CORONERS COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of H P
Hearing dates:	26 & 27 November 2018
Date of findings:	13 December 2018
Place of findings:	State Coroner's Court, Glebe
Findings of:	**State Coroner Les Mabbutt**
Case number:	2016/371530
Catchwords	CORONIAL – Death in the course of a police operation. Policies and procedures regarding enforcement of breaches of Community Treatment orders under the *Mental Health* Act 2007
Representation:	Mr J Harris Counsel Assisting the Coroner instructed by Mr H Gillespie of the Crown Solicitor's Office Mr R Coffey, instructed by the Office of General Counsel for the Commissioner of Police Mr P Rooney instructed by Ms A Reberger for the Sydney Local Health District Mr P Madden instructed by Mr J Francis for Senior Constable M Lambert
Publication Orders	Pursuant to s75(2)(b) of the *Coroners Act* 2009 I direct that there be **no publication** of any matter that identifies HP or any of his relatives.

Introduction

1. HP was born on 7 November 1964 and died on 9 December 2016. At the time of his death HP was subject to a Community Treatment Order (CTO) issued under the *Mental Health Act* 2007. Shortly after 12.50pm HP was being taken from his third floor unit at a residential complex in Camperdown to Concord Hospital for mental health treatment by police and mental health workers. HP was in breach of the CTO and had refused to allow mental health workers to enter his unit and administer

medication. Whilst being escorted along the landing on the 3rd floor, HP jumped over the balcony railing. HP fell three floors landing on a grassed area.

2. Immediate attempts were made to resuscitate HP at the scene and he was conveyed to Royal Prince Alfred Hospital by ambulance. Tragically HP was pronounced deceased at 1.40pm. HP was 52 years of age

Why was an inquest held?

3. The role of the Coroner pursuant to s 81 of the *Coroners Act* 2009 is to make findings regarding:
   - The identity of the deceased
   - The date and place of that person's death
   - The cause and manner of that person's death

   An inquest is mandatory where the death occurred in the course or as a result of a police operation in accordance with s 23 and 27 of the *Coroners Act* 2009. HP's death occurred whilst police were conveying him to a mental health facility in accordance with s 59 of the *Mental Health Act* 2007.

   Pursuant to s 82 of the *Coroners Act* 2009, a Coroner has the power to make recommendations concerning any public health or safety issue arising out of the death in question.

Background

4. HP was born in Vietnam in 1964. He was one of four children. In 1987 HP left Vietnam with his younger brother VP arriving in Hong Kong. Whilst in Hong Kong HP met and married NN. They had a child together, QP. In 1990 the family emigrated to Australia. HP separated from his wife in 1991. QP remained with his mother.

5. From 2011 onwards HP had contact with the Camperdown Community Mental Health Service. HP was commenced on antipsychotic medication "paliperidone" but was resistant to mental health treatment. In 2012 he was referred to the service again with depression, in the context of illicit drug use.

6. In April 2014 police attended HP's address where he made remarks about jumping from the top floor of the building. Police took HP to Royal Prince Alfred Hospital for a mental health assessment. HP was not admitted for treatment as a mentally ill person and was referred back to Camperdown Community Mental Health Service.

7. In November 2014 HP was referred to the Service but was not considered psychotic on assessment. In December HP was referred again to the Service by Centrelink but was not found to be a mentally ill person. He declined a follow up doctor's appointment.

8. In July 2015 HP was referred to the Service by his GP. A home assessment was conducted. HP presented as psychotic with other thought disorders. He was treated in the community with risperidone and his condition improved but he disengaged with the Service within a short period of time.

9. In 27 September 2016 HP self presented to the Service with paranoia, delusional thoughts and psychosis. He believed a computer chip had been inserted during surgery and there was a conspiracy with Centrelink, Police and medical staff to control him. HP did not accept he had a mental illness.

