CORONERS COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of JSZ
Hearing dates:	9 and 10 September 2025
Date of findings:	20 October 2025
Place of findings:	Lidcombe Coroners Court
Findings of:	Deputy State Coroner, Magistrate Hosking
Catchwords:	Manner of death, assessing and identifying risk of self-harm and/or suicide during the unsupervised day leave of a forensic patient.
File number:	2023/304388
Representation:	Counsel Assisting the Inquest: Meg O'Brien of Counsel instructed by Francesca Lilly of the Crown Solicitor's Office Family of JSZ: Sarah Love of Counsel instructed by Sheeza Naz of Legal Aid Western Sydney Local Health District (**WSLHD**): Patrick Rooney of Counsel instructed by Danielle Ashton of Makinson d'Apice Dr Ramu Gopal Tulasi: Cameron Jackson of Counsel instructed by John Kamaras of Avant Law
Findings:	**Identity of deceased**: JSZ **Date of death**: 20 September 2023 **Place of death**: The Queen Elizabeth Lookout, Echo Point, Blue Mountains, NSW

	Manner of death: Intentionally self-inflicted
	Cause of death: Multiple blunt force injuries
Recommendations:	Not applicable.
Publications 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.

Introduction

1 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.

2 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 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.

3 In addition, s 82 of the Act states 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.

4 This inquest is held pursuant to the jurisdiction conveyed by s 23 of the Act in circumstances where, at the time of his death, JSZ was in lawful custody within the meaning of s 23(1)(a) or while attempting to escape lawful custody within the meaning of s 23(1)(b).

The issues examined at the inquest

5 An inquest into JSZ's death was held on 9 and 10 September 2025 at the Coroners Court at Lidcombe.

6 The issues identified in the coronial investigation to be explored in the inquest follow.

(1) Findings required pursuant to s 81 of the Act: the identity of the deceased; the time, date and place of death; the cause and manner of death.

(2) Whether the decision to recommend to the Mental Health Review Tribunal (**MHRT**) that JSZ be permitted to take unsupervised day leave was appropriate.

(3) Whether the decision that JSZ be permitted to take unsupervised day leave on 20 September 2023 was appropriate.

(4) Whether Cumberland Hospital's policies and procedures in relation to unsupervised day leave and managing the risk of patients absconding were adequate and appropriate. In particular:

(a) identifying the relevant policies and procedures.

(b) whether relevant stakeholders received adequate training in relation to the application of the identified policies.

(c) whether the identified policies and procedures were followed when JSZ took unsupervised day leave on 20 September 2023.

(d) whether the identified policies and procedures were sufficient to address the risk of mental health patients absconding.

(e) whether there have been any changes to the identified policies and procedures since JSZ's death.

(5) Whether the response of Cumberland Hospital and Western Sydney Local Health District (**WSLHD**) to JSZ's abscondment was adequate and appropriate.

(6) Whether any recommendations are necessary or desirable arising from any matter connected with JSZ's death.

The evidence

7 Tendered to the court was an 8-volume brief of evidence compiled by the Officer in Charge of the coronial investigation, Detective Senior Constable David Screech and supplemented by the Assisting Team.

8 At the inquest, the court received oral evidence from:

(1) Senior Constable David Screech, officer in charge of the coronial investigation

(2) Dr Ramu Gopal Tulasi, forensic psychiatrist in the former Bunya Unit

(3) A/P John Basson, Senior Staff Specialist and Clinical Director of the former Bunya Unit

(4) Dr Sara Ghaly, Psychiatrist and Acting Executive Director of Mental Health Services at WSLHD.

Findings

9 I have concluded that:

(1) JSZ died at or after 6:57pm on 20 September 2023 at the Queen Elizabeth Lookout, Echo Point, Blue Mountains, NSW from multiple blunt force injuries. JSZ's manner of death was intentionally self-inflicted.

(2) The decisions to recommend to the MHRT that JSZ take unsupervised leave and that he be permitted to take such leave on 20 September 2023 were appropriate.

(3) While I consider that Cumberland Hospital's policies and procedures in relation to unsupervised day leave and managing the risks of absconding patients at the time of JSZ's death were appropriate:

(a) on 20 September 2023 they were not complied with (or their compliance was not documented), such non-compliance representing a lost opportunity to identify JSZ's increased risk profile. In particular:

(i) a bag inspection may have revealed the Note and the amount of money JSZ was carrying. If discovered, these

items should have raised a ‘red flag’ as to JSZ’s intentions and enabled his leave to be suspended.

(ii) the failure to appropriately monitor JSZ during his leave to ensure he was complying with his leave plan and to identify him as having ‘absconded’ in a timely manner.

(4) I welcome the policy and procedure and training improvements which have been undertaken as a consequence of JSZ’s death and in conjunction with the move to the Budyari Gumada unit.

(5) While a more timely response would not have been likely to prevent JSZ’s death, I find that Cumberland Hospital (and the WSLHD) failed to respond to JSZ’s absconding in a timely manner reflecting the risk of harm to JSZ and to the community given the context being that JSZ was a forensic patient.

Recommendations

10 For the reasons outlined below, I make no recommendations in this inquest.

Background

11 I have drawn from submissions by Counsel Assisting in relation to non-contentious factual matters and issues. I am grateful for this assistance.

Early life and migration to Australia

12 JSZ was born on 5 April 1957. He was much loved by his wife[1] BX and his son YZ who both attended the inquest via AVL. BX and YZ were helpfully represented by Sarah Love of Counsel instructed by Sheeza Naz of Legal Aid NSW.

