CORONERS COURT

Inquest:	Inquest into the death of Benjamin Gilligan
Hearing dates:	8 November 2016 -11 November 2016 (at Dubbo Local Court), 23 May 2017- 26 May 2017(at the State Coroner's Court, Glebe)
Date of findings:	7 July 2017
Place of findings:	The State Coroner's Court, Glebe
Findings of:	Deputy State Coroner, Magistrate Harriet Grahame
Catchwords:	CORONIAL LAW – Death in a police operation; flight from psychiatric care
Non publication orders	Pursuant to section 74(1) *Coroners Act* 2009 (NSW), I order, No publication of any exhibit or material including photographs and/or DVDs tendered in these proceedings that may contain any image of Benjamin Gilligan. No publication of the specific sections of the NSW Police Safe Driving Policy at Exhibit 1, Volume 2, Tab 30. (These parts are blacked out on the document tendered)
File number:	2014/173338

Representation:	Mr R Ranken, counsel assisting instructed by Ms Tracey Howe, Crown solicitors Office. Mr J Brock of counsel, instructed by Ms H Cooper of the Legal Aid Commission for the Gilligan Family. Mr P Rooney of counsel, instructed by Henry Davis York, solicitors for the Western NSW Health District. Ms L McFee of counsel, instructed by MDA National for Dr Aniza Ghazalli. Mr Gregg of counsel, instructed by Meridian Lawyers for Dr Barden. Mr N Regener solicitor, Makinson d'Apice Lawyers for the NSW Commissioner of Police. Ms P Kava, solicitor, New Law solicitors for the Nurses Association and Mr Suresh Stephen.

Findings:	**Identity of deceased**: The deceased person was Benjamin Gilligan. **Date of death**: Benjamin Gilligan died on 5 June 2014. **Place of death**: He died on the side of the Oxley Highway, about 30 kilometres north east of Coonabarabran, NSW. **Cause of death:** He died as a result of multiple injuries caused when the vehicle he was driving collided with a tree. **Manner of death:** Ben was affected by methylamphetamine at the time of his death and was in need of psychiatric care.

Recommendations	**To the Minister for Health** That the Minister give consideration to having his Department convene a state wide forum to discuss best practice management procedures for patients with acute behavioural disturbances presenting to NSW Emergency Departments. **To the Western NSW Local Health District** That the Western NSW LHD give effect to the requirements of the existing leave policy by developing a written document to be provided to patients exercising gate leave and any family or carers who may be responsible for the patient while they are on such leave. The document should set out information concerning leave, including the purpose of leave, the time at which the leave commences and when the patient is due back and any particular requirements or restrictions such as ensuring the patient remains in the carer's company at all times or does not attend certain locations etc. That, pending the redevelopment of the Emergency Department at Dubbo Base Hospital, the Western NSW Local Health District develop and implement a site-specific policy relating to the use of the "Purple Room" to give effect to the intent and aims of the existing NSW Health Policy concerning aggression, seclusion and restraint in mental health facilities in NSW.

Table of Contents

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

These are my findings in relation to the death of Benjamin Gilligan.

Reasons

Introduction

This is an inquest into the death of Benjamin Gilligan. Ben was 22 years of age at the time of his tragic death on a roadside near Coonabarabran. In the months prior to his death Ben had been increasingly unwell. He had recently been receiving mental health treatment at Dubbo Base Hospital and medical staff had come to believe that it was most likely that he had been suffering from a drug induced psychosis. Ben absconded from Dubbo Base Hospital on 22 May 2014, whilst on gate leave. He remained in the community until his parents again sought urgent assistance on 5 June 2014. That evening Ben was brought to Dubbo Base Hospital under police escort. Shortly afterwards he made a violent escape from the Emergency Department. Ben took his father's car, telling him that he was on his way to Queensland. Police were contacted and the vehicle was later seen on the Newell Highway. There was a short pursuit, which was terminated after police lost sight of the vehicle. Shortly afterwards, it appears that Ben lost control of the car and smashed into a tree on the Oxley Highway, about 30 kilometres from Coonabarabran. Emergency Services were called, but Ben could not be revived.

Ben's parents Wayne and Astrid Gilligan attended each day of the inquest and their love for their son was evident. They felt let down by the mental health system and unsupported in their efforts to help the child they loved so dearly. Ben's death has been a devastating loss for the Gilligan family.

The Role of the Coroner and the scope of the inquest

The role of the coroner is to make findings as to the identity of the nominated person, and in relation to the date and place of death.[1] The coroner is also to address issues concerning the manner and cause of the person's death. In addition, the coroner may make recommendations in relation to matters that have the capacity to improve public health and safety in the future[2].

In this case there is no dispute in relation to the identity of Ben Gilligan, or to the date and place or medical cause of his death. For this reason the inquest focused on the circumstances surrounding Ben's death, in particular his treatment prior to leaving the Dubbo Base Hospital.

It should however be noted that this is a mandatory inquest because Ben's death occurred "during the course of a police operation". Parliament requires that inquests

[1] Section *81 Coroners Act* 2009 NSW
[2] Section *82 Coroners Act* 2009 NSW

of this kind are conducted by a senior coroner[3]. This statutory position reflects the importance of independence and transparency when it comes to investigating deaths in this category. The circumstances surrounding these deaths should be carefully scrutinised and care must be taken to ensure that all relevant police policies and practices are most carefully reviewed. For this reason Ben's death was investigated pursuant to the NSW Police critical incident guidelines[4]. However, as will become apparent, the issues requiring most attention during the inquest related to Ben's medical care, rather than the conduct of the police search for Ben after he had absconded from hospital. This focus was one which was supported by the Gilligan family.

A draft list of issues was circulated prior to the commencement of the inquest. Aside from the formal findings pursuant to the Act, the following issues were identified

1) Was the management of Mr Gilligan by Dubbo Hospital following the determination by the Mental Health Review Tribunal on 21 May 2014 appropriate, particularly in so far as the decision to grant Mr Gilligan "gate leave" on 22 May 2014 and to subsequently discharge him on 23 May were concerned ?
2) Having regard to the circumstances in which Mr Gilligan was discharged from the Hospital on 23 May 2014, was there adequate follow up from the Western NSW Local Health District?
3) What were the circumstances in which Mr Gilligan was able to abscond from the Hospital? In particular:
    - Were the procedures, facilities and arrangements for his placement in the "purple room" appropriate to secure him and prevent him from escaping?
    - Were there any alternative facilities available that would have better ensured he was secured and prevented from escaping?
4) Are there any recommendations that are necessary or desirable to make in relation to any matter connected with the death?

The Court heard evidence over eight hearing days and received extensive documentary material including written statements, photographs, expert reports and various recordings. Much of the material was summarised by counsel assisting the court in his detailed opening. I intend to largely adopt the factual summary distilled by counsel as the basis of my chronology[5].