10. That same day Mr Matthew Douglass a social worker with the Service and Registered Nurse (RN) Vella attended HP's unit in company with police officers. HP presented as illogical, irrational and with delusional thoughts. A decision was taken to detain HP under the *Mental Health Act* 2007 and convey him to Concord Hospital for assessment by a psychiatrist. Eventually HP agreed to be transported to hospital without the need for a police escort.

11. At Concord Hospital HP was assessed as a mentally ill person and detained involuntarily for mental health treatment. Upon receiving oral paliperidone HP's condition improved. HP was discharged on 5 October. Further follow up was conducted by the Service but on 10 October HP declined to take any further medication.

12. Dr Trenaman a psychiatrist conducted a home visit to HP's Camperdown unit on 14 October 2016. HP reported delusional beliefs involving persons in his unit block jumping off balconies and disappearing. HP stated he did not have a mental illness and was unwilling to take any medication. Following that visit on 21 October Dr Trenaman submitted a report supporting an application for a CTO that would require HP to receive depot (injections) of paliperidone. HP's case manager on 17 November made an application to the Mental Health Review Tribunal for a CTO.

13. On 1 December the Mental Health Review Tribunal held a telephone hearing at Camperdown Health Centre. HP was present represented by a solicitor. During the course of the hearing HP threatened that if he was forced to have the injection he would jump off the balcony. However, later in the hearing he retracted those words. The Mental Health Review Tribunal made a CTO for a six month period requiring HP to comply with medications as prescribed (depot paliperidone). Further, HP was to attend an appointment with Dr Crawford on 6 December to receive that medication. However, the CTO issued contained an error, HP's name was spelt incorrectly. HP was very upset and stated he wanted to appeal the CTO.

14. On 6 December HP attended upon Dr Crawford (late) as required under the CTO. Dr Crawford was of the opinion HP was suffering from paranoid schizophrenia, had no insight into his illness and refused to accept the depot injection despite the CTO. Dr Crawford explained a failure to accept his medication could result in breach action. HP stated there was an error on the CTO and he wished to contest the CTO.

15. HP discussed the threats he had made during the hearing but adamantly denied any thoughts of self harm. He spoke about his close connection with his son and that he was looking forward to the birth of a grandchild. HP stated he was a good person, had not hurt anyone and did not think he was mentally ill. Dr Crawford considered in those circumstances HP's risk of self harm as low. HP left without receiving his medication.

16. On 7 December the director of community treatment issued a breach order requiring HP to be taken to the Professor Marie Bashir centre at Camperdown for treatment. On the same date the Mental Health Review Tribunal corrected the error on the original CTO regarding the misspelling of HP's name.

17. At 8.50am on 8 December RN Benfield, the Care Team Coordinator attended HP's unit and provided him with the amended CTO order. HP said it was not him and would be seeing his solicitor on the 19th of December. He challenged RN Benfield to call the police. RN Benfield then left the premises. That afternoon RN Benfield referred the breach to the Acute Care Service (ACS) for the breach of the CTO to be actioned.

18. That evening (RN) Olivia De Dear and another member of the Acute Care Service attended HP's unit to administer the medication. The unit was in darkness and HP could not be raised.

Events of 9 December 2016 leading up to the death of HP

19. On 9 December 2016 at 10.20am two members of the Acute Care Service (RN) De Dear and Mr Douglass a social worker attended HP's unit on the third floor of the unit complex. They planned to administer HP with paliperidone at his unit. If that occurred without incident, the plan was HP would not be taken to a hospital for assessment.

20. HP refused access to his unit. For the next 45 minutes attempts were made through the locked screen door to persuade HP to let them in and receive the injection. HP contended the wrong name was on the order.

21. At 10.58am HP contacted 000 requesting police assistance. He informed the operator someone was trying to give him medicine, that the paperwork was wrong and he was very scared. The operator recorded HP as hard to understand (English was not HP's first language) and disorientated. A message was broadcast for police to attend the address.

