CORONERS COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the disappearance and suspected death of Christine Joyce Dorothy Young
Hearing dates:	4-7 September 2018
Date of findings:	7 September 2018
Place of findings:	State Coroners Court, Broken Hill
Findings of:	**Deputy State Coroner, Magistrate Teresa O'Sullivan**
Catchwords:	CORONIAL LAW – Cause and manner of death, mental health inpatient, schizophrenia, involuntarily detention, Mental Health Act, absconding from Mental Health Inpatient Unit, Missing Person, Aboriginal person, Aboriginal Health Liaison Officers
File number:	2017/177396
Representation:	**Counsel Assisting** Dr Peggy Dwyer, instructed by Mr Alex Jobe, Office of General Counsel **Far West Local Health District** Ms Lyn Boyd, Crown Solicitors Office **Dr Lam-Po-Tang** Mr Timothy Hackett **The Young Family** Ms Emily Winborne, Aboriginal Legal Service

Findings:	**Identity of deceased**: The deceased person was Christine Joyce Dorothy Young. **Date of death**: Ms Young died between 24 April 2016 and 26 April 2016. **Place of death**: She died in the desert scrubland surrounding Broken Hill in NSW. **Manner of death:** The death was unintentionally caused by misadventure in that she absconded from the Mental Health Inpatient Unit of Broken Hill Base Hospital on 22 April 2016, while she was an involuntary patient, and while she was suffering from paranoid schizophrenia, and she walked into the desert scrubland and was not located. **Cause of death:** The medical cause of the death was unable to be determined.
Recommendations:	**To the Far West local Health District (FWLHD)** 1. That funding is requested for an additional Aboriginal Health Liaison Officer to be rostered to work on the weekends and to be on call overnight, for Aboriginal mental health patients at Broken Hill Hospital. 2. That consideration is given to the implementation of a system to ensure Aboriginal Mental Health Inpatients, who do not have leave, be granted personal access to an Aboriginal Mental Health Worker or an Aboriginal Health Liaison Officer.

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The Coroners Act 2009 (NSW) *in s81 (1) requires that when an inquest is held, the coroner must record in writing his or her findings as to various aspects of the death.*

These are the findings of an inquest into the death of Christine Joyce Dorothy Young.

Introduction:

1. This is an inquest into the disappearance and possible death of Christine Joyce Dorothy Young. Her family are happy for her to be referred to as "Christine" and I that is how I will address her in these findings.

2. Christine was born in Broken Hill on 7 August 1975. She is the daughter of Cynthia Vine and Douglas Young, and is Cynthia's only child.

3. Christine was herself a mum and has two beautiful children with a man named Jeffrey Naden. Those two children, Lillian and Tyson are now grown up and Christine was a grandmother. Both of Christine's children were raised by her mother, given Christine's significant health problems, but there is no doubt that Christine loved her children very much, and I am told that she doted on her granddaughter. Another grandchild is expected shortly and no doubt she would have been excited to share that with her daughter.

4. I have been very moved by how much Christine's family loved her, and how much she loved them. I thank Christine's family for coming to Court and for the grace and dignity they showed while listening to the very sad evidence in this inquest. That must have been extremely hard for them.

5. Cynthia Vine, Christine's mum, told me that Christine (or Chrissy as she and others called her) had a connection to and an interest in her culture. She was interested in Aboriginal art. She was very connected to her family. Her father had a big family (the Youngs and the Johnsons) so she had family all over: Broken Hill; Wilcannia; Dubbo; Wagga Wagga; Sydney; Dareton and Wentworth.

6. Christine did well at school and was a bright and happy child. She left school at year 11 to be an apprentice landscaper and did very well in that job.

7. Unfortunately, Christine had a relationship with an unhappy man and she developed an addiction to drugs and alcohol. This appears to have triggered some significant mental health issues. Since at least 2004, Christine had experienced mental health issues with included depression, suicidal ideation, and schizophrenia.

8. By 2010, Christine had been diagnosed with schizophrenia and between 2010 and 2016, she had a mental health history which included being found wandering naked on a number of occasions, non-compliance with antipsychotic medication, multiple hospital admissions and many occasions when she absconded from Hospital.

9. Even when Christine was sick, she maintained a relationship with her family, and was especially close to her mother. Usually, Christine called Cynthia Vine daily to talk to her, including when she was in Hospital and the last time Ms Vine spoke to her was a day or so before she went missing, when she sounded agitated.

10. Around 11pm on 21 April 2016, Christine was found semi naked by police at the Broken Hill airport, having apparently walked there from town. Police officers took her to Hospital, but for the reasons outline below, she was not admitted, and police found a bed for her at the Salvation Army Women's refuge and drove her there. Before 6am, Christine left the Refuge, and around 8.30am, Police officers, who had been notified of her absence, found her wandering on the road.