[3] See sections 23 and 27 *Coroners Act* 2009 NSW

[4] Having reviewed the evidence of independent eyewitnesses and had access to contemporaneous police radio communications I am well satisfied that the short police pursuit that occurred had been terminated at least ten minutes prior to the fatal collision. I am also satisfied that any technical breaches of the NSW Police Force's Safe Driving Policy did not play a contributory role in the circumstances of Ben's death. It is extremely disappointing that some CCTV footage was misplaced before the investigation was taken over by a Critical Incident Investigation Team, however, I do not believe that it greatly impacts on my ability to understand the later collision.

[5] I thank those assisting me for carefully summarising the material.

A short chronology of events

Social history:

Ben Gilligan was born in Sydney in 1991. He had one older sister and was close to his parents Wayne and Astrid. The family moved to Dubbo when Ben was in his last year of primary school. He loved sports and had a large group of friends. His family described his warm smile and sense of humour.

Ben's parents reported that he had been a happy and healthy child.

At about the age of ten Ben was diagnosed with Tourette's syndrome after developing facial and body ticks.[6] He did not have verbal symptoms and the physical symptoms seemed to cease after puberty. However, Ben is reported to have developed mild symptoms of obsessive-compulsive disorder and some anger management issues around this time.

Ben left school in year 10 and commenced, but did not complete, a chef's apprenticeship. Later he worked in the food industry as a cook.[7]

In 2010 Ben and his then partner, Sinead had a child, Maddie. Ben was apparently overjoyed to be a father. Unfortunately, the relationship with Sinead did not last and Sinead and Maddie moved to Queensland.

At the end of 2012 or the beginning of 2013 Ben moved to Queensland to be closer to Maddie. He began working in a coffee shop and later commenced a personal trainers course. However, he injured his right thumb and required surgery to repair it. Ben could not work during the recovery period and this led to financial difficulties. Ben returned to Dubbo in about July 2013 and his father noticed that he appeared depressed and demonstrated some anger management issues.[8]

In around November 2013, Ben began working as a casual labourer through an employment agency and developed "an obsession with the gym", attending up to three times a day[9]. There is some evidence that he had experimented with the use of steroids around this time.

In around January 2014, Ben began to turn down work with the employment agency. His depression persisted and his behaviour deteriorated. He became rude and uncharacteristically aggressive towards his mother. He was secretive, irrational and made threats of suicide and violence against others. Ben's parents were worried and

[6] See Statements of Wayne Gilligan, Exhibit 1, Volume 2, Tab 25 [4] and Astrid Gilligan at Exhibit 1, Volume 2, Tab 23 [4] onwards
[7] Statement of Wayne Gilligan, Exhibit 1, Volume 2, Tab 25 [6]
[8] Statement of Wayne Gilligan, Exhibit 1, Volume 2, Tab 25 [7] onwards
[9] Statement of Wayne Gilligan, Exhibit 1, Volume 2, Tab 25 [11]

tried to persuade him to seek help. Ben refused to see a doctor or counsellor despite his father's encouragement and efforts.

Unfortunately, Ben's behaviour became increasingly irrational with talk of suicide and threats of violence towards anyone he thought might be persecuting him. Around this time, his mother, Astrid became increasingly frightened of Ben and his behaviour.

Dubbo Base Hospital Attendance – 5 April 2014

On 5 April 2014 Ben had contact with the psychiatric liaison service in Dubbo after he was brought into the Emergency Department of the Dubbo Base Hospital by the police. These events coincided with Ben breaking up with his girlfriend of the time. He apparently made suicidal threats and told his family that he would never see them again. Ben was diagnosed with "anxious impulsive personality" and immediately discharged home with plans for follow-up by a general practitioner with input from a psychologist.[10]

Dubbo Base Hospital Attendance – 17 April 2014

During April 2014, Ben began a brief relationship with Christina Dowling, which lasted about three or four weeks. His parents remained concerned about his mental state. On 17 April 2014 Ben's father contacted police to report that Ben was agitated and exhibiting paranoid behaviour and threatening self-harm[11]. This followed a serious dispute between Ben and Christina at her home in Dubbo after they had apparently broken up. Police attended and described Ben as appearing to be "very ignorant, [sic] despondent and agitated."[12] Police apprehended Ben and took him to the Emergency Department of Dubbo Base Hospital under section 22 of the *Mental Health Act* 2009. Ben was assessed as not being "mentally ill" and was discharged from hospital into the care of his parents. They felt helpless in their efforts to assist their son.

Dubbo Base Hospital Attendance – 14 May 2014

In May 2014, Ben began a relationship with Priscilla Smith, who for a time lived with Ben and his parents at their Dubbo home.

On 14 May 2014, Ben and Priscilla attended an appointment at the Dubbo office of Centrelink. On this occasion, it seemed that Ben suffered a severe psychotic episode. Ben was having paranoid delusions about Priscilla. He believed that she

[10] For discussion of these events see Dr Ghazalli's supplementary statement, Exhibit 1,Volume 2,Tab 21
[11] See Wayne Gilligan's statement Exhibit 1, Volume 2, Tab 25 [17] onwards
[12] COPS Event Report E4207552, Exhibit 1,Volume 2, Tab 24

was involved with people who were bugging his phone and placing special Bluetooth devices in her earrings and jewellery that were capable of tracking him.[13]

Once again Wayne Gilligan contacted the police to report Ben's paranoid and psychotic behaviour, which included shredding Priscilla's handbag with a Stanley knife and attempting to destroy her telephone. Police apprehended Ben under section 22 of the *Mental Health Act* 2009.

An ambulance arrived at the family home and took Ben to Dubbo Base Hospital, where he was admitted and came under the care of consultant psychiatrist, Dr John Bardon and psychiatric registrar, Dr Anizar Ghazalli[14]. It appears that on initial presentation to hospital, Ben strenuously denied any drug use. At this stage his family were also unaware that Ben had apparently been using amphetamines. In the circumstances, a plan was developed involving Ben staying in the hospital as an involuntary patient for 4 weeks. This was on the basis that there was no clear evidence of the cause of Ben's psychosis, Ben demonstrated a lack of insight into his condition and was resistant to treatment.

Mental Health Review Tribunal – Involuntary Treatment Order – 21 May 2014

On 21 May 2014, the Mental Health Review Tribunal made an order that Ben was "a mentally ill person, and must be detained in or admitted and detained in Dubbo Base Hospital for further observation or treatment, or both, as an involuntary patient until a date no later than 18 June 2014".[15]

The reasons recorded by the Mental Health Review Tribunal refer to the fact that Ben had a "strongly supportive family" who "want him home when well". It is also recorded that Ben "had been brought in by police after family registered their concerns about Ben. He had been very paranoid and irrational - still guarded and unwilling to engage. First presentation psychosis – CT scan scheduled. Says medication is making him drowsy. No memory of allegations about mobile in water, shredding handbag. Prior misadventure, family concerned about his safety. Concerns regarding compliance [indistinct] medication and relapse. No insight at all."[16]

In her report to the Tribunal, dated 19 May 2014, in support of the application for involuntary detention and treatment, Dr Ghazalli noted that Ben's "resistance, guardedness and lack of insight into his condition makes it unlikely that he will be able to be managed outside a secure hospital setting. His family have also requested for him to be treated in hospital and not prematurely discharged as they have grave concerns for his safety and have not been able to care for him at home"[17]. Ben

[13] See statement of Priscilla Smith, Exhibit 1, Volume 2, Tab 26 [6] onwards
[14] Dubbo Hospital Records, Exhibit 1, Volume 2, Tab 21
[15] Dubbo Hospital Records, Exhibit 1, Volume 2, page 60
[16] Dubbo Hospital Records, Exhibit 1, Volume 2, page 60
[17] Annexure A, Dr Ghazalli's supplementary report, Exhibit 1, Volume 2, Tab 20A

opposed the inpatient order. However, when it was granted his parents were somewhat relieved and sincerely hoped that Ben may finally get the assistance he needed.

