a psychologist.

23. On 22 December 2020, IE attended Bankstown-Lidcombe Hospital ED, with symptoms of anxiety. He was reviewed by a Clinical Nurse Specialist. He described a range of symptoms including weight loss. He had passive suicidal ideation (thinking about driving into a pole or jumping in front of a train). He was given temazepam and was discharged with a referral to the community mental health team.

24. The next day, 23 December 2020, IE attended Bankstown-Lidcombe Hospital ED again. He was then assessed by Dr Chris Lindall (psychiatry registrar). IE reported symptoms of anxiety and depression, weight loss, racing thoughts, poor sleep and said he was having suicidal ideation. He believed taking mushrooms 6 weeks prior was the cause of his symptoms. Dr Lindall also spoke with his mother. At that stage she did not have acute concerns for his safety. Dr Lindall did not identify symptoms of psychosis or mania and he did not consider IE required admission. The plan was for IE to be followed up in the community.

25. Four days later, on 27 December 2020, IE's mother became more concerned about IE. He told her he had been let down by Bankstown-Liverpool Hospital, and so she took him to Liverpool Hospital instead.

26. IE was reviewed at Liverpool Hospital by Dr Janet Berry (psychiatric registrar). He reported suicidal ideation, poor sleep, appetite, and depressed mood. He said his antidepressant had not made much difference. He had a mental health clinic appointment for 6 January 2021, but he did not think he could wait that long. The psychiatrist considered IE should be admitted on a voluntary basis and commenced on olanzapine and lorazepam. However, there were no beds available in Liverpool Hospital, and so he was transferred to Campbelltown Hospital instead.

27. Notably, IE was transported between the two hospitals in a patient transport vehicle, described as a large van, with one nurse and a driver. Those were similar arrangements to the transport between the CCMH and Banks House on the day of his death.

28. IE was admitted to the Birunji Unit (a youth mental health unit) at Campbelltown Hospital on 28 December 2020.

29. During the admission, the treating team had a working diagnosis of depression and anxiety, with a differential diagnosis of obsessive-compulsive disorder (OCD). The team commenced IE on a different antidepressant, venlafaxine (Effexor-XR) and olanzapine (Zyprexa) (an antipsychotic, also used for sleep and appetite).

30. IE was reviewed on 4 January 2021 by Dr Adnan Younus (psychiatrist). IE denied thoughts of self-harm and there were no signs of formal mood or thought disorder or psychotic symptoms. The team spoke with his mother. The plan was that IE would be discharged, to engage psychology and psychiatry in the community, with a referral to the community mental health team.

31. Over the following days, IE told his family he was having suicidal thoughts.

32. On 6 January 2021, his mother took him to Bankstown Medical Centre to have blood tests. These did not proceed, but he made an appointment with a psychologist for the following week.

33. On the evening of 6 January 2021, IE had a session with a hypnotherapist at home. He wasn't able to focus.

34. In the morning of 8 January 2021, IE went missing from the home. He drove to the cliffs at La Perouse, where he thought about suicide. However, he returned home and told his parents where he had been. He told them he *"wasn't going to come back':*

35. The family were concerned, and they took him to the St John of God Hospital in Burwood, a private mental health facility. However, IE could not be accepted there, because he did not have a referral.

IE's admission to CCMH

36. At around 2pm on 8 January 2021, IE presented to the ED at Concord Hospital. He was reviewed by Dr Jeff Wang, who organised a review by the mental health team.

37. Dr Blades reviewed IE while still in the ED. IE reported having gone to La Perouse, planning to jump. He told her he did not feel safe to go home, but also did not want to be in hospital. He told her he had concealed his suicidal ideation to obtain discharge from Campbelltown. Dr Blades felt IE was unable to engage in safe discharge planning, and therefore considered he was appropriate for involuntary admission under the MHA. She prepared a schedule in Form 1. She considered IE suitable for admission to the Manning Unit (Acute Unit), but she also recorded, "if [he] attempts to abscond will need to go to HOU [High Dependency Unit]".

38. IE was then taken in a patient transport van with two security guards to the CCMH. While he was at the Admissions Office, he made an attempt to leave, pressing the exit button and walking out the door before security walked him back.

39. IE was reviewed by another doctor, and, because he was agitated and irritable, a decision was made to admit him to the High Dependency Unit, which is known as McKay West or the McKay Unit.

40. IE remained in the McKay Unit until 13 January 2021. He was initially anxious, but he settled into the ward. He generally kept a low profile, his mood was low, and his affect was flat, but he did interact with other peers and engage in some activities.

41. On 11 January 2021, IE was reviewed by Dr Fiona McGregor. This was the last review by a psychiatrist prior to his death, although her registrar saw IE the following day. IE was polite, articulate and forthcoming. He said he had been feeling anxious and had intrusive negative thoughts for a few months. He complained of other symptoms, including weight loss and insomnia. He said there had been some improvement since his admission to the Birunji Unit, but he felt overwhelmed. There was no evidence of psychosis, thought disorder or perceptual disturbance. He wanted to be discharged, saying he did not feel he could recover on the ward. Dr McGregor felt he was suffering from a major depressive episode with anxious distress and was at ongoing risk of suicide. However, she agreed that transfer to the Manning Unit would be of benefit. She continued the Form 1 schedule at that time.

42. In the afternoon of 12 January 2021, Dr McGregor made contact with Emma Searchfield, the Demand Management Team Nursing Manager, whose role is to manage bed availability. Dr McGregor noted that IE was cleared to be transferred to the Manning Unit.

43. The next morning, 13 January 2021, a bed became available in the Manning Unit. Searchfield contacted the nurse unit manager at McKay Unit to indicate that IE could be transferred.

44. IE's mother called the hospital that morning. She wanted to speak to IE, who had not returned her call from the day before. She was told IE was going to move to a different ward.

45. At about 11am, IE was told of the plan to move units. He was agreeable to this. Patel walked him over to the Manning Unit. There was then a nursing handover between Patel and Adolfo, the nurse from the Manning Unit who was to be allocated his care. Adolfo began to orient IE in the new ward.