11. It was evident to the Police officers that she appeared to be very mentally ill and she was detained by them under the *Mental Health Act* and transported back to Broken Hill Base Hospital. She was seen by Emergency Department

staff and ultimately admitted to the Mental Health Inpatient Unit, under the care of Psychiatrist, Dr John Kuo-Au Lam-Po-Tang (Dr Lam-Po-Tang).

12. At around 5pm, when another patient was leaving the ward accompanied by nursing staff, Christine pushed past the patient and exited the Unit. She walked down the corridor, followed by a nurse and eventually by a friend who had attended the Hospital to meet her, but she continued to walk out the Hospital Exit onto Thomas Street and right onto Silverton Road.

13. Nursing staff notified Police who attended the Hospital, and later went to Silverton Road in response to calls from concerned members of the public that a woman was walking on Silverton Road towards the bush, and was discarding her clothes and wearing an orange traffic cone on her head. Members of the public were concerned about her mental health and welfare. Police found the clothes that had been abandoned by Christine, but they did not arrive in time to see her.

14. Christine has not been heard of, or seen since. She has not accessed her bank account or phone, or contacted her family. Christine was last seen alive, in Broken Hill at approximately 5.30pm on 22 April 2016.

15. For the reasons outlined below, I have formed the view that, tragically, Christine died some time between 24 and 26 April 2016, in the desert scrubland around Broken Hill. That terrain is unforgiving, and there was no water supply she could access. Given that she was naked and suffering from schizophrenia and paranoia, she would not have been able to get help for herself.

The Inquest:

16. An inquest into Christine's death is mandatory, in accordance with s27 of the *Coroner's Act*. That is because s27 (c) and (d) provides that an inquest must be held if it appears to the Coroner that:

    - it has not been sufficiently disclosed whether the person has died, or
    - the person's identity and the date and place of the person's death have not been sufficiently disclosed, ….. [or]
    - the manner and cause of the person's death have not been sufficiently disclosed.

17. In this case, prior to the inquest, those matters had not been sufficiently disclosed.

18. A secondary, but equally important function of the Coroner's Court is governed by Section 82 of the Act, which empowers the court to make any recommendations that are considered "necessary or desirable" in relation to the death.

The Evidence:

19. At the time of her death, Christine lived between a number of addresses in Broken Hill. Her last recorded address was 1/73 Thomas Street, Broken Hill. She was known to stay from time to time at 175 Williams Lane, the home of Ole Byholm. Christine had agreed to purchase a car from Mr Byholm and had set up regular payments to him from her bank. She had not yet got her license, but apparently she intended to and this was a step towards that goal.

20. The evidence suggests that Christine was future focused and still well connected with her family and some friends. There is nothing to suggest that Christine deliberately harmed herself around the time of her disappearance.

Mental Health History

21. Christine's first documented episode of psychosis was in 2004. She was admitted to the Mildura Hospital Psychiatric Unit from10 to 26 April 2004, but in May, was found wandering in Wilcannia with florid psychosis.

22. The brief of evidence tendered in this inquest contains relevant parts of Christine's mental health history from December 2009 to April 2016. There are similar presentations and themes in the notes over the years.

23. In December 2012, for example, a discharge summary records Christine as being suffering from "Schizoaffective Disorder Bipolar Type". She was admitted to Broken Hill Hospital for 8 days, initially psychotic, although this resolved quickly. She had been non-complaint with her anti-psychotic medication and was found naked and disoriented. On three recent occasions, she had put herself at risk by wandering naked:

a. In bush near Menindee February 2011- requiring search and rescue services to be called out.
b. On Silverton Road November 2012
c. On Broken Hill airport road November 2012

24. Throughout 2013, 2014 and 2015, Christine was treated by the Community Mental Health Team, but there were numerous Hospital admissions for psychotic episodes, most following a similar pattern. On numerous occasions, Christine discharged herself against advice, and she had a history of absconding from Hospital wards.

25. On 10 April 2016, Christine presented to the Emergency Department of Broken Hill Hospital reporting depression and stress and demonstrating paranoia. She said she felt unsafe in her own flat in Thomas Street, and thought that men were following her and youths were coming up in the alley to steal things from her. She was not sleeping and had stopped injections of her anti-psychotic medication, Paliperidone. While she was awaiting a mental health review, Christine became agitated and left the Hospital against advice.