Ben's admission to using "ice" and the diagnosis of drug induced psychosis

After the Tribunal hearing, Ben asked to speak with Dr Ghazalli. He admitted to Dr Ghazalli that he had been "shooting ice" daily for the past few months[18]. Dr Ghazalli apparently discussed with Ben the possibility of engaging with drug and alcohol services. Ben apparently indicated that he was willing to try.

Dr Bardon and Dr Ghazalli reviewed Ben's treatment on the following morning. There appears to have been a further interview with Ben, during the course of which he again made reference to shooting ice over the previous few months.

Dr Ghazalli recorded that at the time of the review, "Ben made good eye contact and displayed no psychomotor abnormalities. He was not sedated and engaged openly. He described his mood as "okay" and his affect was reactive and congruent. His speech was normal as far as rate, rhythm and tone. He displayed no further thought disorder and appeared to be thinking in a logical manner. He denied any thoughts of self–harm, suicide or homicide. There were no perceptual abnormalities and he appeared to have fair insight and rapport. Despite expressing a desire to stop using ice, Ben was still opposed to his parents being informed of his drug use".[19]

As a result of that review, it is apparent that both Dr Bardon and Dr Ghazalli arrived at a working diagnosis of drug induced psychosis and formed a treatment plan that would involve input from local drug and alcohol services, cancelling the brain CT scan, encouraging Ben to inform his parents about his drug use and then liaising with Ben's parents once Ben had told them of his drug use.

Gate leave and discharge – 22 May 2014

At 11.55 am on 22 May 2014, Dr Ghazalli had a further discussion with Ben and stressed to him the importance of telling his parents about his ice use. This needed to happen before he could be discharged. From the notes made by Dr Ghazalli it appears that Ben was too embarrassed to tell his parents himself, but finally agreed to Dr Ghazalli telling them.

Dr Ghazalli then spoke to Ben's father, Wayne and updated him on Ben's progress. This included telling Wayne about Ben's confession to ice use[20]. Dr Ghazalli also

[18] Dubbo Hospital Records, Exhibit 1, Volume 2, page 94
[19] Dubbo Hospital Records, Exhibit 1, Volume 2, page 97
[20] Ben later disclosed to Wayne Gilligan that he been given access to his phone by a male nurse and a friend had told him to admit using ice in order to be discharged.

advised Wayne that Ben could have two hours gate leave with his parents that night, with a view to Ben being discharged the following day.

Although Dr Ghazalli recorded in the notes that Mr Gilligan was agreeable and supportive of the plan to grant Ben leave with a view to discharge, Mr Gilligan says that he always questioned the decision and felt it was too soon to be talking about both gate leave and discharge. In evidence he said "I vehemently deny that I was in favour of it, and I spent half an hour on the phone with the doctor arguing against gate leave and asking her questions like what are your criteria for saying that he's all of a sudden better?"[21] On the other hand, Dr Ghazalli made contemporaneous notes and stated that had Mr Gilligan expressed opposition or objection, it would have been documented and it was not. She said no concerns were raised and in fact Mr Gilligan was agreeable and supportive of the plan.[22]

While I accept that Dr Ghazalli is relying on her careful review of the clinical notes, I think she must be mistaken in her memory of the entire interaction. Mr Gilligan may not have expressed his concerns as forcefully as he now remembers, but I find it very difficult to believe that he expressed no concern whatsoever. By this time the Gilligans were desperate to find appropriate help for their son. It is documented that after the MHRT hearing, they were relieved and felt that finally he might "get the help he needs". It seems inconceivable that they would do such an abrupt about turn and whole heartedly support gate leave and imminent release. I understand that the Gilligans would have done anything to assist their son and it may be that this steadfast position was misinterpreted as support for the therapeutic plan the psychiatrists intended. It strikes me that had a written document been prepared for leave planning, such a miscommunication may not have occurred.

In any event, that afternoon Wayne Gilligan picked up Ben from Dubbo Hospital and took him home. Later that day, Wayne left Ben at the house, in the company of Priscilla, and went to collect Ben's mother, Astrid, from work. Ben took this opportunity to leave the house prior to his parents' return. Wayne returned to Dubbo Base Hospital and was advised to report the matter to the police. Police were also called by the Hospital. Hospital staff advised Wayne that the plan was that Ben was likely to be discharged the following day.

On 23 May 2014 the Hospital formally discharged Ben. It was Dr Ghazalli's evidence that the decision to discharge was based on the fact that staff believed Ben had gone to Queensland and also that following her conversation with Wayne Gilligan she understood Wayne to "be agreeable to discharge" and to "have no acute concerns".[23] Wayne Gilligan denies he was agreeable or that he had no concerns.

[21] Transcript 8/11/16, page 34 at line 17 onwards
[22] See evidence at transcript 9/11/16, page 164 at line 15 onwards
[23] See for example her evidence in relation to her contact with Wayne Gilligan and her documentation of the conversation, 9/11/16 page 162, line 25 onwards

Post discharge involvement by the Local Health District

It appears clear that there was no direct contact between the Hospital or any associated mental health service and Ben following his discharge on 23 May 2014.

Following Ben's formal discharge on 23 May 2014, responsibility for his care was initially handed over to the Consultation Liaison Team for an initial 7 day period and thereafter to the Community Mental Health Team. No introduction or contact between Ben and those who would ultimately be responsible for his care in the community had been established prior to his being granted leave or his subsequent discharge.

It appears that there was an initial attempt to contact Ben made by a registered nurse, Elizabeth Luffman, who had tried to telephone Ben at the family home and who then spoke with Wayne Gilligan. Wayne apparently told RN Luffman that he had spoken with Ben and that Ben was safe. Wayne was unable to provide a mobile telephone number for Ben at that time.[24]

RN Colleen Weaven also attempted to contact Ben at the family home on 24 May 2016. At that time she also spoke with Ben's father, Wayne. Wayne informed the nurse that Ben had gone to Queensland to visit his daughter. Wayne was unable to provide a telephone contact number for Ben at that time.[25]

On 26 May 2014 a case review was conducted by the Community Liaison Team, at which it was determined to discharge Ben from the Community Liaison Team and refer his case to the Community Mental Health Team for follow-up, in the event that he re-presented or returned to Dubbo.