22. By chance two police officers, Constables Beau Wolfenden and Adam Williams from Glebe Police Station were at the unit complex to serve court process on another resident. They informed police radio they were nearby and would attend HP's unit. Around the same time Mr Douglass called Glebe Police Station requesting police assistance to enter the premises. It was noted both calls related to the one incident and the two calls were "merged" into the one Computer Aided Dispatch (CAD) message.

23. At approximately 11.10am the two Constables met up with the two ACS staff at HP's unit. An ongoing negotiation continued between the police and HP through the closed screen door. Constable Williams informed HP they were there to help. Constable Williams considered HP was on a verbal loop and was fixated on the name on the order being wrong. The order was sighted and it was explained to the police the order been amended.

24. After some time Constable Williams advised HP that if he did not let them in they would have to force entry for the injection to be administered. HP responded to this by taking a chair onto the small balcony of this unit (on the opposite side of the lounge room to the front door) and placing his leg up on it. Constable Williams and ACS staff called out to HP, words similar to "*don't do it, it's not worth it,* [H] *… no."*

25. HP then came back to the front door and stated he was only joking and continued with the same conversation about the wrong name on the order and that he was appealing the CTO.

26. Mr Douglass viewed HP's actions as risky and an attempt by HP to make the ACS team go away. RN De Dear was shocked and concerned. Around that time the ACS team decided HP would have to be taken to a hospital in accordance with the CTO breach notice, simply giving the injection and leaving HP was no longer considered appropriate. It was proposed that HP would be taken to RPAH for his medication to be administered and an assessment by a psychiatrist.

27. Constable Williams also become concerned regarding HP's actions and made a phone call to his supervising officer Acting Sergeant (AS) Tsougranis requesting his attendance and assistance. That phone conversation took place via speaker phone in the police car with Constable Williams and AS Tsougranis. Constable Low was also in the police vehicle. Whilst driving to the location Constable Low checked the police computer system which indicated HP had previous entries for drug use and mental health, but no current warnings.

28. AS Tsougranis attended the location with Constable Low at 11.28am. AS Tsougranis recognized HP having seen and spoken to him previously in the general area. AS Tsougranis spoke to the ACS team. AS Tsougranis thought HP also recognized him and he attempted to establish a friendly dialogue with HP through the door. It was clear to the police that HP did not wish to speak to the ACS team. By this point HP was now closing the main wooden door for periods of time but always returned to open the wooden door and speak to the police again through the still closed and locked screen door. AS Tsougranis reinforced to HP that he had called the police, they were there to help him, he needed to let police in to see the paper work he was taking about and he was not in trouble.

29. In the periods when the wooden door was closed police could hear HP making phone calls on his mobile phone and speaking in Vietnamese. By standing on a portion of the external stairway or the balcony railing of the landing, police or the ACS team could see partly through a window on top of the main door. They saw HP walking in his unit and approach the balcony several times. Police were unable to persuade HP to open the front door, the situation remained unresolved.

30. At some point during this period there was a discussion between AS Tsougranis and Mr Douglass about whether police could leave to allow things to calm down and the ACS team return later in the afternoon to try to administer the medication again. Mr Douglass contacted his supervisor who directed in the circumstances the breach notice was to be enforced and HP was to be scheduled. Mr Douglass advised the ACS team could not leave without HP and police assistance was still required. Further phone calls were made regarding bed availability and it was decided by the ACS that HP would be taken and admitted for treatment at Concord Hospital.

Phone contact by HP with his son QP

31. At 11.44am HP rang his son QP. The conversation was in Vietnamese. HP told QP that persons were at his door forcing him to go with them to take a needle. He told QP that his name was misspelt and he didn't want to go with them. QP considered his father was agitated and frustrated. HP told QP that if he had to go with them to have the needle "*I am going to jump*". QP tried to tell his father to go with the workers and have the needle, but HP was adamant he didn't want to take it. HP asked QP to call the police and have them remove the mental health workers (at the time of this phone call police had already been at HP's front door speaking with him for over half an hour).