Lead up to presentation on 21 April 2016– discharge on 22 April

26. On 21 April, Christine was at Wilcannia visiting family and friends. Wilcannia is about 200 Km from Broken Hill.

27. Thomas Saunders, then a solicitor with the ALS in Broken Hill was in Wilcannia for court and he left at about 1.30pm to return to Broken Hill. About 3kms out of Wilcannia- 200kms from Broken Hill, Mr Saunders saw Christine walking on the road. He pulled the car over the check on her welfare and agreed to give her a lift home to Broken Hill.

28. Mr Saunders has provided a detailed statement outlining his interaction with Christine. He states that as they drove she told him that her name was Christine Young. They had a conversation on different topics and Christine played a game to guess the make and model of cars. She did not appear to be intoxicated. Christine told Mr Saunders that she wanted to go home and that she lived in a laneway near the Hospital, which was true. She also stated that she wanted to go and visit two friends who were brothers and lived in Wolfram Street and she did indeed have two friends who were brothers who lived in Wolfram Street. Clearly Christine was capable of clear thought at that time.

29. When they got to town, Christine was indecisive about where she wanted to be dropped off. Mr Saunders was heading back to the ALS office and he dropped Christine at the corner of Sulphide and Beryl Streets.

30. Early in the evening, consistent with what she had said to Mr Saunders, Christine went to visit her friends, Anthony (Tony) and Mark Lavers, at 58 Wolfram Street. Tony has known Christine a number of years and was a good

friend. He has provided a statement in which he explains that she had few beers and then left the house.

31. At about 11pm, three police officers (Officers Peate, Churchill and Parkes) attended the airport after receiving calls that an Aboriginal female was walking around the airport dressed only in her underwear. The airport is 6kms out of town and police have no information as to how she got there. She had time to walk the few hours from the home of the Lavers brothers and may have done so. Police patrolled the car parks and saw Christine when she stepped out of the bushes. She was dressed only in a pink bra and white socks.

32. Senior Constable Vanessa Peate saw that Christine had some minor injuries; she had scratches to her shoulder and stomach, as well as swelling to her eye and lip. She sat Christine in the back of the police car to make her feel comfortable. Christine was very quiet and appeared very scared and she spoke only to request an ambulance.

33. Police called an ambulance, which arrived promptly, but Christine refused to be treated and would not reply when asked how she got her injuries.

34. Christine was taken to the Hospital and police remained with her. Of course they could not tell staff who they had bought in because at that stage they didn't know who they had transported.

35. Christine was triaged by Registered Nurse (RN) Jane Burbury at 12.15am, as a 'queried assault'. She was classified as a Category 2 presentation meaning that she needed to be seen within 10 minutes. She had several injuries including swelling to her left eye, cheek and mouth as well as abrasions. She was alert and shivering, maintaining eye contact. Nurse Burbury recalls that she sat quietly wrapped in a blanket, and despite the efforts of herself, the doctor on duty, Dr Mills, and the female police officer, Christine did not want to talk. She did not consent to a physical examination of Dr Mills. She said to Dr Mills "you're going to hurt me".

36. Since Christine had bright red blood between her legs, there was a concern she had been sexually assaulted, and staff called in a Sexual Health worker, Hannah Dean (nee Downing). Christine told her that she had been drinking with friends at 58 Wolfram Street.

37. Detective Senior Constable (Det. S/C) Daniel Crowley was the on call detective that night and attended the Hospital. He was briefed by police and then spoke with Ms Dean, who said that she had spent some time with the women, but she would not speak.

38. When Detective Senior Constable Crowley approached Christine and introduced himself, she said "I know you", but S/C Crowley did not immediately recognise her. When he tried to get information from her, the only thing she would say is: "They're coming to get me" and "Police are going to shoot me". Detective Senior Constable Crowley continued to try and talk to

her and reassure Christine that she was safe, but she was withdrawn, looking around constantly and appeared scared and confused.

39. A short time later Senior Constable Churchill, who had been following up inquiries with the occupants of 58 Wolfram Street, told Detective Senior Constable Crowley that the women's name was Christine Young, and at that point Detective Crowley recognised that he had indeed had dealings with her.

40. Detective S/C Crowley went and spoke to Christine again and said words to the effect of "Hi Christine, I didn't recognise you, remember me?". Christine smiled and nodded her head. Although Det. S/C Crowley asked other questions, the only additional information Christine would give him is that she had a doctor's appointment the next day at the Maari Ma Aboriginal health clinic in Broken Hill.

41. When Det. S/C Crowley spoke further with Hannah Dean, she informed him that she did not think Christine had been sexually assaulted. Her injuries were determined to be superficial.