46. Shortly after IE arrived at the Manning Unit, a bed became available at Banks House, in Bankstown-Lidcombe Hospital. That is the hospital whose catchment area included IE's home address. In his evidence, Dr McDonald explained that generally, patients are transferred to the hospital closest to their home address as it makes it easier to connect them with services in their community on discharge. That said, Dr McGregor indicated that such transfers do not always occur as it is often that a patient can be discharged prior to a bed becoming available. In fact, IE had been logged on the NSW Health Consumer Flow Portal, in anticipation of a move to Banks House, on 9 January 2021.

47. Searchfield received a call from Patient Flow for the Bankstown area to advise her of the bed at Banks House. In turn, she contacted Lolomanaia. Searchfield asked for a medical team from the Manning Unit to assess IE, to determine whether he was suitable for transfer. No such assessment ever took place.

48. Lolomanaia called the psychiatric registrar's office for the unit. She did not recall who she spoke to. She noted that IE was to be transferred to Banks House that day, although he had not yet been allocated to a medical team. She asked for a transfer form, called a 'Transfer of Involuntary Patient Between Mental Health Facilities' form **(Transfer Form),** to be completed.

49. Dr Blades had seen IE on the ward. She recognised him from the day of his admission. She was asked to complete the Transfer Form. Dr Blades understood that IE had been accepted at Banks House, and that his family was aware of the transfer. She understood the only thing outstanding was to complete the form, and she did so.

50. Dr Blades was not asked to review IE to determine whether he was suitable for transfer and did not review him for suitability for transfer. She merely completed the form.

51. Lolomanaia telephoned IE's mother at around 12.24pm. She told IE's mother that IE was being transferred to Banks House. IE's mother asked to speak to a Doctor and was told she would need to speak to a Doctor at Banks House. In her statement, she described Lolomanaia as sounding 'frantic.'

52. Around the same time, IE was also told about the plan to be moved to Banks House by Adolfo. He said he was okay with the plan. However, given he had previously expressed to his mother that he felt 'let down' by Bankstown-Liverpool Hospital, it is possible that if a thorough assessment of his suitability for transport had been performed, he may have expressed reservations he held. Similarly, if his mother had been able to speak to the Doctor assessing him, she may have been able to express reservations. It does not appear that either IE or his mother were consulted about the transfer - they were merely told it was to happen.

53. Significantly, Dr McGregor who had most recently reviewed IE, was not consulted in relation to this move, despite her being available and on duty that day. Understandably, at the inquest Dr McGregor could not say whether she would have agreed to transfer IE. She said she would have spoken with IE or recommend that someone - a member of the medical team - talk to him and seek his opinion about the plan. She also would have offered to hand over to his Banks House treatment team. She was unable to do any of this as she was not contacted despite being in the hospital with a phone all day.

54. IE was not reviewed by any doctor for suitability for transfer.

55. Subsequently, Searchfield called the Manning Unit again. She says Lolomanaia told her the treating team was happy for IE to be transferred to Banks House.

IE absconding

56. At 12.35pm, IE was escorted from the CCMH by Adolfo and Morgan.

57. The patient transport vehicle was a Toyota Hiace van.

58. In relation to the use of child safety locks, Dr McDonald said that they have a fleet of vehicles, some vans, and some sedans. The sedans have child locks fitted but he did not 'think' the vans had child locks fitted. This is consistent with the SLHD Policy Directive for Transporting and Transferring Consumers. Clause 7 deals with 'Procedures for Escorting Consumers in MHS Vehicles'. Clause 7.1 relating to cars, requires the escort to ensure that child safety locks are in use. By comparison, clause 7.2 in relation to the 'MHS Bus' does not.

59. Dr McDonald indicated that at the time of the inquest, when transporting patients within a vehicle fitted with child locks, the practice was to activate the child lock on the patient's side of the vehicle to prevent them from exiting the vehicle. However, the door on the carer/accompanying nurse side of the vehicle, would not. This is to ensure the carer/accompanying nurse is able to exit the vehicle if necessary.

60. IE was placed in a rear seat, on the passenger side, with Adolfo in the row in front and to his right, in a seat directly behind the driver. Presumably because he was in the van and not a sedan, no child lock was activated to prevent him from exiting the vehicle.

61. A couple of minutes after they left Concord, IE asked if they had all his property. He asked about his phone and a grey backpack. Adolfo gave him his phone but did not know about the backpack. Adolfo had 'checked in' IE's property when he arrived at the Manning Unit, and she did not think he had a backpack with him. We now know that the backpack had not been transferred from the Mackay Unit to the Manning Unit.

62. At about 12.40pm, Adolfo made a call on her personal mobile to Lolomanaia, to ask about IE's backpack. She put the call on loudspeaker so IE could hear. Lolomanaia had no knowledge of the backpack, so the call was put through to Registered Nurse Ferrera (CCMH) in the McKay Unit. Ferrera also did not know about the backpack. She asked for a description of the bag.

63. At this point, IE told Adolfo that he could not hear the call. He asked to hold the phone, which she allowed him to do. The driver had by then pulled the vehicle over to the side of the road, off Homebush Bay Drive, opposite near to the Homebush DFO.

64. About 20 seconds or so later, IE opened the rear van passenger door and stepped out. He then ran off towards the DFO. Adolfo and Morgan called after him and tried to follow, but lost sight of him.

Absconding patients: the legislative and policy background

65. The procedures for dealing with involuntary patients absconding, at a high level, includes Division 4 of the MHA and the MOU (between the NSWPF and NSW Health).

66. Division 4 provides:

> *Division 4 Leave of* absence from *mental health facilities*
>
> ***46 Application of Division***
>
> *This Division applies to an involuntary patient or a person who is detained in* a *mental health facility under this Act.*
>
> ***48 Apprehension of persons not permitted to be absent from mental health facility***
>
> *(1) An authorised medical officer of* a *mental health facility may apprehend a person, or direct* a *person to be apprehended, if-*
>
> *(a) the person fails to return to the facility on or before the expiry of a permitted period of absence granted under this Part or fails to comply with* a *condition of the permission, or*
>
> *(b) the person absents himself or herself from the facility otherwise than in accordance with this Act.*
>
> *(2) The person may be apprehended by any of the following persons-*
>
> *(a) an authorised medical officer or any other suitably qualified person employed at the mental health facility,*
>
> *(b)* a *police officer,*
>
> *(c) a person authorised by the Minister or the authorised medical officer,*
>
> *(d)* a *person assisting* a *person referred to in paragraph (a), (b) or (c).*

(3) A person who is apprehended is to be conveyed to and detained in the mental health facility from which the person absented himself or herself (whether directly or indirectly by way of another mental health facility).