[1] While they were divorced in China prior to JSZ arriving in Australia, JSZ expressed the intention of BX joining him in Australia to re-marry.

13 JSZ died on 20 September 2023 when he was 66 years old. At the time of his death, JSZ's family resided in China, and he had no known family living in Australia.

14 JSZ was born in China and migrated to Australia in 1990 on a student visa. He initially settled in the Sydney suburb of Marrickville but moved around to various places before moving into a unit in Hurlstone Park.

15 On 1 September 1994, JSZ was granted a bridging visa, and on 18 July 1996, was granted a refugee/protection visa. The basis on which he was granted the refugee/protection visa is reported to be his involvement in pro-democracy political protests.

16 There was some suggestion (at least around 2014 to 2019) that JSZ's visa could be cancelled on 'character grounds' under s 501 of the *Migration Act 1958* (Cth) which appeared to have upset him. This did not appear to be an issue at the time of JSZ's death and no record of a decision under s 501 has been located.

17 Very little information was available to the inquest in relation to JSZ's background or his family of origin.

18 JSZ reported that he was separated from his mother at the age of three when his father moved to a city on the other side of China. He had no contact with his biological mother from that age. JSZ refused to provide contact details for his family members in China to his treating team. I understand this caused much angst to BX and YZ as it prevented them from being updated as to his health, wellbeing and treatment. It also resulted in delays in notification following JSZ's death.

19 JSZ said that he achieved tertiary qualifications in agriculture and worked in various positions whilst living in China including for the public service.

20 The information that is presently available about JSZ's life in Australia between the years 1990 and 1997 is also scant. JSZ came to Australia to study English. He does not have a substantiated work history in Australia. He had a deformity in his right arm, acquired whilst in Australia, of no known origin.

Criminal history, self-harm incidents and custody

21 Until 1995, JSZ's criminal history in Australia related only to traffic infringements.

22 On 28 March 1995, JSZ was charged after swinging a confectionery cutting blade at a colleague's head and later chasing him with a steel bar whilst employed at a company called Sweet House Confectionery. JSZ was arrested, charged, and fined over the incident.

23 On 15 April 1995, police discovered JSZ at his home in Hurlstone Park with a wound to his left forearm and various cutting implements and blood-soaked items of clothing nearby. JSZ was taken to Canterbury Hospital for assessment. The incident was considered not to be suspicious and the wound self-inflicted. JSZ provided no reasons for his actions.

24 On 2 May 1995, police were called to JSZ's home where he was found unconscious, with a blue-ish tinge, and was cold to the touch. Five empty bottles of Normison (Temazepam) medication were found on the ground near JSZ. JSZ was taken to Canterbury Hospital where he was found to have sustained renal breakdown, internal bleeding and a possible brain injury due to the overdose of medication.

25 On 8 February 1997, police were called to Flemington Markets in relation to an incident that occurred when JSZ had attempted to buy some vegetables. It was alleged that JSZ had pushed and punched a victim, swung a trolley injuring two

victims, and bit another victim. JSZ was charged with assault occasioning actual bodily harm but was later 'cleared'[2].

26 On 21 May 1997, JSZ went to the office of Guiseppe Arena, who was the property manager of the unit that JSZ was leasing at the time. A dispute ensued about whether enough was being done about two break-ins that occurred at JSZ's home. JSZ was armed with a knife and stabbed Arena 12 times in the armpit, groin, chest and wrist areas, ultimately killing him. JSZ then attempted to stab another person. When police intervened, JSZ resisted arrest, called on officers to shoot him, and seriously injured three police officers. JSZ later revealed that he had taken the knife with him with the intention of killing Arena if he 'didn't get any satisfaction' from him. A subsequent search of JSZ's home revealed an improvised explosive device in a suitcase which was found by specialists to be able to be detonated at any time.

27 JSZ was committed to trial for various offences including murder (the index offence), malicious wounding, assault occasioning actual bodily harm, unlawful possession of explosives and other offences. Although there was some concern about JSZ's mental health at the time, he had refused to answer questions during psychiatric assessments, and he was ultimately convicted. However, he successfully appealed to the Court of Criminal Appeal, where the sentence and conviction was quashed and a new trial was ordered.

28 In 2003, Professor David Greenberg conducted a psychiatric assessment on JSZ for the purposes of the new trial. He struggled to diagnose JSZ (though he considered him to be paranoid). He concluded he was unable to express a view on his fitness to stand trial, and recommended he be institutionalised to facilitate a full psychiatric assessment.

29 On 18 February 2003, JSZ was found not guilty by reason of mental illness. A special adjudication was made that JSZ be held in custody at a mental health facility at the discretion of the MHRT.

[2] Records indicate JSZ was 'cleared'. What that means is uncertain.

30 Following this determination, JSZ was initially detained at Long Bay Hospital in Malabar.

31 On 7 May 2008, JSZ was transferred to the MRRC[3].

32 On 5 March 2009, the MHRT ordered that JSZ be transferred to the Dee Why ward of the Forensic Hospital where he remained until 3 February 2013. He was transferred to the Bronte ward after stabbing a nurse multiple times in the upper right arm and upper right back with a handmade weapon consisting of a wooden chess piece with a metal spike inserted into it.

33 On 1 September 2015, JSZ was transferred to the Clovelly ward, and on 11 August 2016, he was transferred back to the Dee Why ward.