That same day RN Weaven again spoke to Wayne Gilligan and she says that she provided him with contact numbers for the after-hours Mental Health Emergency Care Rural Access Program and the Community Mental Health Team contacts in case he required assistance at a later stage. Wayne apparently told RN Weaven that he believed Ben was in Queensland and was not currently contactable. RN Weaven also placed Ben's progress notes in a tray to be picked up by the Community Mental Health Team.

RN Weaven states that on 27 May 2014, she made contact with a nurse at the Community Mental Health Team, registered nurse Tuapikepike Hickey also known as RN Tu-tu. The precise details of that contact cannot be confirmed and we now know RN Hickey was due to leave her employment with the Dubbo Community Mental Health Team on 30 May 2014 and was not taking on new patients at that time.

In any event, following the telephone conversation between RN Weaven and Wayne Gilligan on 26 May 2014, there was no further contact with Ben or his family from any representative of the Community Mental Health Team or any other health service associated with the Local Health District until the events of 5 June 2014.

[24] Statement of RN Luffman, Exhibit 1, Volume 4, Tab 54 [12] onwards
[25] Statement of RN Weaven, Exhibit 1, Volume 4, Tab 53 [39] and Annexures C and D

Wayne Gilligan has stated that after he spoke with Dr Ghazalli on 23 May 2014, he telephoned Ben's mobile and told Ben that he had been discharged from Hospital. According to Wayne, Ben returned soon afterwards. The exact time of his return remains somewhat unclear.[26]

What is certain is that once Ben returned to the family home in the days after his discharge he continued to behave in a troubling manner. I accept that Wayne and Astrid Gilligan continued to have significant concerns for their son's welfare and that these continued well after Ben's formal discharge. After his return Ben's mental health continued to slowly deteriorate. It appears that the Gilligans, like many families whose adult loved ones are struggling with mental health issues, felt powerless and somewhat unsupported. Ben was not interested in treatment and his family felt they could do nothing until an acute situation arose again.

Dubbo Base Hospital – 5 June 2014

At about 11 am on 5 June 2014, Ben telephoned Wayne. He was talking rapidly and not making much sense. He said to his father, "Come and get me now Dad, I'm in trouble. There are all these people in white cars with "B" on the number-plate chasing me".[27]

Wayne Gilligan told Ben that he did not have the car but he would catch a cab to get him. Ben then screamed into the phone, "I'm fucking dead then! By the time you get here they will have killed me! You gotta steal a car Dad, take one of the neighbour's cars and bring a gun… I don't know what I'm gunna do, I've gotta get out of Dubbo before they kill me. They're all in on it, the police, the hospital and I've found out even the government want me dead. Dubbo's not safe for us anymore. If they kill me, at least get Mum, get in the car and just leave everything and get out of Dubbo." Ben then hung up.[28]

Wayne Gilligan was extremely concerned. He telephoned the police and explained the situation. About 15 minutes later, Wayne saw Ben walking towards the house. He called the police again.

Shortly afterwards Sergeant Bradley Edwards, Senior Constable Todd Williams and Senior Constable David Sendt attended the Gilligan home.[29] According to Senior Constable Williams, Ben was expressing obviously paranoid thoughts about being followed by bikies and needing to get his family out of town.

[26] There is some conflicting evidence about exactly when he returned home. Wayne Gilligan's evidence at the inquest was that Ben did not come home the day after the discharge as he had said in his original statement but some three days later. See his evidence at Transcript 8/11/16 page 44 at line 31 onwards. It is not surprising that Wayne Gilligan may not remember this detail with absolute clarity and one can safely say that Ben's return was some time in the days shortly after 22 May 2014.
[27] Statement of Wayne Gilligan, Exhibit 1, Volume 2, Tab 25 [72]
[28] Statement of Wayne Gilligan, Exhibit 1, Volume 2, Tab 25 [72]
[29] See Police statements, for example S/C Sendt, Exhibit 1, Volume 1, Tab 11, [3]

While Sergeant Edwards and Senior Constable Williams attempted to speak with Ben, Senior Constable Sendt had a telephone conversation with Dr Ghazalli about the previous admission. During this conversation, Dr Ghazalli informed Senior Constable Sendt that Ben had failed to return from leave a week prior and had been discharged in his absence. Dr Ghazalli also advised Senior Constable Sendt that Ben had been suffering from paranoid delusions, which appeared to have been in response to heavy amphetamine usage shortly prior to his earlier admission.

Ben was subsequently detained under section 22 of the *Mental Health Act* 2009, handcuffed and transported by ambulance to Dubbo Base Hospital. Senior Constable Sendt accompanied Ben in the ambulance. The Gilligan family had no complaints about the way police handled this difficult situation.

At about 11.50 am on 5 June 2014, Ben was admitted to Dubbo Base Hospital. Senior Constable Sendt provided Ben's details to the triage nurse, Cindy Graham. At that time Ben was non-compliant, manipulative and tried to leave. Police placed him directly in a "secure" room at the hospital known as the "Purple Room".

The "Purple Room"

The Purple Room is located in the Emergency Department about 6 metres from the ambulance entrance and adjacent to the ambulance holding area. It has a corridor on either side with 2 doors. Both doors have viewing panels measuring 200 mm x 550 mm. The entry door, accessible from the ambulance corridor is lockable from the outside and the other door is a "fob" exit only that leads to what is referred to as the RAFT corridor. Entry can also be gained from the RAFT corridor via that door using an external handle. The room itself is approximately 3.1 x 2.4 metres and contains a vinyl covered foam mattress on the floor. There are two CCTV cameras inside the room and another camera in the ambulance corridor. The room is not acoustically soundproof and does not allow for total privacy for the client. Patients in the room who may be verbally loud and abusive, can be heard throughout the Dubbo Base Hospital Emergency Department.

In addition the Purple Room is not plumbed. As a result of the mental health client needs to be toileted, a security officer or clinician is required to walk the client to the toilet opposite the room. That bathroom contains fittings and fixtures that increase the risk of self-harm or injury to others and are not within the mental health facility guidelines.[30]

As at 5 June 2014, the Purple Room was used, when necessary, to assess patients that were designated as unsafe to be placed in the Emergency Department waiting room, or who were required to be separated due to concerns for the safety of staff, other patients or hospital visitors. The room was also used from time to time to assess inmates from Wellington Correctional Centre and local juvenile justice facilities. The Purple Room was, at the time of these events and indeed remains, the only room available at Dubbo Base Hospital that is capable of being used to control

[30] This information is found in the Assessment Report dated 18/3/2016 annexed to the statement of Debra Bickerton, Exhibit 1, Volume 3, Tab 43

patients in the Emergency Department until they can be moved to a treatment cubicle or resuscitation bay.[31]

Escape from the Purple Room

It appears that Sergeant Edwards and Senior Constable Williams remained immediately outside the secure door to the Purple Room while Senior Constable Sendt completed the section 22 form. It was not until Dubbo Base Hospital health and safety security assistants, Luke Sullivan and Ben Costa arrived at the location, that police were able to leave. During that time Ben displayed various "flight risk" behaviours. At one point he pleaded to use a toilet and attempted to push past the police officers when they allowed him out of the Purple Room to access a nearby toilet cubicle.