42. The on duty doctor that evening was Dr Gavin Mills, then a third year registrar in emergency medicine. Dr Mills was overseas and not available to give evidence. He has provided a statement (T 32) in which he states that it was of the opinion that Christine was not a risk to herself and others and did not warrant a mental health intervention. Christine told him that she would follow up the next day with the Mari Ma, the Aboriginal Health Service. In those circumstances, he thought it appropriate to discharge her from the ED at around 2.30am. He had access to the on call psychiatrist, but he did not use that service as he did not think there was a mental health issue.

43. The evidence establishes that Police knew the name of Christine Young before they left the Hospital and they passed that on to Hospital staff. Hanna Dean had left the Hospital by the time that Police identified Christine, and she had performed the role required of her. Neither Dr Mills, nor nursing staff looked up the medical records for Christine, and had they done, I have no doubt she would have been detained. This presentation was so similar to other psychotic episodes Christine had had over the previous decade.

44. Dr Olav Nielssen is a clinical and forensic psychiatrist who was retained to review this case. I agree with his expert opinion that Christine should have had a mental health assessment in the early hours of the morning on 21 April and it was a missed opportunity that she did not.

45. While it cannot be certain that it would have made a difference to whether she absconded from the Unit, it may well have done, given that Christine would have got some sleep overnight (thus reducing her level of confusion and agitation), and her medication (anti-psychotic and sedative) could have been started earlier. That was a missed opportunity.

46. As Christine was not going to be held in Hospital and Det. S/C Crowley was still concerned about her, he contacted the Salvation Army Women's refuge,

located in Lane Street, Broken Hill, and arranged a bed. Senior Constable Peates then drove her to the refuge, and Det. S/C Crowley spoke with the manager, Raelene Redford.

Christine leaves the women's refuge

47. Ms Raylene Redford, then the Manager of the Catherine Have Women's Refuge, gave evidence that she knew Christine because she had stayed at the refuge on numerous occasions. Christine was not well when she arrived and was agitated. Ms Redford was off site and had come in to open the refuge to get a med for Christine, and she then went back to her home.

48. In the early hours of the morning, Ms Redford received calls from another resident to say that Christine was keeping her up and was wandering in and out of her room. Unfortunately, the Women's Refuge is not staffed through the night by a staff member on site. Had it been, then Ms Redford gave evidence that she would have sat with Christine through the night and could have calmed her. Ms Redford gave compelling evidence in support of an increase in funding for the shelter to employ someone overnight. This would be highly beneficial given the high needs of the women who attend, and the number of women who suffer from mental health issues. It is a great shame that the Refuge was not funded sufficiently to have a staff member overnight, because it may have helped to settle Christine and made a significant difference to her welfare that morning.

49. The following morning, at around 5.30am, Raelene Redford was notified by another resident that Christine had left the Refuge. She then phoned Det. S/C Crowley to tell him.

50. At around 8.30am, police began to receive reports that an Aboriginal female was walking in the middle of the road on Holten Drive Broken Hill. Senior Constable Mitch McKenny and Constable Darren Quinn arrived at the scene and found that other police had detained Christine. Christine was wearing a light blue jumper and black pants. She was bent over and using a stick as a walking aid. Senior Constable McKenny recognised Christine and observed her to be incoherent, unable to recall her name and in poor physical health.

51. Constable Darren Quinn contacted the police station and discovered that she had been treated the night before. Quinn attempted a conversation with Christine. He asked her to confirm her name, where she lived and whether she had any friends nearby who she was walking to. To each question she replied: "I don't know".

Detention by Police and Hospital admission on 22 April

52. Police called an ambulance and Christine was taken to Broken Hill Hospital and scheduled under s.22 of the *Mental Health Act*, which allows a police officer to apprehend the person and take the person to a declared mental

health facility if the officer believes on reasonable grounds that (*inter alia*) it would be beneficial to the person's welfare to be dealt with in accordance with this Act.

53. Constable Quinn completed the s.22 form and explained to a Hospital staff member that he did not think she was well enough to be in public. While he was completing that form, Christine tried to leave the Emergency Department but was directed by Hospital staff to stay. Police arranged for a young female officer, Constable Ally Chambers, to attend the Hospital to search Christine and Constable Chambers found nothing dangerous or of value on her. Police then left the Hospital.

54. The first medical officer Christine saw was Dr Ali Balbaaki, a Career Medical Officer (CMO) in the Emergency Dept. He read the triage notes referring to her mental health and behavioural disturbance. He arranged for her to be seen by the Aboriginal Liaison Officer, Hayley King, who spent several hours with her calming Christine down. I found Ms King to be a very impressive witness and her cultural knowledge skills were invaluable in the circumstances. Christine expressed to her that she was fearful and thought people were after her. Ms King stayed with Christine until about lunchtime, when Christine slept, and she obviously had a very calming and positive effect.

