CORONER'S COURT

Name of Deceased: Sean Leigh MACWILLIAM

File Number: 2011/386910

Hearing Dates: 30 September, 1-3 October 2013 & 18 December 2013

Location of Inquest: Queanbeyan Court House and Downing Centre.

Date of Finding: 13 August 2014

Coroner: Paul MacMahon
Deputy State Coroner

Representations: Mr P. Aitkin – Counsel Assisting
Mr W. deMars – Ms Julie King (Sean MacWilliam's mother)
Mr J. Downing – Dr K. Ngo
Mr S. Woods – Southern NSW LHD
Ms J. Lonergan SC – Dr G. Elliott
Mr M. Spartalis – NSW Police Force
Mr G. Gemmell – Medibank Health Solutions Telehealth Pty Ltd

Non-publication order made pursuant to Section 74(1) (b) Coroners Act 2009:

The publication of the evidence contained in Exhibit 5 in the proceedings is prohibited.

Order made in accordance with Section 75(5) Coroners Act 2009

The publication of a report of the proceedings is granted without restriction except to the extent that such report would breach the non-publication order made in accordance with Section 74 (1) (b).

Findings made in accordance with Section 81(1) Coroners Act 2009:

Sean Leigh MacWilliam (born 15 November 1994) died on 24 March 2011 at 10 Spendelove Street, Queanbeyan in the State of New South Wales. The cause of his death was asphyxia due to hanging which was self-inflicted with the intention of ending his life.

Recommendations made in accordance with Section 82 (1) Coroners Act 2009:

Nil

Paul MacMahon
Deputy State Coroner
13 August 2014

Reasons for Finding:

1. Sean Leigh MacWilliam (who in these reasons I will refer to as 'Sean') was born on 15 November 1994. Sean died on 24 March 2011. At the time of his death Sean was a little over 16 years of age.

2. Sean resided with his parents in Queanbeyan in south eastern New South Wales. He had been suffering from mental health issues for about a year prior to his death and was receiving various types of prescribed medication in order to assist him with this condition.

3. A little over 4 weeks before his death Sean experienced a relationship breakup with his girlfriend. Following this his mental health condition was observed to have dramatically deteriorated and he expressed threats of self-harm.

4. On one occasion he stole his father's car and was involved in a single vehicle motor vehicle collision. Sean sustained no serious injuries however this event was later said by him to have been an attempt at self-harm on his part.

5. On 15 March 2011 police were called to Sean's home where he had taken a large kitchen knife and had gone to the backyard of his home and was threatening to kill himself. As a result Sean was taken to Queanbeyan Hospital and, after assessment, was scheduled under the provisions of the Mental Health Act 2007.

6. Following him being scheduled Sean was admitted to the Chisholm Ross Centre (CRC) at Goulburn. The CRC was an adult mental health facility and as a result special provisions were put in place for Sean to take account of his age. It was hoped that a place for him might be able to be found in an adolescent mental health facility.

7. Whilst at the CRC Sean appeared to show signs of improvement and as no place had been found for him in an adolescent facility on 24 March 2011 Sean was released on leave into the care of his parents. He returned home arriving there at about 11:30am.

8. Initially Sean's return home progressed smoothly however about 7:00pm he became involved in an argument with his parents. The argument concerned his wish to go to stay at the home of his friend Bradley Luttill (Brad). Sean's parents were unable to transport him to Brad's home

9. About this time police became involved and there was the suggestion they might transport Sean to Brad's home. This did not, however, occur.

10. At about 10:15pm Sean was seen on the front porch of the family home by his father.

11. At 10:35pm however Sean's mother located him in the rear yard of the family home hanging from a beam under the rear veranda. Sean's father immediately cut the rope that was used, laid him on the ground and commenced CPR. Ambulance and police were contacted. Notwithstanding their efforts Sean was not able to be revived. He was subsequently taken to Queanbeyan Hospital where he was pronounced deceased.