49 Police assistance

(1) An authorised medical officer may request that a *police officer apprehend, or assist in apprehending,* a *person under this Division if the officer is of the opinion that there are serious concerns relating to the safety of the person or other persons if the person is taken to* a *mental health facility without the assistance of* a *police officer.*

(2) A police officer to whose notice any such request is brought may-

(a) apprehend and take or assist in taking the person to the mental health facility from which the person absented himself or herself, or

(b) cause or make arrangements for some other police officer to do so.

(3) A police officer may enter premises to apprehend a *person under this section or section 48, and may apprehend any such person, without* a *warrant and may exercise any powers conferred under section 81 on* a *person who is authorised under that section to take* a *person to* a *mental health facility or another health facility.*

67. The MOU relevantly provides:

Interagency response to absconding patients

Patients who abscond from care may represent significant risk to themselves or others. Hospital staff will complete a *risk assessment of the person and the hospital's subsequent actions will be guided by that risk assessment.*

If the risk is deemed to require an immediate police response, the hospital is to phone the Police Duty Officer or delegate at the Police Station nearest to the hospital. A request for police assistance is based on the risk the person poses and not solely on their legal status [ie whether they are a voluntary or involuntary patient]. *However, as the legal status of the patient may affect the response, police must be informed of the patient's legal status. The hospital is to send the Absconded Patient Form to the Police station by fax or email as agreed. The Police Duty Officer is authorised to allocate resources to assist to locate the person.* ***A*** *discussion will occur between the hospital and police regarding the role of each agency and any need for other agency involvement, in searching for the person. When involving the police, the hospital should:*

- *Provide the most recent risk assessment conducted on the person....*

The hospital remains the lead agency in locating and returning the patient, with police, or others, providing assistance ...

Health staff are to maintain ongoing liaison and communication with police throughout the process of searching for the absconded or missing person ...

68. As will be seen, the MOU was not complied with.

Events following IE absconding

69. Adolfo and Morgan searched for IE for a period. A call was then made back to the hospital on Morgan's phone. It is unclear at this stage how long they searched before making the

call, as Lolomanaia recorded that the call was received at 1.07pm, which was about 25 minutes after they had left the hospital.

70. Adolfo explained what had happened, before she and Morgan returned to the hospital to provide further details.

71. At 1.16pm, Lolomanaia called police. She did not call 000, instead calling local police at Strathfield, which she believed was the closest station to where IE had absconded. The call was diverted to Auburn, which is the nearest 24-hour station.

72. Senior Constable Shayne Valentine, NSWPF (Auburn), answered the call. She was working station duties that day. SC Valentine said she would create a job for police officers from Burwood Police Station to attend Concord Hospital. However, while she did create a CAD[2] message, she did not specifically ask officers to go to the hospital.

73. At 1.30pm, she created a CAD message with a priority 3 (being non-urgent) and description "Missing Person/ Stealing / Keep Lookout 4". The message said:

> *POI ...[IE] HAS ABSCONDED FROM HEALTH WORKERS WHILE BEING TRANSFERRED FROM CONCORD TO BANKSTOWN. POI REQUESTED HEALTH WORKERS PULL OVER, EXITED THE VEH AND RAN AWAY AFTER STEALING HEALTH WORKERS PERSONAL MOBILE PHONE. POI IS UNDER A SCHEDULE AND NEEDS TO BE RETRUNED TO HOSP. POI MALE WEARING GREY HOODIE AND DARK TRACK/ES . TO BE BROADCAST ON SURROUNDING CHANNELS . POI NOK MARY 042171176.*

74. The incident was sent to Burwood Police Station and was broadcast at 1.33pm, and several times after that. However, it was not acknowledged by any police unit at Burwood Police Station that afternoon.

75. Lolomanaia completed the Absconding Patient Form at 1.45pm, about an hour after IE went missing. However, she did not fax it to police, instead sending it to the Admissions Office at the hospital. She says she also called the Admissions Office and asked a colleague to take a physical copy of the form there, with instructions to send it on to police. However, the form was not sent to police until 5.50pm that afternoon, over 4 hours later.

76. At 1.22pm, Lolomanaia called IE's mother, to inform her that IE was missing. She was understandably distressed. She contacted her other sons, and the family commenced looking for IE.

77. At 1.25pm, IE's brother, JE, called the CCMH. He wanted a description of what IE was wearing, and also wanted to speak to Adolfo to see if her phone could be traced. IE's

[2] Computer aided dispatch.

other brother, ME, also called Concord Hospital, but was told to speak to his other family members to get details about the incident.

78. At 1.52pm, JE called 000. He provided a description of IE to the operator.

79. A CAD message about that call was prepared, with a priority 3 and a description "concern 4 welfare, keep lookout 4". Because it related to the same incident, it was "merged" with the report from Lolomanaia. It did not result in any additional response from police.

80. The family began to search at different locations, attending Homebush DFO, Rookwood Cemetery and La Perouse, among other places. They also accessed IE's computer and what was believed to be his last known location with his phone via Google Maps.

81. At about 4.30pm, JE went to Auburn Police Station. He was told that a missing person report had not been made, and that he needed to go to Burwood Police Station to make the report. In his evidence at the inquest, DI Sim confirmed that JE should not have been sent to Burwood Police Station. A missing person's report can be made at any police station. DI Sim apologised to JE on the basis that he should never have been sent to Burwood Police Station.

82. JE attended Burwood police station at 4.52pm and provided a missing person report to SC McRitchie. SC McRitchie discovered that the hospital had not yet followed the formal process to report IE absconding. He phoned the hospital at 5.40pm, asking about the Absconded Patient Form. At 5.50pm, the form was faxed to Burwood Police Station. That was over 4 hours after IE had absconded.

83. SC McRitchie took the actions that follow.

    a. At 6.02pm, he created a further CAD message. This had a priority 3 rating and the description "Missing person". It asked police to attend Mason Park, which is near to the Homebush DFO. The family had informed police that Mason Park was the last location IE had been visible on Google Maps.

    b. At 6.22pm, he created a further CAD message, asking police from Bankstown and Eastern Beaches to attend locations where IE may have gone.

    c. He completed a Missing Person COPS Event, including a risk assessment. The risk assessment was finalised the following day when it confirmed IE was High Risk.