32. Around this time HP told police through the door he was speaking with his son and provided police with QP's phone number. It was the wrong number. Attempts by police at the scene to ring QP were unsuccessful. HP also advised he was trying to contact the Mental Health Advocacy Service.

33. QP was seriously concerned regarding what his father had said about jumping and rang 000 at 12.03pm. QP spoke to Senior Constable Lambert who was acting as the 000 operator at the time. QP advised SC Lambert "*there's people outside his door from the hospital.. and he's locked the door. He's saying that they have the wrong name on the… And he said if they do take him he will definitely jump*". SC Lambert

recorded a Computer Aided Dispatch (CAD) message including the following information: *"INFT RECEIVED CALL FROM HIS DAD THREATENING TO LOC".*

34. SC Lambert did not type the word "jump" in the CAD message. The message was forwarded to the radio dispatcher Ms Crowther. Ms Crowther did not consider there was any new information contained in the message as police were already on the scene and other CAD messages related to the same incident. No radio broadcast to the police at HP's unit was made. Accordingly police at the unit did not receive any information that HP was threatening to jump if he was taken to hospital.

35. At 12.25pm HP called QP again, He asked if QP had rung the lawyer and the police. QP advised he had called the police. QP considered HP calmed down a little after hearing this but still refused to leave the unit. (By this stage police had been outside the unit for well over an hour speaking to HP. For some reason HP did not communicate this to his son).

Entry gained by police to HP's Unit

36. Police Rescue were called to attend to gain entry. Prior to the Rescue Squad attending Constable Wolfenden managed to manipulate the lock on the inside of the screen door with a stick unlocking the screen door. It was decided the next time HP opened the main wooden door police would enter and restrain him.

37. Shortly after 12.30pm HP opened the main door again and police gained entry to the unit. HP was restrained and sat in a chair. Police promptly closed the door to the balcony, removed a knife and other articles from the table and searched HP. HP was immediately compliant with police and made it clear he did not want the mental health workers in his unit.

38. Mr Douglass remained for some period and recalled HP being calm, focused and denied he was suicidal. HP requested his shoes and keys, asked that his rice cooker be turned off and agreed he would go to hospital but with the police. When asked about the balcony he said he wasn't going to harm himself. In Mr Douglass's opinion HP was "future focused". He did not consider at that time HP was an immediate risk of self harm given his presentation.

39. RN De Dear recalled HP made a joke along the lines of "you got me" and made a comment that he wouldn't do that (referring to balcony).

40. Constable Williams stated HP was calm, he appeared fine and was talking normally not aggressively. In his view HP's whole demeanour had changed and he displayed no self harm risks at that point. Constable Wolfenden was of the same view. AS Tsougranis stated HP showed no signs of resistance once police entered and he was calm.

41. Constable Low recalls HP denying intending to do anything whilst on the balcony previously and said *"no no, you've got it wrong, I wasn't doing anything out there*".

Exit from the unit

42. HP's shoe laces and belt were removed and he was escorted out of the unit by police at about 12.52pm. HP was not handcuffed or restrained in anyway. The group walked along the 3rd floor landing to the right side towards the lifts. A flight of stairs were immediately to the left hand side. RN De Dear was first, followed by Mr Douglass, then Constable Wolfenden, HP, Constable Low, AS Tsougranis and Constable Williams (who was securing HP's unit and front door).

43. After walking along the landing for a short distance HP without any warning placed his hands on the balcony railing that is approximately 1.4 metres high and swung up his right leg jumping over the railing. Constable Low attempted to restrain HP but was unable to hold him. HP fell three floors to the ground. The ACS team and police ran to the ground floor and commenced resuscitation. An ambulance was called and HP was taken to RPAH but was pronounced deceased at 1.40pm.