34 By around 2020, JSZ's mental health had reportedly become more stable. His treating team requested that he be transferred to a less secure facility. As a result, on around 27 October 2021, JSZ was transferred to the Bunya Unit at Cumberland Hospital. He was detained there until his death on 20 September 2023.

JSZ's mental health

35 At the time of his death, JSZ had been diagnosed with Chronic Paranoid Schizophrenia with a mild cognitive impairment. He was being treated for this condition with anti-psychotic medication, Zyprexa Relprevv (Olanzapine) depot injections. He was receiving 405mg IMI every 4 weeks. In the three months prior to his death, JSZ had received injections on 6 September 2023, 9 August 2023, and 12 July 2023.

36 JSZ's diagnosis appears to have been obtained with some degree of difficulty. Although a diagnosis of schizophrenia had been made (albeit provisionally) as early as 1999, other diagnoses including paranoid personality disorder, delusional disorder, narcissistic personality disorder and obsessive-compulsive

[3] Metropolitan Remand and Reception Centre.

disorder were also proffered at various times. JSZ also trialled various medications over time.

37 Over the course of the period in which JSZ was in custody (i.e. from 1997 onwards), he had exhibited behaviours of concern, such as verbal and physical aggression towards others and hoarding objects from which he could fashion weapons. He was also recorded as being irritable, entitled, and having an uncooperative/oppositional personality. In relation to these behaviours, JSZ had demonstrated improvement over time. By around 2020, JSZ was reported to be less irritable, more settled and respectful of his treating team and hospital staff and was less suspicious in his interactions. His treating team believed that he had improved to the point that he was 'calm, cooperative and logical'.

38 There is no indication in any of the records from the period prior to his transfer to the Bunya Unit that JSZ experienced any thoughts of suicide. He repeatedly denied any thoughts of self-harm or suicidal ideation or intent. In August 2021 JSZ was assessed during a mental health screening as having no thoughts of suicide or self-harm. JSZ was also frequently assessed as posing a low risk for self-harm, suicide, and for violence generally.

39 In his Bunya Unit Mental Health Nursing Progress Notes (**MHNP Notes**) there is no indication that JSZ was experiencing thoughts of self-harm or suicidal ideation or intent. JSZ was also assessed as low risk for both self-harm and suicide. In September 2023, the nursing staff repeatedly assessed JSZ's risk of self-harm and suicide as low and he denied any thoughts of self-harm. During a review by medical staff in September 2023,[4] JSZ also denied any thoughts of self-harm. During this period JSZ successfully undertook unsupervised outside day leave on four occasions.

40 However, the MHNP Notes were not always accurate. Some mental health risk assessments recorded that JSZ had not made any previous attempt at suicide and had no history of self-harm, which we know to be false.

[4] Dr Tulasi and Dr Ramy, a psychiatric registrar.

41 Whilst he was detained at the Bunya Unit, JSZ's medical team considered that he was mentally stable, his overall risk of self-harm and suicide was low, and JSZ repeatedly denied any suicidal intent. There is only one occasion (2 August 2022) where JSZ admitted to having suicidal thoughts, namely when JSZ told Dr Dhawan and Dr Nadeswaran he had previously said that he might use explosives to take his own life if he got expelled from Australia. However, it is not clear when JSZ said this, and he also informed Dr Dhawan and Dr Nadeswaran that he had had no thoughts of ending his life since then.

42 The salient aspects of JSZ's medical records from the weeks prior to his death are summarised below.

(1) On 30 August 2023, JSZ was reviewed by Larissa Johnstone (Psychologist), who determined that his mental state was stable, there was no evidence of psychosis or major mood disorder, he was utilising leave without issue and was compliant with medication. Dr Tulasi, Dr Ibrahim, Samantha Lo[5], and Stacey Williams[6], assessed his risk of self-harm and suicide as low.

(2) On 1 September 2023, during Dr Tulasi's ward rounds it was recorded that JSZ reported no thoughts of self-harm.

(3) On 12 September 2023, Dr Ibrahim recorded that during a review conducted by Dr Tulasi, JSZ reported that his mood was good (8/10), he admitted he had a mental illness, he denied any thoughts of self-harm or suicidal ideation, he was compliant with medication, and he had no positive psychotic symptoms or negative symptoms of schizophrenia.

(4) Dr Tulasi considered that JSZ's mental state was stable, and no episodes of relapse were noted. JSZ did not present with symptoms of psychosis such as auditory hallucinations, persecutory or paranoid delusions or thought disorder. He did not report mood disturbances. He

[5] Occupational therapist.
[6] Social Worker.

engaged well during medical assessments and discussed his future. He did not report any thoughts of self-harm or suicide during these assessments. JSZ was generally compliant with his ward routines and medications, and there were no reported or documented incidents where he was aggressive towards peers or his treating team.

43 However, it does appear that after being transferred to the Bunya Unit, JSZ still posed some level of risk (as discussed further below). His insight was still reported to be limited, and his history suggested a high level of risk. JSZ also often denied having a mental illness. Nonetheless, it appears JSZ's treating team considered these risks were manageable through a gradual escalation in JSZ's leave entitlements.

MHRT

44 The MHRT's ability to grant leave is governed by s 94 of the *Mental Health and Cognitive Impairment Forensic Provisions Act 2020* (**MHCIFPA**). In particular, the MHRT can grant leave subject to any terms and conditions it thinks fit, and it must not grant leave unless satisfied that the safety of the patient will not be seriously endangered if the leave is granted.