84. Finally, at about 9.30pm, the family had seen an email receipt from Uber on IE's computer. It showed a trip from Homebush to La Perouse, but the total was only for $14 and a 3.5km trip, which did not appear correct. They checked locations within that distance from

Homebush, and formed the view that IE may have gone to Rhodes. They informed police about this, and a further CAD message was created, asking police to return there.

IE's movements after he absconded

85. The evidence shows that IE died at about 3.15pm on the afternoon of 13 January 2021, about 2.5 hours after he absconded.

86. IE had absconded near Homebush DFO at or around 12.45pm. Shortly afterwards, he booked an Uber to collect him from the intersection of Underwood Road and Cartwright Avenue (not far from DFO), to be taken to the cliffs at La Perouse.

87. At 12.53pm, IE entered an Uber at the intersection of Wentworth Road South and Bellona Avenue (a couple of streets away). This is within a kilometre of the place where he had absconded.

88. IE did not go to La Perouse. He was taken to Tavistock and Homsey Road, Homebush, near to Rookwood Cemetery. At that point, he told the driver he felt sick, and got out.

89. IE's precise movements from that point are unknown. It is likely that he went to Flemington Train Station, which is nearby, and travelled to Wynyard, and then took a B-line bus to Dee Why. That journey would take about 1 hour 45 minutes (ie to at least 2.30pm.

90. At 3.15pm, two members of the public, Ben Garness and Skyla Boer, were walking along the bush track from Dee Why to North Curl Curl. That is a 1.6km track running near to the ocean cliff edge. As they were walking, a man (we now know to be IE) approached them from the bush at the cliff side of the track. He said, "Call the police, I can't deal with this anymore." He also provided a note, which stated:

> *This world, my family and God gave me everything.*
>
> *I just couldn't escape my mind! Call 000.*
>
> *[IE]*

91. IE then turned back towards the cliff. Garness followed him, but IE warned him to get back. Garness called 000. Garness observed IE jump from the cliff onto the rocks below, a height of 20-30 metres.

92. An incident was broadcast to police at Dee Why and members of the NSWPF and NSW Ambulance Paramedics attended. It was apparent that IE was deceased. Police rescue and PolAir were deployed at about 4.20pm to retrieve IE's body.

93. IE's death was verified by Tom Buckle, Paramedic, at approximately 4.30pm on 13 January 2021.

94. IE was initially identified via a tattoo on his body relating to his brother's death. This enabled his family to be notified that he had been found deceased.

95. IE was formally identified via his dental records by Dr Alain Middleton AO on 18 January 2021.

AUTOPSY

96. An external autopsy examination of IE was performed on 19 January 2021 by Dr Irvine. In her report dated 3 November 2021, Dr Irvine opined that IE's cause of death was multiple blunt force injuries. His toxicology analysis revealed no alcohol or illicit drugs. The presence of prescription medications was consistent with those prescribed to him in the context of his admission to the CCMH.

97. The evidence supports a finding that IE's cause of death was multiple blunt force injuries

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ISSUES

What was the nature and duration of IE's mental health condition, including any diagnosis.

98. Dr Ellis considered that IE's most likely diagnosis was major depressive disorder which emerged in 2019, an occurrence which is apparently not uncommon.

99. While IE admitted to substance use, this post dated the onset of his mental health condition such that it was more than likely a form of self medication.

100. It was possible that IE had a more serious condition (bipolar affective disorder or depression with psychosis) but it was difficult to be certain. In part, this was because IE was prescribed an antidepressant (venlafaxine) and antipsychotic/mood stabiliser (olanzapine) at an early stage. This may have masked his symptoms.

101. Dr Ellis did not identify evidence of anxiety disorder, obsessional compulsive disorder, or personality disorder. It was most unlikely he had a personality disorder, given he was known to be affable, likeable, and well-balanced before his deterioration.

Findings

102. While the evidence was not conclusive, IE's most likely diagnosis was major depressive disorder which emerged in 2019.

Was the care and treatment provided to IE during his admission to Concord Hospital from 8 - 13 January 2021 reasonable and appropriate?

Was it appropriate to detain IE on an involuntary basis?

103. IE was detained pursuant toss 12 and 14 of the MHA which provides:

12 General restrictions on detention of persons

(1) A patient or other person must not be involuntarily admitted to, or detained in or continue to be detained in, a *mental health facility unless an authorised medical officer is of the opinion that--*

(a) the person is a *mentally ill person or* a *mentally disordered person, and*

(b) no other care of a *Jess restrictive kind, that is consistent with safe and effective care, is appropriate and reasonably available to the person.*

(2) If an authorised medical officer is not of that opinion about a *patient or other person at* a *mental health facility, the officer must refuse to detain, and must not continue to detain, the person.*

(3) An authorised medical officer may, immediately on discharging a *patient or person who has been detained in* a *mental health facility, admit that person as* a *voluntary patient.*

14 Mentally ill persons

(1) A person is a *mentally ill person if the person is suffering from mental illness and, owing to that illness, there are reasonable grounds for believing that care, treatment or control of the person is necessary--*

(a) for the person's own protection from serious harm, or

(b) for the protection of others from serious harm.

(2) In considering whether a *person is* a *mentally ill person, the continuing condition of the person, including any likely deterioration in the person's condition and the likely effects of any such deterioration, are to be taken into account.*

104. On her initial triage assessment, Dr Blades noted that IE didn't want to come into hospital though he acknowledged that he posed a risk to himself. She considered that IE was not able to engage in safe discharge planning and therefore she considered it was appropriate that he be admitted on an involuntary basis pursuant to ss 12 and 14 of the MHA.

105. On 11 January 2021, Dr McGregor considered IE was still at sufficient risk to warrant his involuntary admission to be continued.

106. Having considered the available medical and other evidence, Dr Ellis opined that IE presented with significant mood disturbance and suicidal ideation. It was appropriate that he be detained in that he met the legal test for detention, and it was the most appropriate way to manage him clinically.

Was IE prescribed appropriate medications, at an appropriate dose?