Police investigation

44. Inspector Anthony Agnew from the Eastern Beaches Local Area Command was appointed as the officer in charge of the critical incident investigation. An extensive investigation took place and a large number of witnesses were interviewed, the coronial scene was examined, a large number of documents were obtained including health records, 000 transcripts and CAD messages.

Cause of death.

45. A post-mortem examination was conducted at the Department of Forensic Medicine at Glebe on 13 December 2016 by forensic pathologist Dr Jennifer Pokorny. The cause of death was found to be multiple blunt force injuries from a fall from height.

Toxicology revealed a therapeutic level of irbesartan (prescribed for hypertension) in the blood. No psychiatric medications were detected.

Was the action taken by Camperdown Acute Care Service appropriate?

46. The CTO issued by the Mental Health Review Tribunal (subsequently amended) and the breach notice issued in accordance with s 58 of the *Mental Health Act* 2007 provided the statutory power for the ACS team to take HP directly to a declared mental health facility.

47. Mr Douglass was involved in scheduling HP for mental health treatment on 27 September. He indicated HP was compliant with police in attendance on that occasion and attended hospital with the ACS team without incident. In the intervening period at the CTO hearing, unknown to Mr Douglass, HP had made threats to jump off the building if forced to have an injection again.

48. Mr Douglass and RN De Dear were not provided with a recent risk assessment regarding HP. This was critical information that should have been provided to any persons enforcing a CTO breach order.

49. The initial decision to attempt to administer the medication without detaining and conveying HP to a hospital was proper. Once HP refused to let ACS team enter his unit, the incident escalated over the following two and a half hours. The decision to enforce the CTO breach, especially in light of the chair on the balcony incident, was also appropriate.

50. Likewise the decision to request police assistance in accordance with s 59 of the Act was also necessary. Mr Douglass was of the view that police involvement (successfully) on 27 September would mean HP may respond to better to police requests. That was a reasonable assessment.

51. Following entry into the unit, Mr Douglass and RN De Dear made observations of HP to gauge any risk he presented at that time. On all the evidence, given the substantial change in HP’s demeanour; requesting his belongings, asking the rice cooker be turned off and his denial of self harm thoughts, the assessment that HP was not an immediate risk of self harm at that time was appropriate in the circumstances.

52. I find the actions of the ACS team appropriate in the decision to enforce the CTO and transport HP to Concord Hospital. I find in the circumstances of the information Mr Douglass and RN De Dear were in possession of at the time of their attendance at the unit, they acted appropriately.

Was the action taken by police officers who attended HP's home appropriate and in accordance with NSWPF policy?

53. Police have a duty to action CTO breaches in accordance with s 59 of the *Mental Health Act* 2007:

"59 Police assistance

(1) A police officer to whose notice a breach order is brought must, if practicable:

(a) apprehend and take or assist in taking the person the subject of the order to the mental health facility, or

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

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

Note. *Section 81 sets out the persons who may take a person to a mental health facility and their powers when doing so."*

"81 Transport of persons to and from mental health facilities and other health facilities

(3) The persons listed below may take to or from a mental health facility or another health facility any person who is authorised by this Act to be taken, or transferred, to or from the facility:

(a) a member of staff of the NSW Health Service,

(b) an ambulance officer,

(c) a police officer,

(d) a person prescribed by the regulations.

(4) A person authorised by this Act to take a person to or from a mental health facility or other health facility may:

(a) use reasonable force in exercising functions under this section or any other provision of this Act applying this section, and

(b) restrain the person in any way that is reasonably necessary in the circumstances….."

54. Once called by the ACS team the attending police officers had a responsibility to provide assistance to enforce the breach of the CTO. Police appropriately conveyed to HP through the front door that he was not in trouble, he had called the police for assistance and they were there to help him.

55. Whilst all four officers indicated they were of the view (correctly) they had the statutory power to enter HP's premises, detain and convey him to a hospital, none could state precisely the source of that statutory power.

56. I am satisfied Constables Williams and Wolfenden appropriately both viewed the CTO prior to taking any action. The evidence of all four police officers established they had a clear understanding of the need to treat HP with dignity and respect balanced against the need to detain him for mental health treatment.