12. Sean's death was reported to the Coroner at Queanbeyan by police on 25 March 2011.

Role and Function of the Coroner

13. It is important at this stage to set out the role and function of the coroner in respect of Sean's death. That is established by the Coroners Act 2009 (the Act). All legislative references, unless otherwise mentioned, will be to that Act. Section 6 defines a *"reportable death"* as including one where a person died a *"violent or unnatural death."*

14. Section 35 requires that all *reportable deaths* be reported to a Coroner.

15. Section 18 gives a Coroner jurisdiction to hold an inquest where the death, or suspected death, of an individual occurred within New South Wales or where the person who has died, or is suspected to have died, was ordinarily a resident of New South Wales.

16. Because of the circumstances of Sean's death it was required to be reported to the Coroner.

17. Section 81(1) sets out the primary function of the Coroner when an inquest is held. That section requires, in summary, that at the conclusion of the inquest the coroner is to establish, should sufficient evidence be available, the fact that a person has died; the identity of that person; the date and place of their death and the cause and manner thereof.

18. Section 82 provides that a Coroner conducting an inquest may also make such recommendations, as he or she considers necessary or desirable, in relation to any matter connected with the death with which the inquest is concerned. The making of recommendations is discretionary and relates usually, but not necessarily only, to matters of public health, public safety or the conduct of services provided by public instrumentalities. In this way coronial proceedings can be forward looking, aiming to prevent future deaths of a nature similar to that with which the inquest is concerned.

19. Section 74 (1)(b) authorises a Coroner during the course of an inquest, if he or she is of the opinion that it is in the public interest to do so, to prohibit the publication of any evidence given in the proceeding.

20. Section 75 also has relevance to the circumstances of Sean's death. Section 75 deals with the situation where it appears to the Coroner that a death is self-inflicted. That section allows a Coroner during the course of an inquest to make non-publication orders and at the conclusion of an inquest where a finding is made that the death was self-inflicted the section automatically prohibits the publication of a report of the proceedings unless the Coroner makes an order permitting the publication of such a report.

Identity, Date and Place of Death

21. Sean's identity and the date and place of his death were not matters of contention.

22. Johannes Casper Van Aggele identified Sean's body to police on 24 March 2011. Mr Van Aggele is Sean's grandfather. I accept his identification of Sean.

23. Sean was found hanging at his home by his mother at about 10:35pm on 24 March 2011. He was unable to be revived. I am satisfied that the date of his death was 24 March 2011 and the place of his death is 10 Spendelove Street, Queanbeyan in the State of New South Wales.

Cause and Manner of Death

24. The cause of Sean's death was also not a matter of contention. Following his death an autopsy was performed by Associate Professor Sanjiv Jain. On the basis of his examination he found that the cause of Sean's death was 'Asphyxia due to Hanging with the aspiration of gastric contents being a factor contributing to but not causing the death. Associate Professor Jain's findings are consistent with the other evidence available to me. I accept his recommendation as to the cause of Sean's death.

25. In addition there is no doubt that Sean's death came about due to his own actions. There is also no evidence available to me that would suggest any third party involvement in his death. I am therefore satisfied to the standard required that Sean's death was self-inflicted.

Issues for inquest

26. The death of a young person at his or her own hand any time is a tragedy for both their family and the community as a whole. This is especially the so when the young person suffers from mental health issues which leave them vulnerable and

pose challenges to parents, family and friends as to how to provide the care and assistance that is required. The quality of a society is often said to be measured by the way it cares for the most vulnerable members. Because of the vulnerability of young persons with mental health conditions the community has a responsibility, as best as it can, to provide care and support to both them and their families.

27. In Sean's case a number of community agencies were involved with him in the period prior to his death. Those agencies included the CRC, Queanbeyan Hospital, the Child and Adolescent Mental Health Service (CAMHS), and the NSW Police Force (NSWPF). The issues that were examined at inquest focused on those interactions, the outcome of such interactions, whether or not there were any systemic failures that contributed to Sean's death and whether any lessons might be learned from the death of Sean that might give rise to recommendations for change in order to prevent similar tragedies occurring in the future.

28. So that this might occur it is necessary, in the first instance, to set out in some detail the history of the events that led up to the tragedy of Sean's untimely death.

29. Sean came from a close family that had strong ties to the Canberra and Queanbeyan area. He is reported to have had a good relationship with his brother and mother however his relationship with his father was strained. His father suffered from Post-traumatic Stress Disorder and alcohol dependence that were said to have been a consequence of his Vietnam War experiences. There was no history of Sean suffering from any physical abuse or ill-treatment.