45 From the time JSZ moved to the Bunya Unit, JSZ was granted increased freedom with each subsequent review of his case by the MHRT.

46 The first hearing of the MHRT in relation to JSZ since he was transferred to the Bunya Unit was held on 3 December 2021. The MHRT decided that JSZ was to be granted escorted day leave. The MHRT handed down the reasons for its decision on 10 December 2021. The MHRT found that:

(1) JSZ had managed the transition to the Bunya Unit well but that nevertheless, his treating team believed he required close observation for the foreseeable future.

(2) JSZ denied thoughts of harming himself or others.

(3) JSZ's risk to himself and others was still not perfectly understood by the treating team and his detention remained necessary for his care and treatment.

47 On 16 December 2021, the MHRT ordered that any escorted day leave was to be allowed at the discretion of, and in accordance with any conditions imposed by, the Medical Superintendent. The Medical Superintendent was required to act in accordance with the Guidelines[7].

48 At the next hearing on 3 June 2022, the MHRT decided that JSZ was to be granted supervised day leave with NDIS support workers, Flourish Australia[8] and with other 'Bunya-approved' supervisors. The MHRT found that this was the next appropriate step in JSZ's rehabilitation and recovery, and that since his last review, JSZ had maintained a stable mental state, he was experiencing no suicidal ideation at his mental state examination on 18 May 2022, and he had reasonable insight into his illness.

49 On 17 June 2022, the MHRT ordered that any supervised day leave was to be allowed at the discretion of, and in accordance with any conditions imposed by, the Medical Superintendent, required to act in accordance with the Guidelines.

50 Following the next hearing on 2 December 2022, the MHRT decided that JSZ was to be granted unsupervised day leave within the grounds of Cumberland Hospital. In reaching this decision, the MHRT found the evidence indicated that JSZ was progressing very well, his mental state was stable, there had been no behavioural concerns, and he had exercised escorted and supervised leave without incident.

51 On 17 June 2022, the MHRT ordered that any unsupervised day leave on the hospital grounds was to be allowed at the discretion of, and in accordance with

[7] NSW Ministry of Health Guidelines for Forensic and Correctional Patient Ground Access, Leave, Handover, Transfer, and Release (PD 2012-50).
[8] An organisation providing employment for persons with mental ill health.

any conditions imposed by the Medical Superintendent, required to act in accordance with the Guidelines.

52 Following the next hearing on 2 June 2023, the MHRT decided that JSZ was to be granted unsupervised day leave. The MHRT found the evidence indicated JSZ remained mentally stable, was compliant with medication, was undertaking his leave without issue, and was positive and future focused. The MHRT also found JSZ posed a 'low to moderate potential for risk of harm to himself' but that 'his continued engagement in his treatment and management of his mental illness will decrease those risks'. The MHRT was also provided with a 'draft leave plan' for the first eight weeks of JSZ's unsupervised day leave which included a six-point 'Risk Management Plan' requiring JSZ to submit to a mental status assessment prior to accessing leave and to always have a mobile phone on him.

53 The MHRT had been provided with a medical report of Dr Kazi[9] and Dr Tulasi dated 19 May 2023 in which they had concluded that JSZ posed a low to moderate potential for risk of harm to himself based on his history. The use of leave was to be dependent on JSZ's mental state and his risk was to be assessed before and after he accessed leave. The draft leave plan could be modified according to changes in mental status and behaviour, including the foreseeability of harmful incidents and any other clinically relevant factors.

54 On 7 June 2023, the MHRT ordered that any unsupervised day leave was to be subject to the draft leave plan outlined above, be allowed at the discretion of, and in accordance with any conditions imposed by, the Medical Superintendent, who was and required to act in accordance with the Guidelines.

The Guidelines

55 The Guidelines set out the standards and governance arrangements for services that are responsible for forensic patients.

[9] Psychiatry Registrar.

56 Part 1.8 sets out the principles for the management of forensic and correctional patients in NSW. It provides that a treating team that intends to apply for a variation to a forensic patient's current order (including applications for leave) should ensure that a full risk assessment and management plan has been prepared.

57 The salient aspects of Part 4, dealing specifically with leave, are set out below.

(1) For all types of leave or ground access, the treating team should discuss the arrangements for the leave or ground access with the patient and satisfy themselves that the patient understands the arrangements and any conditions placed on the leave or ground access. The consultations and discussion should be documented in the patient's health record. The discussion should be undertaken in the presence of the patient, and it is preferable for information about the patient to be disclosed by the patient with the support of the treating team.

(2) The health service should pay particular attention to any belongings of the patient that the patient takes or attempts to take on leave. Generally, the patient should take with him or her only those things that are necessary for the period of leave.

(3) Where appropriate, the health service should consider limiting the amount of money that the patient may carry, preventing a patient from taking credit or debits with him or her.

(4) A description of the clothes the patient is wearing should be recorded in the patient's health record at each time the patient takes leave from the ward or unit.

58 In relation to unsupervised day leave, the salient aspects of the Guidelines are set out below.

(1) The treating team should develop a leave plan that incorporates a risk management plan.

(2) Where appropriate, the leave plan should include arrangements by which the treating team can monitor the location of the patient while on unsupervised leave and the actions that must be taken where the patient does not comply with those arrangements. For example, a leave plan may include requirements that a nominated person at the destination of the patient contact the ward or unit by telephone to confirm the patient's arrival at the destination, at a specified or random time or times during the period of leave, and/or on the patient's departure from the place of leave.