57. AS Tsougranis did not recall being informed of the balcony incident by Constable Williams in the first instance prior to his arrival at the scene. Both Constable Williams and Constable Low have a clear recollection of it being discussed. I find it was discussed and was clearly the main reason Constable Williams sought guidance and assistance from a more senior officer. I am satisfied AS Tsougranis's recollection has been affected by the period of time that has elapsed following what was understandably a traumatic incident.

58. Given the concerns regarding HP's access to the balcony and the period of time the stand off continued, the decision to force access in the manner it was accomplished was proper and appropriate. AS Tsougranis had attended the unit block on multiple occasions prior. He had an overriding concern regarding HP's access to the balcony whilst police were remaining outside.

59. AS Tsougranis as the senior officer considered escorting a person down a stair way less safe than using a lift. None of the witnesses now recall any decision being communicated regarding this issue. The evidence does not allow for a finding whether a decision was made and if so by whom, regarding the use of the lifts rather than the stairway which was closer.

Would it have been appropriate to restrain HP in order to convey him to Concord Hospital?

60. Once inside the unit the actions of the police in securing the balcony, removing any sharp items and searching HP was appropriate and necessary. At that point of time the attending officers were not aware of HP's threat to jump that had been conveyed by QP and then to 000. All officers gave evidence of HP's rapid change in demeanour once they entered the unit and that he had calmed down.

61. I am satisfied HP's change in demeanour was a proper basis in the circumstances to reassess and conclude HP's risk of self harm was lowered. That lowering of risk was also consistent with the views of the ACS team. It is a fundamental requirement for police officers and mental health workers to make on the spot assessments and continually reassess the risk of persons who are required to be detained/arrested and transported.

62. The evidence also supports the view that HP was less agitated and more compliant with the police officers than the ACS team. Whist there were differing versions from all witnesses regarding what transport was to be used to convey HP to Concord, that is consistent with multiple witnesses recalling events that took place nearly two years ago and the lengthy period of time at the scene. No ambulance had been called for the purpose of transportation. The evidence that HP was willing to go with police but not the ACS team members satisfies me the plan for transport was in the ACS vehicle with a police officer (most likely Constable Williams) seated next to HP.

Restraint guidelines for police officers when dealing with mental health patients

63. In July 2007 a memorandum of understanding (MOU) was entered into by New South Wales Health, the New South Wales police force and the New South Wales ambulance service regarding policy and procedures applied relating to mental health emergency response. That MOU was operative at the time of this incident. That MOU has now been superseded by a MOU entered into in 2018.

The 2007 MOU outlines the following principles regarding restraint of patients:

"7.3 Restraint

The principle of least restrictive environment requires a restraint (physical or mechanical) only be used where less restrictive alternatives are ineffective.

The practice of restraint should be viewed as a last line of patient management in response to significant risk to the safety of patients or others and used only where less restrictive alternatives are ineffective or are not appropriate to meet the specific needs of the patient.

When restraint is used, three key issues need to be considered:

- *treating the patient with dignity and respect at all times is imperative*
- *restraint is a temporary intervention. The main aim is to treat the underlying condition*
- *restraint is used for the welfare of the patient and not for staff operational convenience.*

Restraint is to be used consistent with the policies and procedures applied to the respective agencies.

In general police use of restraint is to prevent a breach of the peace or to prevent injury to the patient, service providers, or the public."

64. AS Tsougranis was of the view if he had handcuffed HP all the trust he had attempted to build in his dialogue with HP over the lengthy period he was at the scene would have been broken. HP gave no signs of harming anyone or breaking away, he had not been aggressive. AS Tsougranis did not consider given HP's presentation once police entered the unit and HP's clear preference to deal with the police not the ACS team, that handcuffing HP was in any way appropriate or necessary to transport him to a hospital.