107. Dr Ellis confirmed that venlafaxine was an appropriate antidepressant, and the available evidence did not show it increases suicide risk. While it is possible it increased his agitation, he was also receiving a mood stabiliser (olanzapine).

108. His medication regime was appropriate.

Findings

109. The care and treatment provided by CCMH between 8 and 13 January 2021 was reasonable and appropriate including in respect to detaining him as an involuntary patient and his medication regime.

Was the decision to transfer IE to Banks House on 13 January 2021 reasonable and appropriate?

110. The concept that IE would be transferred to Banks House was not inappropriate.

111. It is the usual practice of SLHD to transfer patients to the hospital closest to their home when a bed becomes available. Doing this enables the hospital to connect the patient with appropriate services in and around their home and it makes it easier for visiting family and friends. However, these perceived benefits should not be given undue weight particularly in respect of patients with precarious mental health issues. In IE's case, there was no regard given to his individual circumstances and a failure to comply with basic procedural steps as detailed below.

Was there an adequate risk assessment?

112. There was no risk assessment undertaken prior to IE leaving CCMH for the purpose of transfer to Banks House.

113. In her statement, Searchfield said that having been advised that a bed was available at Banks House, she called Lolomanaia and:

> *...requested that she get the treating medical team to assess and determine whether [IE] was suitable to be transferred to Banks House and that [I] requested [IE] be assessed by the treating team before any transfer occurred. Ms Lolomanaia replied, 'Which treating team'. I replied with words to the effect of the accepting treating team in the Manning Unit, as [IE] was in the Manning Unit at the time. I also gave Ms Lolomanaia the telephone number to Banks House so that a handover could be provided prior to any transfer.*

> *I rang Sina Lolomanaia again shortly after our first telephone ca/1... She also advised me that she had transport booked for [IE]'s transfer to Banks House. I asked Ms Lolomanaia whether the treating medical team was happy for [IE] to be transferred to Bankstown. Ms Lolomanaia replied and indicated yes, the treating team were happy for [IE] to be transferred to Banks House. I replied with words to the effect that a treating team doctor needed to review [IE] prior to any transfer to assess and determine what was required in relation to the transfer.*

114. It must be borne in mind that Searchfield was not subject to cross examination and her statement was dated 20 September 2024, more than 3 years after IE's death.

115. That said, Lolomanaia's recollection in her own statement largely accords. She agrees that Searchfield told her that IE would need to be 'reviewed by the team.' She asked which team and was told Manning Unit. Lolomanaia says:

> Ms *Searchfield confirmed that she meant for* a *member of the Manning Unit to* assess *[/E]'s suitability for transfer to Banks House.*

116. In her statement she goes on to say that she called the psychiatric registrar, which may have been Dr Blades, and asked that one of them see IE to complete the paperwork and confirm that the transfer to Banks House could proceed. However, in evidence she said that she indicated to the Registrar that IE would need to be assessed to determine if it was appropriate to transfer. On further examination, she conceded that her statement would better reflect her memory of the day. She asserted that for the Transfer Form to be completed an assessment would have to take place. That is clearly not required on the face of the Transfer Form. Lolomanaia ultimately conceded that the only message conveyed to the psychiatric registrar that she spoke to on the phone (whether it was Dr Blades or not) and to Dr Blades at the nursing station, was to the effect that the only thing they needed to do was complete the Transfer Form. She went on to say that her assumption as a NUM is that when she is asking the medical team to complete the Transfer Form, they will make their own assessment as well.

117. In her evidence Lolomanaia acknowledges that the substance of the conversation with Searchfield was 'For [IE] to be seen by our, the team on Manning and for an assessment to take place before the transfer could be approved.'

118. Overall, I found the evidence of Lolomanaia to be problematic. She moved from being unable to remember things to providing details of conversations which, in that context, appeared to be reconstructed. I found her manner of giving evidence was indirect and at times avoidant.

119. Dr Blades says that on entering the nurses' station that morning she was advised that IE was to be transferred to Banks House and that the only thing to be completed was the Transfer Form. She says she was not asked to undertake an assessment. The Transfer Form itself doesn't refer to an assessment, it only refers to reasonable efforts being made to notify the carer of the transfer.

120. In this case, because IE had only been transferred to the Manning Unit less than 2 hours prior, he had not yet been allocated a treating team.

121. Contrary to what Searchfield indicated to Lolomanaia, given Dr McGregor had last assessed IE and been responsible for his treatment, she should have been asked to assess IE in respect of his suitability for transport. On her evidence, she was in the

hospital and would have been able to do it. She did not give an opinion as to whether she would have assessed him as suitable, her evidence was that she would have discussed the proposition with him. No one asked IE what he wanted. No one considered what was appropriate in terms of his treatment in circumstances where he considered his previous experiences with Bankstown-Liverpool Hospital were, in his mind, lacking. Similarly, his mother was told of the transfer, she was not consulted or given an opportunity to express her views or to the extent she was aware of them, to express IE's views.

122. Lolomanaia said in evidence that it was a particularly busy day - this is consistent with IE's mother describing her as 'frantic' on the phone. In the course of this busy day, patient care was lacking. IE's transfer was authorised as a matter of practicality and 'box ticking' without any reference to his clinical needs. There was also no regard to any specific needs he may have had in respect of the actual transfer. He was not assessed as to his risk of absconding for example.

123. The evidence is unequivocal, while Searchfield made it clear in her telephone calls to Lolomanaia that prior to being transported, IE must be assessed by his medical team, there was no clinical review or risk assessment.

124. In addition, there was no consultation with IE or his mother as his carer-they were simply told that he was to be transferred. In doing so, IE's dignity was undermined in that there was no recognition of his right to autonomy or his individual needs. The care provided to IE was substandard and not consistent with community expectations as to dignity in care.

Was it adequate to transfer IE with one nurse and a driver and should the vehicle have activated child locks?

125. Given the decision to transfer was not discussed with IE, he was merely told, it is not apparent how he felt about it. If appropriately obtained, his state of mind and views on the transfer would have, to my mind, significantly impacted any risk assessment including an assessment as to what safety measures ought to be in place.

126. Based on Dr McDonald's evidence, child safety locks could have been applied if a sedan rather than a van was used for transport.

127. On the available evidence I am unable to reconstruct what an appropriate risk assessment would have indicated in respect of safety measures.