(3) Local policy should identify a clinician who has responsibility for conducting a risk assessment immediately before the patient leaves the facility. The leave may be deferred if the patient presents with a significant increase in risk.

(4) The treating team should discuss the arrangements for the leave with the patient and satisfy themselves that the patient understands the arrangements and any conditions placed on the leave. The discussion should be documented in the patient's health record.

59 Part 10, dealing with non-compliance or breach, relevantly provides:

(1) major breaches, such as a serious singular event where the forensic patient does not comply with a condition of leave, require immediate intervention, and should be reported to the MHRT so that it may consider issuing a warrant for apprehension for the person; and

(2) the MHRT should be notified at the earliest opportunity.

Implementation of MHRT orders by Cumberland Hospital

60 According to his health records and Dr Tulasi, JSZ's leave entitlements were undertaken without incident.

61 JSZ's employment with Flourish Australia from around October 2022 was also unremarkable. He worked 5.5 hours one day per week and was reported to be an easy employee to deal with.

JSZ's death

20 September 2023

62 On 20 September 2023, JSZ took unsupervised day leave from Cumberland Hospital and departed the Bunya Unit at or around 9:07am on foot carrying a black bag. He appeared cheerful and advised staff he would be going for yum cha in Chinatown.

63 JSZ travelled to Parramatta and then onto Katoomba by taxi, arriving at around 11:14am. JSZ's phone records show he was in the areas of Scenic World and Echo Point at various points throughout the day, until he turned off his phone at 4:34pm.

64 At 5:35pm, JSZ can be seen in CCTV footage at Echo Point, walking from the Prince Henry Walkway towards the Queen Elizabeth Lookout.

65 At 5:41pm, JSZ was walking around the Queen Elizabeth Lookout, before walking out of frame.

66 At 5:51pm, JSZ walked towards the edge of the Queen Elizabeth Lookout viewing platform and looked over the railing for 27 seconds. There is a sheer drop (150-200m) below the platform towards the valley floor. JSZ then retreated and started walking towards the Prince of Wales Lookout.

67 At 6:49pm, JSZ appears to be at the Western end of the bottom of the platform at the Queen Elizabeth Lookout, when a group of people leave the lookout. He then walks out of frame.

68 At 6:56pm, JSZ returns to the Queen Elizabeth Lookout holding a bag, before disappearing underneath a camera facing West, and around where his bag was later found. No camera covered the actual seat where the bag was located but the only two exit and entry points to the lookout can be constantly observed.

69 At about 6:57pm, JSZ climbed over the railing at Queen Elizabeth Lookout. No other persons were present for the 8 minutes prior, and 5 minutes after. The cliff edge can only be seen clearly in daylight hours. Upon darkness, local lighting becomes poor and both cameras enter UV mode. At the time JSZ climbed over the railing, both CCTV cameras are covered in spider webs and the quality of the footage is diminished.

NSWPF[10] response to JSZ's disappearance and death

70 At 9:06pm on 20 September 2023, a staff member from the Bunya Unit reported that JSZ was missing to the Police Assistance Line. NSWPF records indicate that staff at the time were concerned that JSZ was lost. Dr Tulasi said in evidence, this reflected the fact that JSZ's identified risk of self-harm and suicide was so low that it did not cross the mind of his treating team that he had committed suicide. Details of his diagnosis, appearance and intention to travel to Chinatown were then broadcast on police radio.

71 At 12:12am on 21 September 2023, NSWPF (Const. Serret and Const. Dagres) attended Cumberland Hospital and spoke with staff, conducted a patrol of the hospital, and attempted to call JSZ on the mobile number provided. They then returned to Wentworthville police station (at around 12:57am) to create a missing person event.

[10] New South Wales Police Force.

72 At 1:35am, a NSWPF radio message was broadcast covering the areas of Ryde, the Hills District, Ku-ring-gai, Parramatta and Cumberland and stayed open until 23 September 2023.

73 At 1:37am, Const. Serret wrote in the missing person event report that staff at Bunya Unit were concerned for JSZ as he has a history of violence. There was no mention of any concern of self-harm or suicide. JSZ's risk assessment was determined to be 'Medium.' The rationale for this risk assessment was his diagnosis of schizophrenia, that he had only been recently granted unsupervised day leave and that it was believed he went towards the city being an area he was not familiar with. A secondary risk assessment by Sgt. Fowler was similar; his was based on JSZ's age and his mental illness. The NSWPF recorded that there was no evidence to suggest that JSZ was suicidal and considered that he 'may not have understood the conditions of the leave granted.'

74 On 21 September 2023, Sgt. Harris attempted to call JSZ's mobile phone, again with no response. He also contacted Cumberland Hospital but no new information was provided.

75 On 21 and 22 September 2023, a civilian noticed JSZ's bag on a bench at Queen Elizabeth lookout during his morning walk. After seeing it for the second time he notified the NSWPF. Sgt. Martignago spoke with the civilian witness and located, searched and seized JSZ's bag. He informed the upper mountains rescue coordinator about the discovery of the bag and the possibility of a body below the lookout. At that time rescuers were dealing with the recovery of another body at Blackheath.