55. Dr Ali Balbaaki formed the impression that Christine was suffering from psychosis, but he also queried her physical conditions including Urinary Tract Infection, chest infection and transient ischaemic attack or stroke. He arranged for Christine to undergo a CT scan of her brain, blood test, a chest X-ray and urine analysis. Some time after 12.30pm, Christine was discharged from ED to the MHIPU.

The psychiatric assessments

56. Christine then saw Ms Vanessa Smith, a community health nurse from the Mental Health Intake section, who took a detailed history, which was later passed onto the treating team from the Mental Health Inpatient Unit. Ms Smith made an entry at 1.15pm on 22 April 2016. She documented a history of schizophrenia from 2004, treatment by the Mental Health Service at Broken Hill Base Hospital in 2004 and from 2008 to 2015.

57. The first psychiatric examination was conducted by Dr Preet Gulati, who has seen Christine on other occasions in the ward. He completed the initial Form 1, under the Mental Health Act, determining that Christine was a mentally ill person and required detention in Hospital.

58. At around 3pm or 3.30pm, a second examination was conducted by Dr John Lam-Po-Tang, who was a locum psychiatrist who had started his week at Broken Hill on 20 April. He was working in the Unit during daytime hours and was on call at night. He completed a second Form 1, detaining Christine as a

mentally ill person and formed the impression that she as suffering from Paranoid schizophrenia, based on her history and presentation.

59. Christine was given a dose of Paliperidone 100mg Intra Muscular injection and Paliperidone 6mg tablet stat dose orally, with a plan to continue the injection every 4 weeks. Paliperidone is an antipsychotic mainly used to treat schizophrenia and schizoaffective disorder.

60. Registered Nurse Jane Stephens commenced the afternoon shift at 2pm. She received a handover and was allocated Christine as one of her patients. Nurse Stephens gave evidence that Christine was sitting at a table in a communal area, before she got up and began banging on the nurses door requesting a cigarette. Smoking is not allowed and Christine was offered a nicotine replacement, which she refused. She became more agitated and was seen pushing past nurses trying to reach a drawer where patient's cigarettes are kept.

61. At 2.35pm, she was given a 5mg dose of Diazepam (Valium), which is a sedative, but it had little impact on calming her down.

62. Some time after that, Nurse Stephens told Dr Lam-Po-Tang of how agitated Christine was and about her request to go outside. Dr Lam-Po-Tang decided to permit three periods of 15 minutes of unescorted leave every 24 hours, but he told Christine that she would not get another one if she did not come back.

63. Christine left the Mental Health Unit around 3.45pm and had a cigarette at the rear of the Hospital. She then came back in and at around 4pm she went to speak with the Aboriginal Liaison Officer, Ms Hayley King. Christine said to her: "someone is after me". Ms King reassured her that she was in a safe place and Christine left a short time later.

64. Christine returned to the Mental Health Unit. Some time later she contacted her friends, Tony and Mark Lavers, to ask them to visit her and to bring her cigarettes. Within ten minutes, Christine became agitated again and demanded of RN Stephens that she have more time to smoke. Nurse Stephens suggested that she was until after tea, which is 5pm, but Christine became increasingly agitated and began banging on the door.

65. Christine told her she did not want to eat her evening meal and instead wanted to go outside to smoke. She was vocal and banging on the door and was asked by RN Stephens to sit down and stay calm before she would be allowed to leave.

66. Nurse Stephens observed Christine to then sit on a chair by the table, about two metres from the exit door. She asked a casual Nurse, Li Fang, and a 3rd year University student, to closely watch the main exit door, in case Christine attempted to leave when someone was gaining access. When another patient who had been granted unescorted leave wanted to go out, RN Stephens asked Li Fang to take that patient through the consulting room to let her out to

the exterior door from that room, leading directly into the corridor outside the medical ward.

67. Li Fang and the student nurse took the other patient the wrong way, where their swipe card didn't work, and then had to come back. She then bought the patient back through the consulting room to the main door, which Christine had been closely watching for about 30 minutes. As Li Fang opened the main door to let the other patient out, Christine pushed passed them both and began walking quickly down the main corridor. One of the nurses called out to RN Stephens, in what sounded like an urgent voice, that Christine had left.

68. Christine's friend, Anthony (Tony) Lavers attended around this time and found Christine walking along the corridor near the Mental Health Unit. Christine asked him to come for a smoke, and when he told her that he had none, she asked him to come outside anyway. Tony Lavers followed Christine along the corridor. She was walking fast and got ahead of him. He called out for her to wait.