Ben was triaged by the Nurse Unit Manager, Cindy Graham. RN Graham allocated Ben a triage category of four. Nurse Graham also left a message for the Mental Health Community Liaison Team.

About 12.30 pm Dr Ghazalli attended the Emergency Department to see Ben. It appears that Dr Ghazalli was concerned about the security implications of dealing with Ben alone. She briefly discussed the issue with another registrar, Dr Alexander Matthews.

Dr Ghazalli spoke to Ben through the Purple Room door. At that time she was unable to get a coherent history from him as he was agitated and uncooperative. Dr Ghazalli also said that Ben was "diaphoretic" holding his stomach and saying that it needed to be pumped[32]. Ben's agitated presentation prevented any full assessment by Dr Ghazalli.

Dr Ghazalli determined that Ben required sedation by Acuphase injection and physical restraint. She consulted Dr Barden and discussed her proposed management plan. It was decided that the use of Zuclopenthixol Acetate (Acuphase) was appropriate and that Ben should be admitted into the Mental Health Unit. While Dr Ghazalli was away from the Emergency Department, Ben continued to complain of being unwell, having chest pains and claiming that he had heroin in his stomach. He asked for and was given water.[33]

When Ben asked for more water, Mr Sullivan opened the door to take the empty cup from him. At this point Ben grabbed the door and pulled it out of his grasp. Ben ran out of the door pushing at Mr Sullivan and Mr Costa and throwing punches. He ran towards the X-ray department with Mr Sullivan and Mr Costa behind him.

The CCTV footage shows that Ben was very agitated. He was a strong man and was apparently threatening violence verbally. Nearby was an exit door to the Hospital which could be activated by pushing a green button. Mr Costa said to Ben "push the

[31] Statement of Clinton Grose, Exhibit 4, paragraph 26
[32] For an account of this assessment see Statement of Dr Ghazalli, Exhibit 1, Volume 1, Tab 26
[33] See the statements of Luke Sullivan and Ben Costa, Exhibit 1, Volume 1, Tabs 14 and 15.

green button". Ben pushed and when the door released he ran immediately towards the exit. The security officers followed, but Ben escaped by jumping a fence and running towards a nearby TAFE campus.

About 6 pm on 5 June 2014, Ben telephoned his father.[34] He was apparently in the company of another unidentified man at the time. Ben demanded that Wayne provide the family car to him. The unidentified man also spoke to Mr Gilligan and suggested that Ben was in trouble and needed to get away to "sort himself out". Ben got back on the telephone line and threatened to shoot anyone who got in his way of taking the car. A short time later, Ben called again saying that he was going to take the car. Mr Gilligan decided that the threat of violence from Ben or his friend was real and decided to give him the keys to the car. Ben arrived at the family home with an unidentified male and his father gave Ben a plastic bag containing his jacket, his telephone and the car keys. About 30 minutes later, Mr Gilligan telephoned the police. Later, Ben telephoned Wayne from the car and told Wayne that he was on his way to Queensland.

The pursuit in Coonabarabran

At 7.55 pm, police officers in two separate vehicles attached to the Coonabarabran Police Station heard a "keep a lookout for" radio broadcast in relation to a silver Ford XR6 registration AD 24 AM, being the vehicle in which Ben was driving.

Detective Senior Constable David Aitken and Detective Senior Constable Scott Bennett were patrolling Coonabarabran in police vehicle CNB 105. Senior Constable David Yeo and Sergeant Cheyne Gasson were using police vehicle CNB 16 which was a marked caged vehicle.[35]

The radio broadcast requested that officers be on the look out for Ben Gilligan, who had mental health issues and who had absconded from Dubbo Base Hospital earlier that day. Shortly after 9.17 pm Officers Yeo and Gasson in CNB 16 saw the relevant vehicle travelling fast in a southerly direction along the Newell Highway. They followed the vehicle back towards Coonabarabran with a view to catching up with it.

Shortly after Ben's vehicle reached Coonabarabran and with CNB 16 behind it, Officers Aitken and Bennett in CNB 105 followed behind CNB 16. At that point CNB 16 advised that Ben's vehicle was failing to stop and they were in pursuit. The time was then 9.20 pm.[36]

As the three vehicles proceeded south along the Newell Highway through the township of Coonabarabran their speed was approximately 40 km/h. Shortly after the pursuit was called in, Ben's vehicle appeared to stop outside Coonabarabran High School with police vehicle CNB 16 nearby and CNB 105 to the rear. However, the vehicle did a quick U-turn evading both police vehicles and sped away. Police

[34] For an account of this conversation see Statement of Wayne Gilligan, Exhibit 1, Volume 2, Tab 25 [86] onwards
[35] See statements of D S/C Bennett, D S/C Aitkin, S/C Yeo and Sergeant Gasson at Exhibit 1,, Volume 1
[36] For confirmation of these reports see VKG audio and transcript (track 2) Exhibit 1, Volume 1

vehicle CNB 105 followed. Some of this action was apparently recorded on CCTV footage later obtained by police. It is however most unfortunate that the footage was lost during the investigative process.

At 9.22 pm, Officer Gasson transferred to a marked police vehicle CNB 36. Officer Yeo continued in pursuit in CNB 16 with police vehicle CNB 105 in front. They soon lost sight of the vehicle.

At 9.23 pm, police radio advised officers to terminate the pursuit. Police radio further required that permission be sought before re-engaging the pursuit.

Shortly after 9.30 pm, a witness, Glynne Stone was driving along the Oxley Highway about 20 km out of Coonabarabran and towards her home. She noticed a vehicle fast approaching from her rear. Without slowing, the vehicle, which she observed to be a silver sedan, overtook her vehicle on a blind bend and over double unbroken lines, only narrowly avoiding a head-on collision with a large truck. Ms Stone estimated that the silver vehicle was travelling at about 180 km/h.

Shortly afterwards Ms Stone came round a sweeping right-hand bend and saw a huge dust cloud on the right-hand side of the road and ultimately Ben's vehicle completely wrecked and wedged part way up a tree. Ms Stone tried to call 000 at about 9.34 pm but she could not get a mobile phone signal. She was able to make contact at 9.39 pm and reported the accident to police. At 9.42 pm police radio broadcast information concerning the accident. Officer Gasson was the first to arrive on the scene at about 9.55 pm, shortly followed by Officer Yeo. Officers Aitken and Bennett arrived in CNB 105 at about 10 pm. Ben was apparently already deceased.

Investigation of the crash

Senior Constable Steve Redden of the Dubbo Crime Scene Section investigated the crash site. After a thorough examination of the scene and consideration of all the information provided to him, Constable Redden concluded that Ben had been driving along the Oxley Highway in a generally easterly direction at a speed in excess of 100 km/h.

Shortly after negotiating a right-hand bend in the road his vehicle left the bitumen surface and commenced a yaw on the gravel or dirt shoulder for a distance of 33.2m. The vehicle became slightly airborne and commenced a rolling movement which resulted in the vehicle impacting heavily with a tree on the left side and roof area of the vehicle.