30. In 2003 Sean suffered from serious eczema that resulted in him being hospitalised. This condition also resulted in him suffering from teasing and bullying at school.

31. Sean commenced his secondary education at Queanbeyan High School. It initially appeared that the problems he had suffered during primary school had stopped. In 2008 however he was involved in a fight with another pupil. Both were suspended.

32. Whilst suspended Sean was the subject of a number of threats and other forms of bullying. His parents considered that it was in his best interest that he should change schools. In October 2008 he was enrolled at Campbell High School in the ACT. This change of school appeared to have a positive effect and the balance of 2008 and in early 2009 he appeared to be fitting into his new school well.

33. In about mid 2009 Sean commenced using marijuana. He also began skipping classes and expressing some concerns about undertaking year 10 in 2010. Sean also expressed his fears to a family friend who told Sean's mother that she believed Sean was suffering from depression.

34. In early 2010 Sean spoke to Dr John Azoury a general practitioner who referred him to Dr Graham Bench a paediatrician. Dr Bench diagnosed him to be suffering from depression. In March 2010 Sean was prescribed various medications including an anti-depressant. Initially this appeared to have a positive effect however after several months the benefit was less and as a result medication was increased however he still showed signs of scattered depression, restlessness and abnormal sleeping patterns.

35. Sean continued to be enrolled at school but would rarely attend classes. Sean's mother was informed of this by the school and Sean was confronted. He indicated he was having problems with his teachers. He subsequently admitted to not being able to attend classes due to severe anxiety.

36. Following consultation with the school it was decided that Sean would have leave of absence from school for the balance of 2010.

37. During his leave there appeared to be a positive improvement in Sean's behaviour and he indicated that he was looking forward to a fresh start at College in 2011. In November 2010 Sean also met a girl of his age and they subsequently commenced a relationship. Sean appeared very happy with his situation and it seemed to his family that things had taken a turn for the better in his life.

38. On 28 February 2011 Sean noticed a posting on Facebook that led him to believe his girlfriend was 'cheating' on him. He confronted her. She told him that she wanted a week apart. He interpreted this as being the end of the relationship.

39. Sean's family noticed an immediate and dramatic change in his behaviour. He began to consume alcohol, smoke marijuana, sneak out of the house during the night and have inconsistent sleeping habits. On 7 March 2011 Sean's mother found him in his room crying over the breakup of the relationship. She did her best to console him. He subsequently went to sleep.

40. Early the next morning, however, Sean stole his father's car and having picked up a female friend was involved in a single vehicle collision. Sean's mother was called to collect him from the scene and he told her at that time the collision had been an accident. He was subsequently to suggest that the collision was in fact a joint suicide attempt on the part of himself and his friend.

41. On 11 March 2011 Sean informed his mother that the relationship with his girlfriend was officially over. Soon after this the male person his former girlfriend was believed to have been seeing wrote to Sean on Facebook saying 'Why don't you just go and hang yourself.'

42. At 7:30am on 11 March 2011 Sean was involved in an argument with his mother. He packed his bag and left the family home making threats of self-harm. He subsequently sent an SMS message to his mother with further threats of self-harm. The assistance of the police was sought. Constables McKay and Papanicolaou arrived about 20 minutes later and began a patrol of the area. Sean was not able to be found at the time.

43. About 10:00am Sean returned home. He made further threats of self-harm. He acquired a knife from the kitchen and walked into the backyard. Police were once again again called. After talking to Sean police took him to Queanbeyan Hospital for a mental health assessment. He was assessed by Dr Ellis and found to be at risk of injuring himself. As previously mentioned he was scheduled under the provisions of the Mental Health Act 2007. Sean was subsequently transferred to the Chisholm Ross Centre (CRC) in Goulburn.

44. Sean was a patient at the CRC between 15 March 2011 and 24 March 2011.

45. At the CRC Dr Ngo undertook a further assessment of Sean. She made an initial diagnosis of Major depressive Disorder with concurrent substance abuse disorder due to his Cannabis use. Sean stated that he was using up to 18 cones of the drug on a daily basis.