76 Sgt. Martignago took JSZ's black bag to Katoomba police station and at about 11:30am the mobile phone within the bag started to ring. Sgt. Martignago answered the phone and had a conversation with Frankie Motila of Flourish Australia who said that JSZ had not attended work. Motila provided details about JSZ's residency and treating doctor. At about 12:00pm, Sgt. Martignago spoke with Dr Tulasi, who explained that JSZ was a resident who was on day

leave and had failed to return, and had been reported missing. The description of JSZ provided by Dr Tulasi matched the person sighted on CCTV footage obtained by the NSWPF.

77 In addition to the mobile phone, police retrieved from the bag:

(1) $500 cash;[11] and

(2) a note with the words 'sisters in the blue' written in blue pen (**Note**).

78 The items retrieved from JSZ's bag are significant in that:

(1) the amount of money exceeds what would have been required for JSZ's 'reported' intended trip to Chinatown for yum cha; and

(2) the Note was written in blue ink and JSZ was not carrying a blue pen. From this I infer that the Note was written before JSZ left the Bunya Unit indicating his intended destination presumably for the purpose of showing to a taxi-driver or otherwise to assist in his reaching his actual intended destination.

79 At 3:36pm a police radio message was opened in relation to the search for JSZ. Shortly after 4:00pm, a search by POLAIR 5 resulted in the discovery of JSZ directly below Queen Elizabeth Lookout. JSZ was conveyed to Katoomba police station where his body was examined by Snr. Const. Schwizler.

80 On 23 September 2023, JSZ was conveyed to Auburn Hospital where he was certified as deceased.

81 On 24 September 2023, Det A/S Thompson of Fingerprint Operations was able to identify JSZ based on fingerprints held by the NSWPF.

[11] An additional amount of $1,200 was located on his person in the course of his post-mortem,

Cumberland Hospital/Bunya Unit response to JSZ's disappearance and death

82 At the start of his shift at around 9.30am on 20 September 2023, RN Liu was informed that JSZ was missing. He attempted to contact JSZ on his mobile phone at 9:30pm, 2:50am, and 6:50am without success.

83 When the NSWPF attended Cumberland Hospital at 12:15pm on 21 September 2023, RN Liu informed them about JSZ's age and background, medical condition and history. He also arranged for JSZ's treating consultant to speak to police. RN Liu provided police with a 'Report to Police (Part A)' that was completed by a colleague and signed by him. It recorded that the current concern for JSZ in relation to suicide was 'low' and the concern about harm to self, to others or from others was low to medium.

84 On 21 September 2023, RN Liu completed an 'Absent Without Leave Patient's Report' which noted that the overall assessment of risk of suicide and self-harm was 'low' and the mental health of the patient at the time he was last seen was 'stable'.

85 On 21 September 2023, Dr Tulasi contacted the MHRT by telephone and informed it that JSZ had not returned from leave. On 22 September 2023, Dr Tulasi provided the MHRT with a 'Notice of Potential Breach or Deterioration in Mental Conditions' informing it that JSZ had not returned from unsupervised outside day leave on 20 September 2023. The MHRT issued an Order for Apprehension and Detention under s 109 of the MHCIFPA. The MHRT expressed concern that the notice was received two days after JSZ was due to have returned from leave.

Issues

Findings required pursuant to section 81 of the Coroners Act: the identity of the deceased; the time, date and place of death; the cause and manner of death

86 JSZ was found deceased on or after 4:00pm on 21 September 2023 at the bottom of the valley below the Queen Elizabeth Lookout, Echo Point, Blue Mountains, NSW.

87 Further investigations revealed that JSZ climbed over the railing of the look out at 6:57pm on 20 September 2023.

88 Following her external post-mortem examination of JSZ on 4 October 2023, Dr du Plessis opined that JSZ died from 'multiple blunt force injuries.'

89 I find that JSZ died at or after 6:57pm on 20 September 2023 at the Queen Elizabeth Lookout, Echo Point, Blue Mountains, NSW from multiple blunt force injuries.

90 In relation to manner of death, 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.[12]

91 I consider that the evidence satisfactorily supports the finding that JSZ intentionally climbed over the railing and fell or jumped to his death in circumstances where:

(1) as outlined, the Note suggests an intention formed prior to his leaving the Bunya Unit to attend the Blue Mountains and to conceal that intention by indicating he would go to Chinatown;

(2) he is seen scoping the look out and returns when there is no one else around;

(3) the way in which he can be seen climbing over the railing, and

(4) there is no evidence suggesting psychosis contributed to his actions.

92 I find that JSZ's manner of death was intentionally self-inflicted.

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

Whether the decision to recommend to the MHRT that JSZ be permitted to take unsupervised day leave was appropriate

93 There was no evidence adduced in the inquest which indicated that it was inappropriate for unsupervised day leave to be recommended. On the contrary, the evidence indicated that JSZ had successfully completed periods of supervised day leave, demonstrated socially appropriate behaviour and remained compliant with his medication and his leave conditions. Significantly, the was no indications of an increase in his risk of self-harm or suicide.

Whether the decision that JSZ be permitted to take unsupervised day leave on 20 September 2023 was appropriate.

94 While the decision to permit JSZ was appropriate on the information available to decision makers at the time, there was a lost opportunity to make further appropriate and mandatory inquiries which may have unveiled JSZ's increased risk of self-harm or suicide.

95 As outlined at paragraph 4.1.11, Part 4 of the Guidelines provide that:

> The health service should pay particular attention to any belongings of the patient that the patient takes or attempts to take on leave. Generally, the patient should take with him or her only those things that are necessary for the period of leave.
>
> Where appropriate, the health service should consider:
>
> - limiting the amount of money that the patient may carry
> - preventing a patient from taking credit or debits with him or her

96 We now know that when JSZ was found he was carrying:

(1) the Note, and

(2) $500 in his bag and $1,200 on his person. It is unknown whether any or all of these funds were in his possession when he left the hospital.