As a result of impacting with the tree the roof of the vehicle compressed and came into contact with Ben. He sustained fatal injuries as a result. There was no evidence to indicate the involvement of an animal strike or any other vehicle in the accident and there was no roadway evidence to suggest that Ben had attempted to brake prior to the collision. The extent of the collision damage was such that a subsequent examination of the vehicle was unable to identify any defects or component failures that may have contributed to the collision occurring. All four tyres were still inflated, however they were observed to be in a poor condition with significant wear and tear.

I am satisfied that the collision occurred at a time when Ben was not being pursued and that no other vehicle was involved.

Post mortem examination and medical evidence

An autopsy was conducted by forensic pathology registrar Dr Leah Clifton under the supervision of Dr Brian Beer, Senior Staff Specialist in Forensic Pathology at the Newcastle Department of Forensic Medicine on the afternoon of 12 June 2014. The cause of death was noted to be the result of multiple injuries. The multiple injuries identified in the course of the post-mortem examination were consistent with blunt force trauma sustained in a high-speed motor vehicle collision. It is considered likely that the injuries were so significant that they would have caused instantaneous death.

Toxicological testing showed that Ben's post-mortem femoral blood had 0.10 mg of amphetamine per litre and 0.60 mg of methylamphetamine per litre, as well as low levels of alprazolam (less than 0.005 mg/l) and nordiazepam (less than 0.005 g/l) .[37]

These results were later analysed by a forensic pharmacologist Dr Judith Perl.[38] Dr Perl concluded that because the blood taken from Ben was femoral blood, the concentrations are likely to have closely resembled the concentrations at the time of his death. In her opinion the blood concentration of methylamphetamine was within the toxic and potentially fatal range.

She told the Court that the blood level of methylamphetamine found is indicative of a very high dose of methylamphetamine having been used, but that the high level of amphetamine (expected to have resulted from the metabolism of methylamphetamine) also suggested repeated dosing (ie doses only a matter of hours apart) and possibly some residual level due to use within the previous few days.

Significantly the blood level of methylamphetamine was such that there would have been very significant psychomotor impairment and impairment of driving ability. A psychotic episode due to methylamphetamine toxicity was certainly possible. It was her view that the impairing effects of methylamphetamine would have been a significant factor contributing to Ben's manner of driving. The low levels of alprazolam and nordiazepam where not suggestive of recent use and are unlikely to have impaired Ben's driving ability.

The conclave of experts

As has been stated, the real issue as it emerged during the inquest, was not the police pursuit, which had been terminated by the time of Ben's death, but the need for close examination of Ben's mental health care in the context of his flight from Dubbo Base Hospital and the circumstances of his tragic death.

[37] See Dr Farrer's report at Exhibit 1, Volume 2, Tab 32
[38] Dr Perl, Exhibit 1, Volume 2, Tab 29

In this regard the court was assisted by the expert evidence of four psychiatrists, Dr Danny Sullivan, Professor Matthew Large, Dr Peter Klug and Dr Michael Giuffrida[39]. Each of the doctors was highly qualified and eminent in their field. Each of the doctors provided reports and they gave evidence over two days during an expert conclave. The conclave process was extremely useful in distilling the important issues and in identifying the significant areas of agreement that existed between them. I do not intend to review their evidence in great detail, as it will be sufficient to examine it in relation to the limited number of relevant topics that emerged.

The diagnosis and treatment

On reflection, during the conclave all experts agreed that after Ben Gilligan admitted his ice use, the most likely diagnosis was drug induced psychosis. Dr Sullivan, speaking for them all, said "at the time at which Mr Gilligan professed to substance use and given that there had already been collateral information from others about likely substance abuse we agreed that it became at that time much more likely than not that a drug induced psychosis was the likely diagnosis".[40] There was also general agreement that at some later time, had Ben's symptoms kept recurring, even after a period of abstinence that some other diagnosis would be considered. However, Dr Sullivan explained that given Ben's presentation and the absence of "negative symptoms", the reduction of his symptoms after minimal medication and the admission to heavy ice use, it would be a "very long bow " [41] to diagnose schizophrenia during the May 2014 admission and that "not very many psychiatrists" would do it. Even Dr Giuffrida, who said he had a "slightly different view"[42] and was suspicious that there may be an underlying psychotic illness such as schizophrenia appeared to accept that at this point in Ben's presentation it would be too early to make a definitive diagnosis of schizophrenia.

It follows and I accept that the diagnosis made by Dr Ghazalli and Dr Bardon was open to them and based on sound clinical judgement.

Gate leave

Each of the experts was asked about the appropriateness of granting "gate leave" to Ben Gilligan on 23 May 2014, particularly in the context of his very recent admission to drug use. In summary each of the experienced psychiatrists was of the view that leave is a useful part of inpatient psychiatric practice and can be used as respite from the ward, as a testing mechanism, as a chance to get some fresh air and sunlight or as an opportunity to undertake small jobs outside the hospital. Each seemed to accept that it always involves the risk that a patient could abscond and that assessing the likelihood of that risk is sometimes difficult.

[39] Dr Danny Sullivan (for the Coroner), Dr Michael Giuffrida (on behalf of the family), Dr Peter Klug (on behalf of Dr Ghazalli) and Professor Matthew Large (on behalf of the Local Health District)
[40] Transcript 23/5/17, page 6 at line 29 onwards.
[41] Transcript 23/5/17, page 10 at line 24 onwards.
[42] Transcript 23/5/17, Page 13 at line 1 onwards.

Dr Giuffrida was of the view that a more graduated leave program may have been appropriate, such as allowing leave on the hospital grounds with a staff member. Each of the other doctors thought any lesser leave than a couple of hours may have been impractical and in reality it would test very little. Dr Klug described staff escorted leave as something from a "bygone era".

Counsel for the Gilligan family submitted that the leave planning which took place was "cursory and rushed". It was "intimately linked with discharge" and based on an inadequate assessment of any behavioural changes in Ben, which were tenuous, time-limited and potentially explained by medication.[43] However, aside from Dr Giuffrida's reservation about the type of leave allowed, none of the other doctors were critical of the decision to grant leave, in itself. I accept that while the decision to grant leave involved risk, it was not inappropriate in the circumstances of this case. Counsel for the family suggested that Benjamin Gilligan was sent through a 'revolving door'[44]. I do not accept the implication inherent in this phrase that there was little or no care given to the decision.

Even gate leave in the Hospital grounds would have provided Ben with an opportunity for flight, if he was determined to go. I accept the opinion of the treating psychiatrists that Ben appeared well enough to be tested and I accept that finding the balance between safety concerns and the principle of "least restrictive care" presents a real and ongoing difficulty for clinicians.