Findings

128. While it was appropriate to consider IE for transfer to Banks House, the process by which the transfer was attempted was inappropriate in the circumstances that follow.

a. There was no clinical assessment undertaken to determine if the transfer was appropriate. Given IE was transferred on the morning of his death from the high dependency unit to the acute unit, the psychiatrist that had treated and assessed him on the high dependency unit, Dr McGregor, should have been approached to undertake the assessment. Dr McGregor was available and would have undertaken the assessment if asked to do so.

b. There was no discussion or consultation with IE or his mother (as his carer) in relation to the transfer. We know from his mother that IE did not have confidence in Bankstown-Liverpool Hospital because of his prior attendances there. This should have been explored with him prior to the decision to transfer being made. Failing to consult IE in this way undermined his autonomy and failed to recognise his individuality. The care given to IE was substandard and failed to meet community expectations as to dignity of care.

c. There was no risk assessment undertaken to inform the mode and method of transport in circumstances where IE was an involuntary patient at risk of self-harm.

Was information to the NSWPF about IE absconding provided promptly and was their response reasonable and appropriate?

The timing of the call to police

129. Based on the evidence adduced, the relevant sequence of events is understood as follows.

12.35pm	IE leaves the CCMH ward enroute to Banks House with Adolfo and Morgan.
12.45pm	IE absconds from the van and books an Uber to La Perouse.
	Adolfo and Morgan attempt to locate IE.
12.53pm	IE is picked up in an Uber at the intersection of Bellona Avenue and Wentworth Road North in Homebush. He is dropped off at the intersection of Tavistock and Homsey Road, Homebush West, about 3km away.
12.57 - 1.02pm	Ferrera made a progress note stating that she had received a call from Morgan indicating that IE had absconded.
1.07pm	Lolomanaia says she received a call from Adolfo from Morgan's phone advising her that IE has absconded. Adolfo does not recall that conversation but indicated it was possible.
1.16pm	Lolomanaia calls the Police and speaks to SC Valentine at Auburn Police station to report IE as having absconded.

130. Based on the above chronology, Police were called 31 minutes after IE absconded. However, IE had left the immediate area within approx. 8 minutes in an Uber. Even an immediate call to NSWPF would not have resulted in a response within that time frame.

131. The chronology suggests that there was about a 15 minute delay between IE absconding and Adolfo and Morgan contacting the hospital. It is not unreasonable for them to initially focus on trying to locate IE prior to contacting the hospital. Had they been successful they may have averted the crisis.

132. The timing of the call to the NSWPF is not unreasonable in the circumstances. Noting how quickly IE had left the area, even an immediate call by Morgan or Adolfo to the NSWPF is unlikely to have resulted in any steps being taken by the NSWPF prior to IE leaving the location.

The provision of information to police

133. Lolomanaia said she decided to call Strathfield Police Station, not because of any policy but because she learned the vehicle had stopped in that area. Importantly, she did not call 000. She understood she would call 000 if she felt there was a risk to the patient or public. As outlined above, Lolomanaia's evidence was problematic. In relation to this aspect, it was difficult to follow. It was unclear what she remembers saying to the NSWPF. She believed she gave a description of what he was wearing, and what direction he was last seen running. She accepted she was not great with directions, and said they pulled over at the DFO and he ran off towards the ramp. Her retrospective progress note contains information to that effect.

134. However, she accepted, when shown the CAD message, that it was possible she did not tell police about the precise location that IE had absconded. She made the point that normally police say what information they need to initiate the job.

135. Given the issues with the reliability of Lolomanaia's evidence generally, I consider the best record is the CAD message regarding the information conveyed in that first call. The CAD message stated:

> *Missing person/Stealing*
>
> *KL04 [IE] LS CONCORD HOSPITAL, HOSPITAL ROAD, CONCORD WEST, CANADA BAY (LGA), 2138,2138 BU*
>
> *POI [IE]... HAS ANSCONDED FROM HEALTH WORKERS WHILE BEING TRANSFERRED FROM CONCORD TO BANKSTOWN, POI REQUESTED HEALTH WORKERS PULL OVER, EXITED THE VEH AND RAN AWAY AFTER STEALING HEALTH WORKERS PERSONAL MOBILE PHONE. POI IS UNDER A SCHEDULE AND NEEDS TO BE RETURNED TO HOSPITAL. POI MALE WEARING GREY HOODIE AND DARK TRACK/ES ...*

136. Lolomanaia was told a job had been initiated. She did not make any further contact with police about the absconding, although did speak to an officer at 15:52pm about arranging statements to be taken, regarding the theft of Adolfo's phone. I find this somewhat disturbing. That there was a focus on the purported theft of a mobile phone rather than the safety of a patient that was so unwell he had been deprived of his liberty. The primary concern of his medical team and the NSWPF should have been on his safe return. The evidence suggests that there was no urgency conveyed in this initial report to the NSWPF.

137. At the time of the initial report to police, there is no evidence of a risk assessment to identify whether IE was at risk to himself (which he clearly was) or to the community. The information provided to the NSWPF does not appear to have included the fact that IE was at a significant risk of suicide.

Absconding Patient - Report to Police form

138. Lolomanaia said she commenced completing the report after receiving Adolfo's report. She would have completed the form while fielding calls.

139. She said her risk assessment on the form was based on a review of the notes and IE's initial presentation. Yet she described his risk of self-harm as "medium".

140. Her assessment of the risk of the situation was hard to follow. She said she ticked the box suggesting a 'prompt' police response because IE had absconded in an area where there was no safe access for pedestrians, and because it was an unusual occurrence for a patient to abscond. She only later accepted his status as an involuntary patient assessed to be at risk of harm to himself was relevant.

141. She also said that while she was on the phone with IE, he did not appear aggressive and as he had left his belongings behind, she considered he had limited resources. Those matters appear to lesson her view of the seriousness of the situation.

142. She accepted, in retrospect that asking for an immediate response would have been appropriate.

143. The risk assessment undertaken was underwhelming and inadequate. IE's involuntary admission was, amongst other things, in recognition of his risk of self-harm. This appears to have been ignored in the hospital's response to his absconding.

How the form was sent to police

144. Lolomanaia followed the CCMH's policy at the time which involved sending the form to the Admissions Office for it to be forwarded on to police. The rationale for this seems to be that the Admissions Office would be the single point of contact with external agencies.