69. RN Stephens had come out of the Unit and was calling out Christine's name, but she kept walking towards the main entrance door, out the front and right into Thomas Street. Her image is captured on CCTV, where she can be seen walking out the Thomas Street main entrance with Tony Lavers following. She turned right and headed along Thomas Street, towards her home, which is only 800 metres along. She was then observed by RN Stephens to start running. RN Stephens did not follow but went inside and told her supervisor, before calling Broken Hill police.

70. Tony Lavers followed Christine along Thomas Street for a while until the intersection of Bromide Street. He couldn't get her to stop and so went home. He last saw her walking west along Thomas Street.

71. Christine walked past her home at 73 Thomas Street. At the intersection of Brookfield Avenue (AKA Silverton Road) she turned right and headed north, walking on the eastern side of Brookfield Avenue. That road leads to Silverton, which is 25kms away and is surrounded by bushland. At some point Christine located an orange traffic cone, known colloquially as a Witch's' Hat, and she put that on her head and kept walking.

72. I heard evidence from a citizen of Broken Hill named Paegan Evans. She was driving to her parents' home on Brookfield Avenue. She noticed an Aboriginal woman about 40 years of age, wearing a blue T shirt and tracksuit pants, with a Witch's' Hat on her head. She was holding an armful of weeds in front of her, as if cradling a child. After telling her parents what she saw, the family became concerned and Ms Evans drove up the road. She saw the woman, we now suspect to be Christine, walking on the dirt track next to the road. I had the opportunity to view this area during the course of the inquest. This part of the road to Silverton has dirt tracks on either side. By this time, Ms Evans noted that the woman had no clothes on, but she still had the Witch's' Hat on her head. Ms Evans called the Broken Hill Police and was told that

police were looking for the women and would attend. She continued to follow her in the car.

73. About 700 metres down the road, half way between Brown Street and Quandong farm, Christine took the cone off her head, and Paegan could no longer see her. There are no street lights and no houses on that part of the road and it was dark. Paegan called the police and told them that she had lost sight of the woman. She then drove the dirt track, starting from the intersection with Brown Street. About 10 metres along the track, Paegan found Christine's track pants and shoes. Police then arrived and Paegan showed them where she had located the belongings.

74. There was one other sighting of Christine after she left the Hospital. About 5.30pm, Heidi White was driving along Brookfield Avenue. She saw an Aboriginal female on the north eastern corner of the intersection with Brown Street, and recalled her wearing a blue t-shirt, dark track suit pants and the orange Witch's' Hat on her head, holding weeds and flowers in her hands. She was walking north towards Silverton. Ms White drove home. She spoke to her husband about it after he came home at 6pm and then she called the police.

75. Inspector Leslie Andrews attended the scene and set up a command post where Christine had last been seen. S/C Vanessa Peate and Constable Ryan Parkes attended, along with 16 State Emergency Services (SES) personnel to assist in the search, which was conducted on foot and in vehicles.

76. A number of items belonging to Christine were located. S/C Peate located shoes, socks, tracksuit pants and a pink bra and she recognised them as the clothes Christine had worn the previous night. Police made inquiries with friends and relatives. The search that night finished at 10.30pm.

77. About 7am on 23 April, Inspector Andrews set up the command post near the intersection of Silverton Road and Brown Street and the search continued with Police and the SES. A number of items connected to Christine were located on the eastern side of the Silverton Road, about half way between the intersection of Brown Street and Quandong Farm. That included a pair of Nike running shoes, a blue jumper, pink underwear and an orange coloured traffic cone. Footprints were located heading along a creek from the Silverton Road in an easterly direction, but disappeared about 300metres after leaving the creek.

78. From this point a full search was coordinated by Sgt Mark Fisher, who is an accredited Land Search Coordinator, and Detective Inspector Michael Fuller, and other experienced officers from outside Broken Hill were called in. The search involved police and SES, on foot, motorcycles, 4WD's, aircraft and helicopters and the brief of evidence has statements from those involved. The community supported police by providing information.

79. The most notable thing discovered over that time was a pair of socks, which had been located about 50 metres further north along the dirt track, past

where the traffic cone was found. One was light blue and one was a purple/white colour and S/C Crowley recognised them as the ones worn by Christine.

80. On 27 April 2016, at around 10am, Detective Sergeant Mark Fisher contacted Dr Paul Luckin, an anaesthetist, to find out what Christine's prospects of survival were. He analysed the known circumstances of Christine's disappearance and factors like, the bushland she was in, her mental health, the fact she discarded her clothes, lack of water and the weather conditions. Dr Luckin thought that Christine had a 10% chance of survival at that time. In his expert report he provided the opinion that Christine died some time between 24 and 26 April 2016.