One area of possible improvement was, however, identified. Professor Large suggested that the granting of leave in NSW Hospitals could perhaps be better documented. He said "it is my belief that we should formalise the conditions under which we grant patients leave in New South Wales a little bit more than we have done so… I think we should get better at articulating what we mean by conditions of leave"[45] It is certainly easy to see that it would have been preferable had the conditions of leave been plainly articulated in a signed document for the Gilligans in this case. As I have already stated, there are conflicting accounts about the family's attitude towards Ben being granted leave. Formalising this process may provide a clearer process for families to express their fears and concerns.

Treatment prior to discharge

The experts appeared to accept that different psychiatrists may hold differing views about whether medication should be reduced or ceased prior to discharge in the circumstances of Ben's case.[46] However, they appeared comfortable with the range of clinical opinions that may exist here.

In relation to establishing drug and alcohol treatment prior to discharge, Dr Klug suggested that "in an ideal world that would be a very good thing to do", but that it is not always possible. Professor Large cautioned against "too much magical thinking

[43] See Gilligan Family submissions, annexed to the Court file.
[44] See Gilligan Family submissions, annexed to the Court file
[45] Transcript 23/5/17, page 37 at line 49 onwards
[46] Transcript 23/5/17, page 38 at line 42 onwards

in relation to what a drug and alcohol counsellor might do"[47] He noted that psychiatric registrars should have skills to deal with this issue and stressed that one cannot detain someone purely for the purpose of arranging drug and alcohol counselling. He said that if a person wants to stop using drugs, arrangements can be made for outpatient services and it is not essential for counselling to commence on the ward.

It is clear that the treating doctors in this case had noted on the written plan for Ben, that Drug and Alcohol Services would be contacted. Of course we now know that he absconded prior to that happening. However, none of the doctors including Dr Giuffrida appeared to suggest that commencement of Drug and Alcohol counselling on the ward was a necessary pre-requisite to the granting of limited gate leave.

Decision to discharge

There was considerable discussion about the decision to discharge Ben after his failure to return from leave on the evening of 22 May 2017. The possibility of holding a bed open for Ben was discussed, but given that the Hospital had been informed that Ben had gone to Queensland, this appeared impractical when one took into account the very real pressure for beds in public hospitals and the unlikelihood of his early return.

Each of the doctors agreed that while there is legislation which allows for an interstate apprehension order, it is used very rarely. The doctors seemed to agree that it was only likely to be considered in relation to forensic patients or where extreme risk could be established. None of the doctors would have considered going down this path. There was also some acknowledgement that it also would involve risk for Ben if the police had to pursue him over state borders.

I have considered whether the attitude of Ben's family would have realistically affected the decision to discharge at this point. As I have stated, Wayne Gilligan denies that he told Dr Ghazalli that he agreed with the plan to discharge. On reflection it appears to me that whatever was said during the conversation between Dr Ghazalli and Mr Gilligan, it appears likely that the Hospital would have gone ahead with discharge at that point. It was almost inevitable in the circumstances of Ben's short mental health history and his flight from Dubbo Hospital. It is certainly significant that at that time clinicians believed Ben had travelled to Queensland. I note that it was Dr Bardon's unchallenged evidence that had he been told that Ben had returned to his parents' home in Dubbo, after his flight from the Emergency Department, he would have "asked the police to go around and bring him back to the hospital".[48]

In the end there was some agreement that the decision to discharge was, at least in part, as Professor Large described it, "pragmatic". Once Ben removed himself from the Hospital, there was no treatment that they could offer and the bed was needed for other patients. In the circumstances of the case, I am not critical of that decision.

[47] Transcript 23/5/17, For discussion of this point see page 40, line 5 onwards
[48] Transcript 10/11/16, Page 259 at line 21

Adequacy of follow up after discharge and the need for discharge planning

Dr Sullivan stated that in general terms there was agreement between the experts that the follow-up after discharge was adequate. While he had initially thought the two stage process involving the Community Liaison team and the Community Mental Health team was unnecessarily complicated, he now understood that it was based on a desire to make sure that patients were contacted in the first seven days after discharge. He accepted that there were efforts to contact Ben and his family and that given that the Hospital had been informed that Ben had absconded and gone to Queensland the efforts appeared reasonable, under all of the circumstances.

Dr Giuffrida had a slightly different view. While he agreed that in the circumstances they did what they could, once Ben had been discharged, he felt that the lack of early discharge planning became an issue[49]. I take this to mean that Ben left without contacts for help in the community.

Dr Sullivan, Dr Klug and Professor Large believed that discharge planning had "commenced" and would have been completed had Ben returned after his gate leave. Dr Giuffrida conceded that "some effort" had been made. There was certainly a documented plan which included the provision of Drug and Alcohol services, but contact had not yet been made prior to gate leave being granted. There was some difference of opinion expressed by the experts about whether drug and alcohol counselling was best commenced in the community or prior to discharge. It was also acknowledged that as Ben had denied drug use on his arrival, a referral could not have been made at an early stage.

The Gilligan family submitted that a care co-ordinator should have been appointed at the beginning of the admission. This was in breach of standards set by NSW Health.[50] Dr Sullivan agreed that this would be "ideal" while Professor Large and Dr Klug were concerned that this was a standard that could not be met across the state. It is certainly troubling if health standards which have been identified as best practice cannot be reached consistently throughout NSW.

Ben's management at Dubbo Base Hospital on 5 June 2014

Counsel for the family submitted that Ben was incorrectly triaged on his arrival at Dubbo Base Hospital and this is likely to be correct.[51] However, when the experts were asked about the allocation of the triage category given to Ben on his arrival at Dubbo Hospital on 5 June 2017, there appeared to be general agreement that even if a lower triage category was appropriate, Ben was dealt with as a matter of urgency and seen as quickly as was possible. It was Dr Giuffrida's view that he should have

[49] Transcript 24/5/17, Page 6 at line 7 onwards.
[50] See NSW Health Policy Transfer of Care from Mental Health Inpatient Units – Standard Principles and Procedures at Exhibit 1, Volume 3, Tab 46
[51] See Gilligan Family submissions, annexed to the Court file.

been a category 1 or 2, not a category 4 but he agreed that little turns on it as he was dealt with as a 1 or 2 in any event.

Each of the doctors was in agreement that notwithstanding any relevant definitions found in NSW Health Policies[52], they regarded placing Ben in the Purple Room as a form of seclusion. Mr Grose from the Local Health District described the Purple Room as a "safe assessment room" rather than a "seclusion room", but there was no real dispute about what it was used for.

There were differing views about the adequacy of the facility and whether plumbing and other facilities needed to be provided. It appears that standards differ greatly across the regions and across the country.

Each of the doctors spoke of the difficulties faced by staff in situations such as the one that presented at Dubbo Base Hospital Emergency Department on 5 June 2014. The doctors seemed to agree that the particular problem faced by staff where drug affected psychotic patients demonstrate significant violence is increasing. There are a variety of ways to deal with the situation depending on the size of the unit, the number of staff present and the resources available. There were differing opinions on the best approach. Clearly not all facilities will have the capacity to restrain and medicate a patient on a trolley in a resuscitation bay[53]. Not all facilities will have the staff capacity to quickly organise a controlled restraint.