145. She says she asked someone, a ward clerk or nurse, to fax the form to the Admissions Office, and then to take a photo to confirm it had been sent. She says she saw the photo but did not keep it. She also says she spoke to someone at the Admissions office, to explain the form was coming, and to ask them to contact her if it was not received. She never confirmed it had been received.

146. Dr McDonald explained that it was NSW Health policy to use fax as it is considered to be more secure than email.

147. Lolomanaia also believes either she or someone else physically took the form to the Admissions Office before she left for the day, about 5.30pm, 2 hours later than her shift ended. She accepted it was possible this was not done until shortly prior to her leaving.

148. There is no evidence the form was sent to police prior to 5.52pm, following McRitchie's call. As such, the form was not sent to police until over 4 hours after IE had absconded. That was an error and should not have happened. The form should have been sent to police promptly.

149. The CCMH response failed to comply with the MOU. As a consequence, neither Concord Hospital nor the NSWPF were actively pursuing IE's absconding as an urgent missing person's case in recognition of the risk of harm he posed to himself.

150. It was clear from her evidence that significant aspects of the MOU were unknown to Lolomanaia indicating a failure on the part of SLHD to ensure adequate training had been provided[3].

151. In this case, given that IE had left the vicinity within 8 minutes, and there was no information available which would have suggested that he was heading to Dee Why, it is unlikely that an appropriate notification to the NSWPF and an immediate response would have prevented IE's death. That said, it is significant that the procedures in the MOU were not adhered to as in different circumstances, compliance could be lifesaving.

Should IE have been identified as a missing person at the time of the first report, and prior to the report made by JE at about 4.52pm?

152. The response by the NSWPF must be considered within the context of the information provided to them by representatives of the CCMH outlined above.

153. At the time of the initial call, there had been no risk assessment and the NSWPF were not advised of IE's risk of self-harm at all prior to his death.

[3] Transcript 145 lines 20-24.

154. While it could be said that a patient absconding during a hospital transfer was an urgent matter, the institution best placed to identify that risk was the SLHD/CCMH. It is not unreasonable for the NSWPF to respond with the level of urgency that was conveyed to them.

155. There is no doubt that the initial action by SC Valentine could have been improved. Unfortunately, she was unable to give evidence. DI Sim and OS Burton each opined she ought to have specifically asked for police units to attend Concord Hospital to take a report. This may have commenced the process of a missing person report, and likely would have commenced action taken by SC McRitchie later that day.

156. However, it is clear that police were not advised about IE until 13:16, possibly up to 30mins after he had absconded. We now know he had likely already taken an Uber ride and been dropped near Flemington station.

157. Police were not advised of the precise location until 13:52 - over an hour after he absconded, and by which time IE was likely in the city or beyond.

158. DI Sim said there would be "no chance" of police detecting IE in those circumstances.

Should the incident have been escalated to a higher priority?

159. The incident should have been escalated to a higher priority and supervisors should have been alerted to the incident. It is not clear on the available evidence why no supervisor became aware of the report, or recalled becoming aware as they would usually be monitoring the radio.

160. The type of incident "keep a lookout 4" is usually not acknowledged by police, and is left on the system, so cars can remain aware. OS Burton's evidence was that he expected local units would have made themselves aware of IE's description and the nature of the incident, and would have maintained a lookout for him during the shift.

161. However, any failures in this regard need to be considered in the context of the report received by the NSWPF. For the reasons outlined, the initial report received by the NSWPF was wholly inadequate. It is difficult to criticise the NSWPF when they were acting on insufficient information.

Which NSWPF Area Command was required to respond to the reports?

162. Having considered the available evidence, I find that Auburn area command ought to have responded to the initial call from Lolomanaia and they also should have taken JE's initial missing persons report rather than directing him to Burwood Police Station.

Should there have been earlier attempts made by police to locate IE?

163. Again, this question needs to be answered in the context of what information was provided to the NSWPF and when. The NSWPF were not advised of IE's risk of self-harm, nor were they provided with the Absconded Patient Form in a timely manner. We heard evidence as to tools available to the NSWPF including triangulation of phones and the sending of text messages to all people within a particular area. However, given the brief window within which IE remained in the area, these tools would not of have yielded a result in this case. More information, such as the fact that he had caught an Uber, became known once his family accessed his email account. However, even then his ultimate destination was not known.

Findings

164. The approach by Adolfo and Morgan to first try and locate IE before calling the NSWPF or the hospital was appropriate. The evidence indicates they looked for him for about 15 minutes before the CCMH was called. Then, within 15 minutes of the CCMH being notified, a call was placed to the NSWPF.

165. I find that the process of notifying the NSWPF and the information provided to them at first instance was inappropriate and inadequate in that:

    a. The NSW Health - NSWPF MOU was not complied with in that: the Police Duty Officer or delegate at the Police Station nearest to the hospital was not called; as there had been no risk assessment undertaken, the request for NSWPF assistance could not be based on the risk IE posed to himself or the community; the Absconded Patient Form was not provided to the NSWPF until hours later; and, there was no discussion between Concord Hospital or the CCMH as to the role of each agency in the search for IE.

    b. There was an inappropriate emphasis on the 'theft' of Adolfo's phone. IE was a patient who had self-presented with suicidal ideation, and he had been deemed to be so unwell that he was deprived of his liberty and admitted to the CCMH involuntarily. The primary concern of his medical team and the NSWPF should have been on his safe return.

    c. The seriousness of the situation or the need for an urgent response given IE's risk of self-harm was not conveyed to the NSWPF.

166. While inadequacies in the initial notification could be explained by the need to notify promptly and then gather more information, there was no follow up with the NSWPF when Adolfo and Morgan returned to the CCMH to provide further information. The next contact

with the NSWPF occurred more than 2 hours later and, as we now know, after IE had died.

167. As acknowledged by the NSWPF, when JE attended at Burwood Police Station, a missing person's report ought to have been taken by them and he should not have been sent to Auburn Police Station.

168. The response by the NSWPF must be considered within the context of the information provided to them by representatives of the CCMH.

Statutory findings: Was IE's death intentionally self-inflicted?