65. Constable Wolfenden did not consider handcuffing HP was appropriate and that HP was compliant and would go with police. Constable Williams was of the view HP's whole demeanour had changed and handcuffing HP was not necessary. Constable Low also saw no need to restrain HP given his change of behaviour once police entered the unit.

66. The need for police officers to effectively communicate with persons who may be suffering a mental illness is an important component of any interaction. The ability to establish a level of rapport and trust, an appropriate de-escalation technique, is not always possible. Having got to the point where HP was willing to talk to police but

not the ACS team and HP's compliance with police once they entered his unit, I find any decision to handcuff HP may well have been detrimental to any ongoing communication and/or escalate HP's behaviour. I find the decision not to handcuff or restrain HP based on the information available to the attending police at the time was in accordance with existing police policy.

Was the information provided by Mr QP to 000 that his father had made a threat to jump if he was taken to hospital accurately recorded?

67. Senior Constable Lambert was performing duty as Police Liaison operator at the Police Communication Centre. SC Lambert had four years experience in that role. Her primary role was to assist radio operators/dispatcher with police computer checks and other information required in the course of dispatching/receiving police radio messages. SC Lambert also performed the role of the police radio rescue coordinator for a considerable portion of her shifts.

68. Infrequently, due to overload on the system or when not tasked with conducting computer or other inquires SC Lambert received direct 000 calls from the public. That would occur infrequently perhaps once in every two shifts.

The Computer Aided Dispatch (CAD) System

69. When a call is received the 000 operator opens a new message and records the details on screen. Certain prompts will appear if a computer field is missed or not completed properly. The operator must listen very carefully to the caller who is often distressed, ascertain the nature of the call, obtain the relevant and necessary information, record it (often at the same time as listening to the caller), determine the priority of the message and what specific information must be contained in the CAD message. The CAD is then reviewed by the operator prior to being electronically forwarded and allocated to a dispatcher.

70. SC Lambert made an error in not recording the word "jump" in the CAD message. SC Lambert agrees the message "INFT RECEIVED CALL FROM HIS DAD THREATENING TO LOC" did not make sense and when she reviewed the message prior to forwarding it to the dispatcher she must have missed that error. In addition, in hindsight, SC Lambert considered the information in the 000 call required an upgrade of priority from Category 3 "Concern for Welfare" to Category 2 "Self Harm". SC Lambert described her error as a serious mistake. I find as a result, information

received that a threat of self harm was made was not recorded or actioned appropriately.

Why was this information not broadcast or otherwise communicated to police at the scene?

71. Ms Crowther was the civilian radio operator/dispatcher for Channel F on duty at the time and received SC Lambert's CAD message. Ms Crowther had 11 years' experience as a radio dispatcher and commenced duty at midday. Prior to her commencing the shift the two separate CAD messages (one from HP and the other from Mr Douglass) had been received, actioned and merged as they related to the same incident.

72. Ms Crowther received SC Lambert's message at 12.07pm. Ms Crowther's recollection is it was obvious the message related to the same incident. The message remained at Category 3, concern for welfare. In Ms Crowther's experience it is a common situation that multiple calls are received for the one incident, such as a serious motor vehicle accident. The information she had to hand was the police were already on the scene.

73. Ms Crowther was of the view the message as sent by SC Lambert provided no new relevant information that required a decision to broadcast a message to police who had been at the scene for some considerable time. Accordingly no radio message was sent. Ms Crowther merged the new message into the existing entry. Ms Crowther stated if the message had contained information that a person was threatening to "jump" she would have broadcast the message to the attending police at the scene immediately. I find Ms Crowther's decision not to broadcast the message based on the information she had to hand was appropriate.

Should any recommendations be made pursuant to s 82 of the *Coroners Act* 2009?

Failure by SC Lambert to record on the CAD message the threat of HP to jump

74. I am satisfied that the evidence demonstrates the failure to record and action HP's threat to jump occurred due to human error on SC Lambert's part. I do not find there was any systemic error that contributed to critical information not being provided to police at the scene. In those circumstances no recommendation is necessary or desirable.