81. On Friday, 29 April 2016, the Command Post was stood down and the search discontinued. Christine's case became a Missing Persons case, with Detective Senior Constable Crowley in charge.

82. By 8 and 9 June 2016, Det S/C Crowley arranged for the services of a specially trained cadaver dog and his handler to assist in the search to identify any remains. It did not result in the discovery of Christine.

83. On 31 October 216, a further search was coordinated by Det S/C Crowley using 2 police motorcycles, but again it was unsuccessful.

84. There are many signs that point to the fact that Christine is likely to be deceased, rather than deliberately hiding. Most importantly, Christine has a large loving family that she loved and kept in contact with, and I am told that she never missed the birthdays of her children or grandchildren. She was particularly close to her mother, who she called to speak to most days. They have not heard from her since she went missing.

85. Christine had a Commonwealth Bank account and she has not made an active withdrawal since she went missing. She has not been heard of by Mark or Anthony Lavers, by the staff at the Women's Refuge or any other friends that she had in and around Broken Hill.

86. The police officer in charge of a Missing Person investigation must report the matter to the Coroner once they are satisfied that no further enquiries can be made as to whether a missing person is alive or deceased. This should occur as soon as the investigator is of the belief that the missing person is now deceased. Missing Persons' cases are reported to the Coroner by investigating police officers in the form of a 'P79B Police Report of Suspected Death', which outlines the factual background of the Missing Persons' case. Detective Senior Constable Crowley has completed such a form.

Lessons learnt and changes introduced by the Hospital

87. As a result of Christine's disappearance, the Far Western Local Heath District (FWLHD) was asked to provide information in relation to:

- the “lessons learnt” following Christine Young’s escape from the locked Mental Health Inpatient Unit; and
- What actions had been taken to address any issues identified surrounding the circumstances of Ms Young’s absconding.

88. In response, the FWLHD produced an excellent document, with multiple annexures. It was excellent for these reasons. Firstly, it demonstrated that comprehensive internal and external reviews had been commissioned by the District; secondly, it was not defensive and it openly acknowledged some missed opportunities to provide better care for Christine; thirdly, it outlined clearly some important changes that had been introduced.

89. It is not necessary to outline every improvement made, but some of the most significant are:

(a) Access to and from the MHIPU presented a risk of absconding due to the lack of an “air lock” double entry system. At the time, when someone entered or exited the MHIPU this presented an opportunity for another patient to leave, from a point which was obscured from the view of the staff member at the location of the “door release” at the staff station. In March 2017, an airlock double door system was installed in the main entry/exit to the MHIPU.

(b) After conducting a safety audit of the physical environment of the MHIPU and related improvements, in May 2017 the courtyard wall was raised to prevent patients absconding, and new courtyard furniture was purchased and secured to the ground in the courtyard.

(c) Since August 2016, the Ministry of Health has collected data on a monthly basis from all Local Health Districts about patients who have absconded from mental health inpatient units (classified as Absconding Type 1).

(d) On 26 July 2017, the Ministry of Health released *Policy Directive PD2017_025 Engagement and Observation in Mental Health Inpatient Units* (“Policy Directive”) (Annexure 5). On 27 July 2017, MHIPU staff have been advised via email about the release of the Policy Directive.

(e) Observation and leave is now included in the FWLHD’s quality audit reporting system under the National Safety and Quality Health Service Standards (“NSQHS”). It is being audited on a quarterly basis. The results of the audits are monitored by the FWLHD’s Clinical Governance Unit. If the NSQHS are not being met in any respect, action plans are implemented to achieve compliance with the standards.

(f) The FWLHD is updating its local policy (to replace its previous policy *FW_PD2012_004 Approved Patient Leave – Mental Health Inpatient Units*.) The new leave policy, *Levels of Engagement, Observation and Leave in the MHIPU* is currently in draft form and has been circulated for comment to all relevant stakeholders.

(g) Even prior to the release of the Policy Directive, the FWLHD sought to improve staff engagement with patients. For example, in February 2017, MHIPU staff were educated about "patient rounding", an hourly patient engagement technique.

(h) Increased awareness of the importance of nicotine replacement therapy.

(i) The clinical handover to MHIPU staff did not reveal Ms Young's high risk of absconding. The MHIPU has renewed its focus on the importance of clinical handover and tools which can assist with improved clinical handover. For example, a clinical handover tool called the Electronic Patient Journey Board ("EPJB") is being presently trialled in the MHIPU using the ISBAR format[1] to aid in the clinical handover process.[2] The EPJB is now in place instead of the previously used hybrid paper / electronic health care record. If the EPJB was in place in the MHIPU during Ms Young's admission, her history of absconding and her care level (as well as other relevant clinical information) would have been clearly apparent to the MHIPU staff involved in her care.