169. The evidence must be sufficiently clear and cogent to allow for a conclusion to be reached in relation to intention. The evidentiary standard to be applied to a coronial finding of intentional taking of one's own life is the Briginshaw standard *(Briginshaw v Briginshaw* 60 GLR 336).

170. The evidence establishes on the balance of probabilities that IE died on 13 January 2021 from multiple blunt force injuries approx. 300m South of the Monash Avenue entrance into the Dee Why to North Curl Curl bush track, off Oaks Avenue, Dee Why NSW 2099.

171. I am satisfied on the balance of probabilities that IE died from intentional self-harm in jumping of the cliff. This conclusion is supported by, amongst other things:

a. the evidence of IE's mental health in the months leading up to his death including his expressions of suicidal ideation.

b. the evidence of Garness regarding his conversation with IE, the note IE gave him and IE's conduct on the cliff.

WAS THIS INQUEST MANDATORY PURSUANT TO SS 23(1)(C) AND 27(1)(B) OF THE ACT

172. Section 23 of the Act relevantly provides:

> *(1) A senior coroner has jurisdiction to hold an inquest concerning the death or suspected death of* a *person if it appears to the coroner that the person has died (or that there is reasonable cause to suspect that the person has died)-*
>
> *(c) as* a *result of police operations, or*
>
> *(2) In this section-*
>
> ***police operation*** *means any activity engaged in by* a *police officer while exercising the functions of police officer other than an activity for the purpose of* a *search and rescue operation.*

173. Section 27(1)(b) provides that an inquest is 'required' to be held if the jurisdiction to hold the inquest arises under s 23 of the Act.

174. Counsel Assisting submitted that the phrase 'as a result of' would include a situation where the police operation was not the sole or predominant cause, but one of the elements in the chain of events that leads to the death.

175. The NSWPF were notified by Lolomanaia at 1.16pm that IE was missing. A CAD message was created at 1.52pm stating, *"Concern 4 welfare, Contact Inft if required I Keep Lookout 4".* This message was broadcast to Burwood Police at 1.53pm. On the evidence, that alerted the Police that he was missing and required them to keep a look out for him. They were not actively searching for him. He was not identified as a missing person until after he had died - following receipt by the NSWPF of the Absconded Patient Form.

176. Pursuant to the MOU, Concord Hospital remained the 'lead agency' in locating and returning IE, police were providing assistance.

177. Having reviewed and considered the evidence, I find that the creation and broadcasting of the CAD message would satisfy the definition of a 'police operation'. However, I find that IE's death was not 'as a result of' NSWPF operations given:

    a. the inadequate information provided to the NSWPF in the initial call; and

    b. the fact that IE had left the immediate area in an Uber by 12.53pm, before the NSWPF were notified, and before they could have taken substantive steps to locate him even if they were given appropriate information in the 1.16pm call.

178. I find that the inquest was not mandatory pursuant toss 23(1)(c) and 27(1)(b) of the Act. Notwithstanding that, it was appropriately held in the circumstances of IE's death.

IS IT NECESSARY OR DESIRABLE TO MAKE ANY RECOMMENDATIONS IN RELATION TO ANY MATTER CONNECTED WITH THE DEATH?

179. In response to IE's death, policy changes have been made by the SLHD including:

    a. initially, all patient transfers were conducted by the NSWA while the transportation policy was revised

    b. the revised policy requires consideration by the medical team as to the risks of transfer with an increased emphasis on engaging with patients and preventing absconding rather than responding to it

    c. the type of transport used for patients is now determined by reference to a risk assessment with only low/medium risk transfers being undertaken by patient

transport vehicles and only then with authorisation by the Clinical Director, Mental Health Services

d. in the event of a patient absconding, the Absconding Patient Form is now faxed by the relevant person on the ward rather than via the Hospital Administration

e. an 'AWOL' huddle will take place in the event of a patient absconding - this will involve multiple staff engaging to determine the appropriate response.

180. In the evidence adduced at the inquest, an inconsistency was highlighted as between the MOU and the SLHD 'Consumers Absent Without Leave' Policy in that the latter did not require the staff member contacting their local Police Station to speak to the 'Duty Officer' when seeking assistance in relation to an absconding patient. DI Sim explained that from the NSWPF perspective, the importance of doing this is that the Duty Officer is responsible for resources and can commence a response. While Police could adopt their own escalation procedure, the MOU is the current agreed policy and should be adhered to or changed so that agencies within NSW Health and the NSWPF are acting consistently.

181. The MOU is a high level policy relevant to NSW as a whole. It provides the scaffolding within which the various health districts within NSW should be framing their local policies. The SLHD's failure to implement procedures that accord with the MOU resulted in IE not being promptly reported as a 'missing person.' It is not for the SLHD or Concord Hospital to determine its own unique response. In this case, various units within the NSWPF were engaged (ie, Auburn, Burwood and the first responders at Dee Why). This required a consistent institutional response.

182. Following the inquest, this inconsistency has been addressed by the SLHD and I re-opened the evidence phase to receive evidence to that effect from the SLHD. In particular, the SLHD Memo - Mental Health Services, dated 4 February 2025 and the amended policies referred within.

183. The SLHD has changed its 'Consumers Absent Without Leave' Policy to remove the inconsistency and the Policy now requires those seeking Police assistance to speak to the Duty Officer (or delegate).

184. In light of the changes adopted by the SLHD, it is not necessary for any recommendations to be made.

CONCLUDING REMARKS

185. I will close by conveying to IE's family and friends my sympathy for the devastating loss of IE.

186. I thank the Assisting team for their outstanding support in the conduct of this inquest.

187. I thank the officer in charge, Sgt Christian, for his work in conducting the investigation and compiling the brief of evidence.

FINDINGS REQUIRED BY S81(1)

188. As a result of considering all the documentary and the oral evidence heard at the inquest, I make the following findings:

Identity

The person who has died is IE.

Place of death

Approximately 300m South of the Monash Avenue entrance into the Dee Why to North Curl Curl bush track, off Oaks Avenue, Dee Why NSW 2099

Date of death

13 January 2021

Cause of death

Multiple blunt force injuries

Manner of death

Intentional self-harm by jumping off a cliff following absconding from a patient vehicle whilst detained as involuntary patient under the Mental Health Act 2007, travelling to Dee Why and jumping from a cliff.

Magistrate R Hosking
Deputy State Coroner
Lidcombe
17 February 2025