As Dr Large explained medical staff are faced with "a range of unsatisfactory alternatives with no strong sort of, no consensus actually within accident and emergency specialists and within psychiatrists working in this area as to what is precisely the best thing to do, and that would also be influenced by factors such as …the nature of the room involved, the staff and their training…This is a contemporaneous decision that takes place.. So I'm not critical of them placing him in a seclusion room. I don't think they could have foreseen that he would escape from the Purple Room/seclusion room."[54] There is great force to his evidence.

I am certainly satisfied that Dr Ghazalli, a first year trainee registrar, was faced with an extremely difficult situation when she was called upon to treat Ben Gilligan on 5 June 2014. I am satisfied that it was appropriate for her to consult Dr Bardon in relation to the prescription of sedatives. Having reviewed all the expert evidence, I am satisfied that the decision to place Ben in the Purple Room was appropriate, given the options available, at least until arrangements could be made for further treatment. I am satisfied that those arrangements were being made in a timely manner when Ben escaped. Dr Ghazalli was an impressive witness who appeared both thorough and caring in her approach. I am satisfied she acted appropriately on this day.

[52] For further discussion of the relevant guidelines pertaining to the Purple Room see Exhibit 4, Statement of Clinton Grose.
[53] For discussion of this issue see Transcript 24/5/17, page 42 at line 29 onwards
[54] Transcript 24/5/17, Page 43 at line 38 onwards

Changes made since Ben's death

The Inquest received material from the Local Health District which outlined a number of changes that have been made or are planned since Ben's tragic death.

Some of those changes relate to streamlining the process of transferring patients to the Community Mental Health Team and were described in the evidence of Ms Rebecca Leman and elsewhere.[55]

There was also evidence that as a result of Ben's death, there had been training for clinical and security staff in relation to the Purple Room and in relation to the management of aggressive patients.[56] The way patients are monitored has changed and there is a register in use.

Other evidence provided by Mr Clinton Grose, Mr Jason Crisp and Ms Debra Bickerton related to changes foreshadowed with the renovations currently in planning for the Hospital. The new Emergency Department will have a purpose built seclusion room(s). The redevelopment is currently scheduled for completion in 2019.

The need for Recommendations

One of the issues that emerged from the expert conclave was the real difficulty presented by the growing problem of acute behavioural disturbance in emergency departments across the state. This appears to have been exacerbated by increasing amphetamine use in the community. The problem may be more extreme in smaller hospitals with fewer resources and lower staffing levels. Dr Giuffrida described the level of violence as alarming. Dr Klug spoke of the difficulties faced by registrars and others working in this environment. Professor Large spoke of the rising number of psychiatric presentations in emergency departments generally.

What emerged is that there is no easy answer about how best to deal with these kind of presentations in emergency departments. Professor Large noted that each unit does things a little differently and that leaves practitioners exposed when something goes wrong. While he accepted that it would be a complicated process to get anaesthetists, emergency doctors and psychiatrists all on the same page, he suggested that it would be a worthwhile process to encourage all those involved to consider a joint approach to acute behavioural disturbance in this context. He asked the questions, when is it appropriate to use heavy sedation? When is it appropriate to seclude a patient? When is it appropriate to physically restrain and how should it best be done? [57] A further issue raised by the circumstances of this case may be the role of security staff and their training to deal with these issues.

The answers to these complex questions are beyond the scope of this inquest. However, violence and behavioural disturbance in emergency departments and how

[55] Transcript 11/11/16, page 17 onwards.
[56] Letter from Debra Bickerton, Exhibit 1, Volume 3, Tab 43A
[57] Transcript 24/5/17, Page 62 at line 1 onwards

to deal with it is a critical current issue and I intend to urge the Minister for Health to consider having his Department convene a forum for open discussion of the issues raised by Professor Large. A copy of the transcript of the expert evidence in this matter should be forwarded to the Minister to facilitate this process.

More specifically, the evidence raises matters for the consideration of the Local Health District. I thank the Local Health District for their co-operation and willingness to openly discuss the issues involved. Some significant changes to the relevant policy and procedures have already been made. However, I intend to recommend that the Local Health District review the formal requirements of their gate leave policy and that it reconsider its policy in relation to the Purple Room. I note that as a result of the expert evidence, Debra Bickerton, General Manager of Dubbo Health Service has already expressed a commitment to review the local policy and to take into account the reality that the Purple Room acts as a seclusion room.[58]

Conclusion

It is important to remember that the right to refuse medical treatment is a basic common law right and should not be interfered with lightly. The *Mental Health Act* seeks to strike a balance between this important right and the need to protect people who may be incapable of making rational decisions or of displaying insight into the dangers their illness presents to themselves or others. Decisions made in relation to a person's care pursuant to the *Mental Health Act* 2007 are often difficult and very finely balanced. When assessing "mental illness" practitioners must take into account a person's "continuing condition" and treatment decisions need to take into account any likely deterioration.[59] At the same time there is an emphasis on the "least restrictive care" that is safe and effective. Decisions to allow gate leave and discharge involve inherent risk and must be carefully considered. I am satisfied that the clinicians involved in Ben's care used sound professional judgement in the decisions they made.

Finally, I again offer my sincere condolences to the Gilligan family and I thank them for their participation in this inquest. I am confident that they will continue to remind Ben's daughter, Maddie of all his positive attributes, good humour and love for her. Wayne and Astrid Gilligan's attendance at this inquest is a testament to the love they have always expressed for their son. I would like to reassure them that many people will continue to reflect upon the difficult issues which surround involuntary mental health care in the hope that improvements to our system can be made.

[58] Transcript 25/5/17 Page 20, line 45 onwards
[59] See s 14(2) *Mental Health Act* 2007

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 Benjamin Gilligan.

Date of death

Mr Gilligan died on 5 June 2014.

Place of death

He died on the side of the Oxley Highway, about 30 kilometres north east of Coonabarabran, NSW.

Cause of death

He died as a result of multiple injuries caused when the vehicle he was driving collided with a tree.

Manner of death

Ben was affected by methylamphetamine at the time of his death and in need of psychiatric care.

Recommendations pursuant to s 82

To the Minister for Health

I recommend,

That the Minister give consideration to having his Department convene a state wide forum to discuss best practice management procedures for patients with acute behavioural disturbances presenting to NSW Emergency Departments.

To the Western NSW Local Health District

I recommend,

That the Western NSW LHD give effect to the requirements of the existing leave policy by developing a written document to be provided to patients exercising gate leave and any family or carers who may be responsible for the patient while they are on such leave. The document should set out information concerning leave, including the purpose of leave, the time at which the leave commences and when the patient is due back and any particular requirements or restrictions such as ensuring the patient remains in the carer's company at all times or does not attend certain locations etc.

That, pending the redevelopment of the Emergency Department at Dubbo Base Hospital, the Western NSW LHD develop and implement a site-specific policy relating to the use of the “Purple Room” to give effect to the intent and aims of the existing NSW Health Policy concerning aggression, seclusion and restraint in mental health facilities in NSW.

I close this inquest.

Magistrate Harriet Grahame
Deputy State Coroner

Date: 7 July 2017