97 If there was any 'attention paid' to what JSZ had in his possession prior to his departure in the form of a bag search or otherwise, it was not documented. If

these items had been identified then they ought to have raised a red flag and further enquiries should have been undertaken as to JSZ's intended destination and purpose prior to his departure. Such enquiries may have revealed his increased risk of self-harm or suicide and caused his leave to be cancelled.

98 I describe this as a lost opportunity as it is possible that JSZ would have concealed these items from any search. If a search had been undertaken it would not have been an invasive search.

99 I find that while it was appropriate to allow JSZ to undertake unsupervised day leave on 23 September 2023, a search of his bag ought to have been undertaken prior to his departure in accordance with the Guidelines.

Whether Cumberland Hospital's policies and procedures in relation to unsupervised day leave and managing the risk of patients absconding were adequate and appropriate.

100 I preface this discussion by raising the two points below.

(1) The Bunya Unit no longer exists. A/P Basson is now the medical superintendent of the Budyari Gumada unit at Blacktown Hospital. The relocation occurred in around December 2024. In his evidence, A/P Basson indicated that when the move to Blacktown Hospital occurred, a clear decision was made not to transfer 'like for like.' The intention was to improve governance and risk management processes and procedures going forward.

(2) I acknowledge that risk management policies and procedures are inherently balancing exercises. In this case, the risk of JSZ's unsupervised leave was sadly realised. JSZ's death may not have been preventable in circumstances where the process of allowing graduated leave is a necessary element of re-integration.

101 A/P Basson and Dr Ghaly identified the relevant policies and procedures (in addition to the Guidelines) in their statements.[13]

102 In this case, the risk assessment process undertaken prior to JSZ's leave did not reveal what we now know to be a risk of suicide. There was no evidence before me that suggests that this reflects a defect in the Hospital's policies or procedures or their implementation. On the contrary, either JSZ's risk materialised at some time closer to his departure on 20 September 2023 or he was able to mask it. Either way, policy change is unlikely to address this inherent risk which weighs in to the balancing exercise.

103 However, there were identified gaps in respect of the implementation of the Guidelines on 20 September 2023. In particular:

(1) No regard was had to JSZ's belongings (or if there was some sort of inspection it was not documented) prior to him leaving the ward. This represents a missed opportunity as outlined above to identify his increased risk profile.

(2) JSZ was not adequately monitored while he was on leave by way of telephone 'check ins.' If he was, they were not recorded. It is possible that if attempts were appropriately made to check in with JSZ through the day, a staff member may have identified that he was not where he was supposed to be and he was at risk of self-harm. His death may not have been prevented; I raise it as another missed opportunity.

104 While not risk free, I consider the policies and procedures in place, if appropriately implemented, would have been adequate. However, I welcome

[13] NSW Health Policy Directive PD2012_050 Forensic Mental Health Services; NSW Health – NSW Police Force Memorandum of Understanding 2018; NSW Health Policy Directive PD2019_045 Discharge Planning and Transfer of Care for Consumers of NSW Health Mental Health Services; WSLHD Policy Directive Implementation Plan regarding PD2019_45; NSW Health Policy Directive PD2021_039 Mental Health Clinical Documentation' WSLHD Policy Directive Implementation Plan regarding PD2021_039; WSLHD Policy Directive Implementation Plan regarding GL2014_002.

the improvements that were identified in evidence to further address the risk of absconding patients.

105 Dr Ghaly gave evidence as to the current regime whereby staff at the Blacktown Mental Health Recovery Centre, including Nursing and Allied Health staff, receive specialised training on forensic patient leave arrangements, relevant legislation, the AWOL process, and the use of PEXIP for remote monitoring.

106 Prior to commencing work on Budyari Gumada, all staff participate in an orientation, and an orientation session was held for all existing staff in November 2024 prior to the unit coming into operation.

107 In addition to the orientation training, all clinical staff undergo refresher training specifically around the forensic leave processes approximately every 2 months.

108 A/P Basson gave evidence that in practice:

(1) issues have been identified and addressed where newer staff have not appropriately adopted a risk management culture

(2) the timing and process of monitoring patients on leave has been reformed such that regular calls are made and the risks associated with absconding patients are identified more promptly triggering a response earlier

(3) a patient may be required to take a photo of a street sign or another identifying feature to prove they are in the right place

(4) staff perform bag checks before patients depart for leave and if an issue, such as money exceeding $150, was identified then the leave may be suspended while the staff member escalates the issue as a ‘red flag’

(5) these additional steps are now documented within the patient’s progress notes.

109 The evidence did not suggest that there was any inadequacy in training of staff at the time of JSZ's death so much as a cultural issue of failing to appreciate the gravity of the risk, failure to comply with the Guidelines and failure to document where there was compliance.

110 The evidence before the inquest reflects a shift in culture which accompanied the physical move to Blacktown Hospital. In the context of this Inquest, I am unable to determine whether the changes have been adequately adopted and implemented.

Whether the response of Cumberland Hospital and WSLHD to JSZ's abscondment was adequate and appropriate.