Police training regarding specific powers under the Mental Health Act 2007

75. On the basis all attending police were not specifically aware of their statutory powers under ss 59 & 81 of the *Mental Health* Act 2007, I direct a copy of these findings be forwarded to the Commander, Leichhardt Local Area Command. Appropriate education and training of police officers in that Command should take place regarding this issue. On that basis I make no formal recommendation in this regard.

The failure to provide the ACS team with a recent risk assessment regarding HP prior to their attendance at the unit.

76. The important and difficult role fulfilled by ACS staff must be acknowledged. The facilitation of community based treatment for persons with mental illness presents many challenges to staff. That Mr Douglass and RN De Dear attended the address without all relevant information is a matter of concern.

77. Information was received during the course of the inquest from the Sydney Local Health District (SLHD) advising of the following:

    In November 2015 the SLHD published a guideline document regarding procedures for "*Intake/ACS Transfer of Care Procedure for SLHD Eastern Sector Community Mental Health"*

    Part 1 of the guidelines state:

    "All efforts should be made by Care Coordinators to enact breach proceeding in working hours. If unable to breach, verbal handover to ACS in evening/weekend with complete recent assessment and breach paper (and medication if required)"

78. The tragic circumstances of HP's death have highlighted the need for clarification between the various teams of what information a "*recent assessment document"* should contain. It is not defined in the SLHD guidelines. The SLHD is currently in the process of updating those procedures to clarify exactly what documentation is required on handover to the ACS team for breach actions.

79. A Home Visit Safety Checklist is a mandatory form to be completed for all community based mental health consumers. It is a centralised document available via the electronic medical records system. It is updated every 13 weeks or earlier if there are significant changes. The current checklist is being reviewed and updated to ensure additional risk factors are appropriately recorded to include the inclusion of historical risk events.

80. I am satisfied that the SLHD is taking appropriate and active steps to address the failings identified in this matter to ensure the provision of relevant information to field staff. Accordingly I do not consider the making of any recommendations necessary or desirable.

Conclusion

81. HP's death occurred where mental health workers and police in difficult circumstances were attempting to ensure HP received necessary mental health treatment. In accordance with the principles of s 3 (a)&(b) of the *Mental Health Act* 2007 HP was receiving treatment in the community for his mental illness. The ACS team and the attending police dealt appropriately with HP whilst in possession of an order that required HP's detention and transfer to a mental health facility for treatment.

82. The sudden actions of HP jumping over the balcony railing have deeply affected HP's family and all persons present at the scene. HP's mental state at the time must be closely examined. HP was non compliant with medication and treatment. The last review of HP on 6 December resulted in Dr Crawford expressing an opinion HP was suffering from paranoid schizophrenia. A finding of suicide should only be made if the evidence is clear, cogent and exact, *Briginshaw v Briginshaw (*1938) 60 CLR 336.

83. That HP was suffering delusional thoughts at the time of his death is supported by the two phone calls to QP asking him to call the police to remove the mental health workers. The evidence clearly demonstrates police had been there and speaking with HP for some time. Accordingly I find HP's thought processes were overborne by the mental illness he was suffering. I find HP was incapable of forming an intention to end his own life at the time of his death.

I offer my sincere condolences to HP's son QP and all of HP's family.

I thank Counsel Assisting Mr Harris and Mr Gillespie from the Crown Solicitors Office for their assistance.

Findings pursuant to s 81 of the Coroners Act 2009

Identity
The person who died was HP

Place of death
Royal Prince Alfred Hospital Camperdown

Date of death
9 December 2016

Cause of death
Multiple blunt force injuries

Manner of Death
HP whilst suffering from a mental illness jumped over a balcony railing on the third floor of his unit block during the course of a police operation. HP fell to the ground receiving fatal injuries.

Les Mabbutt
State Coroner