(j) In October 2017, the MHIPU established a leadership group, comprised of the Deputy Director of the Broken Hill Mental Health and Drug & Alcohol Services ("the Services"), the MHIPU NUM, the MHIPU Clinical Director / Psychiatrist and the Clinical Nurse Specialist ("CNS") of the Services. Subsequently, the Consumer Engagement Coordinator, an employee with lived experience of mental ill health, joined the group. The aim of the Leadership Group is to provide strategic clinical oversight for the MHIPU and implement change in the MHIPU with the aim of providing care that is of the highest standard, in line with key performance indicators and auditable measures.

90. I heard oral evidence from Ms Daly that there is still room for improvement. In particular, she regards it as very important that the environment be improved to provide a more therapeutic space for patients, including greening the garden area, bigger spaces, more appropriate furniture and bathroom facilities. Having seen the facility, I agree with her assessment. I was pleased to hear that the 2017-2018 FWLHD Asset Strategic Plan includes a plan to redesign the MHIPU.

Support for Recommendation – Aboriginal Health Liaison Officer

91. A persistent theme in this inquest was the importance of Aboriginal Health Liaison officers, such as Hayley King. The evidence establishes that there are only two Aboriginal Health Liaison officers at the Hospital, and they do not

[1] ISBAR (Identify, Situation, Background, Assessment and Recommendation) is a mnemonic created to improve safety in the transfer/communication of critical information.

[2] See http://www.health.nsw.gov.au/pfs/Pages/epjb.aspx for details of EPJB, its aim and benefits.

work weekends or after hours. They can be called in, but only when that is approved by the Nurse Manager and that does not happen regularly.

92. As I have already said, Hayley King's presence helped Christine feel safe which in turn helped her to communicate and sleep.

93. Had Hayley King been contacted when Christine was bought by Police into the Hospital around midnight on 21 April 2016, she would have immediately identified Christine and told Dr Mills that she had a long history of schizophrenia. I am confident that is likely to have resulted in Christine's admission. I intend to make a recommendation in support of an increase in the resourcing for Aboriginal Health Liaison officers, so that they are available after hours and on weekends.

Conclusion

94. Christine was very unwell when she walked into the bushland on 22 April 2016. She has not been seen since that day. Christine has a large loving family that she loved and kept in contact with. I am told that she never missed the birthdays of her children or grandchild. She was particularly close to her mother Cynthia, and spoke to her most days. They have not heard from her since she went missing. Sadly, there are many signs that point to the fact that Christine is deceased.

95. Christine's disappearance and apparent death is a tragedy and her family has been deeply affected by her loss. I am sure that they must still have so many questions. I acknowledge their heartbreak in not knowing what happened to their "Chrissy".

96. I would like to thank Cynthia and Tyson and Christine's other family members for participating in this inquest when it has been so difficult and sad for them.

97. I have been so impressed by their courage and dignity. It is obvious how much they loved Christine and how much Christine loved them.

98. In closing, I would like to thank the officer in charge of the investigation, Detective Senior Constable Daniel Crowley. I would also like to thank Dr Peggy Dwyer, my counsel assisting, and her instructing solicitor, Alex Jobe. They have worked tirelessly to assist me before and during this inquest.

Recommendations:

To the **Far Western Local Heath District**

1. That funding be requested for an additional Aboriginal Health Liaison Officer to be rostered on the weekends and on call overnight, for Aboriginal mental health patients at Broken Hill Hospital.

2. That consideration is given to the implementation of a system to ensure Aboriginal Mental Health Inpatients, who do not have leave, be granted personal access to an Aboriginal Mental Health Worker or an Aboriginal Health Liaison Officer.

Findings required by s81(1)

As a result of considering all of the documentary evidence and the oral evidence heard at the inquest, I am able to confirm that the death occurred and make the following findings in relation to it.

The identity of the deceased

The deceased person was Christine Joyce Dorothy Young.

Date of death

Ms Young died between 24 April 2016 and 26 April 2016.

Place of death

She died in the desert scrubland surrounding Broken Hill in NSW.

Cause of death

The medical cause of the death was unable to be determined.

Manner of death

The death was unintentionally caused by misadventure in that she absconded from the Mental Health Inpatient Unit of Broken Hill Base Hospital on 22 April 2016, while she was an involuntary patient, and while she was suffering from paranoid schizophrenia, and she walked into the desert scrubland and was not located.

I close this inquest.

Teresa O'Sullivan
Deputy State Coroner

7 September 2018