111 According to the 11:00pm, 20 September 2023 progress note:

(1) JSZ failed to return to Bunya on the evening shift from his 8 hours of unsupervised leave[14]. The note does not record the time his leave commenced or when he was supposed to return.

(2) Parramatta Police were informed 'by the afternoon.' However, based on the COPS event form it appears they were notified at around 8:00pm.

(3) Dr Tulasi was informed of JSZ's failure to return at 8:00pm and he said he would inform the MHRT the next day.

(4) The 'NUM and Dr Basson's mobile numbers were called with nil success'.

112 Parramatta Police attended the Bunya Unit at 12:15am on 21 September 2023 and collected the 'Report to Police (Part A)' form.

[14] A/P Basson said in evidence that JSZ was due back at 5:00pm though this was not recorded in JSZ's progress notes.

113 Attempts were made to call JSZ's mobile on the morning of 21 September 2023 with no success.

114 Thereafter a report was made to the MHRT. There was a lack of understanding as to the appropriate form of the report.

115 While a more timely response would not have been likely to have affected the outcome, in the circumstances of dealing with a forensic patient, this delay is unacceptable. There seemed to be no real appreciation of the risk to JSZ or to members of the public. The perception appeared to be that he may have gotten lost.

Findings

116 I find that JSZ died at or after 6:57pm on 20 September 2023 at the Queen Elizabeth Lookout, Echo Point, Blue Mountains, NSW from multiple blunt force injuries. JSZ's manner of death was intentionally self-inflicted.

117 I find that the decisions to recommend to the MHRT that JSZ take unsupervised leave and that he be permitted to take such leave on 20 September 2023 were appropriate.

118 While I consider that Cumberland Hospital's policies and procedures in relation to unsupervised day leave and managing the risks of absconding patients at the time of JSZ's death were appropriate:

(1) on 20 September 2023 they were not complied with (or their compliance was not documented), such non-compliance representing a lost opportunity to identify JSZ's increased risk profile. In particular:

(a) a bag inspection may have revealed the Note and the amount of money JSZ was carrying. If discovered, these items should have raised a 'red flag' as to JSZ's intentions and enabled his leave to be suspended.

(b) the failure to appropriately monitor JSZ during his leave to ensure he was complying with his leave plan and to identify him as having 'absconded' in a timely manner.

(2) I welcome the policy and procedure and training improvements which have been undertaken as a consequence of JSZ's death and in conjunction with the move to the Budyari Gumada unit.

(3) While a more timely response would not have been likely to prevent JSZ's death, I find that Cumberland Hospital (and the WSLHD) failed to respond to JSZ's absconding in a timely manner reflecting the risk of harm to JSZ and to the community given the context being that JSZ was a forensic patient.

Whether any recommendations are necessary or desirable arising from any matter connected with JSZ's death.

119 JSZ's family submitted that the following recommendations ought to be made:

(1) Cumberland Hospital and WSLHD consider amending their policy and staff training to incorporate a requirement to provide important documents such as unsupervised leave plans in translated form to forensic patients with language barriers to ensure they are properly understood. This should include translation of a document that is provided to patients when leaving the unit that identifies important contact information.

(2) Cumberland Hospital and WSLHD consider amending their policy and staff training to incorporate a requirement to provide written details in clinical records in relation to the provision and explanation of unsupervised leave plans to forensic patients including their understanding.

(3) That Cumberland Hospital and WSLHD consider amending their policy and staff training to incorporate a consideration of utilising a translation

device or phone application which assists patients with cultural and language barriers interpreting matters when on supervised or unsupervised leave to assist and aid in their transition into the community.

(4) That these recommendations be provided to NSW Health to consider implementation of these recommendations in forensic Mental Health Services state-wide.

120 At the time of his death, JSZ had been residing in Australia for some 30 years.

121 In relation to JSZ's comprehension of the English language, Dr Tulasi told the court that if you spoke to JSZ in English using short sentences he would understand. When more complex matters were required to be explained to him an interpreter service would be used.

122 Dr Tulasi also explained that in Western Sydney they would have many bilingual staff members and those that could speak Mandarin would speak to JSZ in Mandarin.

123 In periods of supervised leave, JSZ's carers did not report that language was a barrier to JSZ being able to conduct himself away from the Hospital.

124 There was no evidence before me that indicated that a language barrier was a contributing factor in JSZ's death. On the contrary, the evidence indicates that JSZ was able to purposely navigate to the Blue Mountains. The Note indicates that he did not get lost, his conduct was intentional. It was not that he did not understand his leave plan, he chose not to follow it.

125 In the circumstances, I do not consider that the recommendations sought by JSZ's family are necessary or desirable in the context of JSZ's death.

Concluding remarks

126 I close this Inquest by conveying to JSZ's family members my respectful condolences for the loss of JSZ. I acknowledge the additional trauma suffered as a consequence of the delays in being notified that JSZ had passed.

127 I thank the assisting team, Meg O'Brien and Francesca Lilly, for their outstanding work in the course of this inquest.

128 I thank Det. Snr. Const. Screech for his work in conducting the investigation and compiling the brief of evidence which was supplemented by the assisting team.

Statutory findings required by s 81(1)

129 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 JSZ

Place of death

The Queen Elizabeth Lookout, Echo Point, Blue Mountains, NSW

Date of death

JSZ died at or after 6.57pm on 20 September 2023

Cause of death

JSZ died from multiple blunt force injuries

Manner of death

Intentionally self-inflicted

I close this inquest.

Magistrate R Hosking
Deputy State Coroner
Lidcombe

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