46. Dr Ngo recorded that Sean said he had attempted to commit suicide on 18 different occasions since 2009, he had ongoing feelings of hopelessness and worthlessness, low energy, reduced enjoyment in once pleasurable activities, sleep disturbance and poor appetite. He also complained that he felt overwhelmed by his personal circumstances including school, the breakup with his girlfriend and the poor relationship with his father.

47. Following his admission to the CRC Sean's medication was varied and he was prescribed 10mg per day of Fluoxetine and anti-depressant commonly used to treat major depression. The dose was subsequently increased on 24 March 2011 to 20mg per day.

48. The CRC was a facility for adults with acute mental health conditions. As an adolescent Sean's admission posed a number of problems for the facility. Attempts were made to accommodate those difficulties with Sean being provided with what is

known as a 'special.' This is a nurse, or other attendant, who is required to remain with the patient at all times. This meant that Sean was confined to his room most of the time; however he was also able to go to the courtyard from time to time under supervision. Sean was also seen by Dr Ngo each day.

49. During this time Sean's disposition appeared to be improving, he engaged with nursing staff, was noted to be warm and reactive, his intake of food and fluids was satisfactory and he appeared to be sleeping well. He spent a lot of his time drawing and writing in his diary.

50. On the weekend of 19-20 March 2011 Sean asked if he could have weekend leave with his parents however this was declined. His level of anxiety and frustration appeared to increase after he received this decision however he subsequently settled down.

51. On 23 March 2011 Sean was reviewed by Dr Elliot, Dr Ngo and Ms Godfrey. He said that he was bored and missing his home environment. He said that his suicidal thoughts were still present but were fading. He accepted that cannabis use was a problem for him. He denied any negative consequences of his medication change. He wanted to go home.

52. Following this assessment Dr Elliot formed the opinion that Sean did not meet the requirements of the Mental Health Act 2007 for continued involuntary admission. Dr Elliot was also of the opinion that the continued admission in an acute adult mental health facility was not beneficial to Sean. The efforts to arrange for Sean to be admitted to an adolescent mental health facility had also been unsuccessful.

53. Dr Elliot, following this assessment, decided that Sean should have extended leave (referred to as 'gate leave') from 24 March 2011 with the intention of discharging him on 31 March 2011 if there had been no further deterioration in his mental health condition.

54. A management plan was developed under the supervision of Dr Elliot that involved Sean being seen by the mental health teams on 25, 26 and 27 March 2011 and Dr Elliot on 30 March 2011.

55. On 24 March 2011 Sean was conveyed home by CRC staff Debbie Gibson and Yvonne McViney. A discussion occurred with Sean's mother and Sean was informed of the appointments that had been arranged and that if he was to miss any of them he would have to return to the CRC.

56. At 6:00pm on 24 March 2011 Sean appeared to be settled and was observed to be playing his guitar in his room. At about 7:10pm however Sean told his mother

that he wasn't comfortable staying at his home and wanted to go to his friend, Brad's, home at Bywong; some 40 kilometres away. Sean's mother did not think this was a good idea because of the need for Sean to attend the appointment arranged for the next day and in addition she was unable to provide transport because the family was down to one car because of the damage that resulted from the incident on 8 March 2011.

57. Following this Sean had a conversation on the phone and then left the family home with his mother's phone, his own phone and an iPad. As he did so his mother suggested that he have a walk and that they talk about it again in half an hour. Sean returned home again at about 8:45pm and then left again. He appeared to be upset at not being allowed to go to his friend's home; he had not made any treats of self-harm to his family.

58. In the meantime Sean had been speaking to his friend Brad. The conversation between them resulted in Brad becoming concerned for Sean's wellbeing. Shortly after 9:00pm Brad phoned Queanbeyan Police Station and spoke to S/C Papanicolaou who had had the previous dealings with Sean on 11 March 2011. She agreed to phone Sean. When she did he told her that he did not want to return home and was planning to sleep on the streets. S/C Papanicolaou agreed to try and assist Sean to get to his friend's home. Sean agreed to return home and on his arrival told his parents that the police were going to arrange to take him to Brad's home.

59. After S/C Papanicolaou spoke to Sean she had a conversation with her shift supervisor S/C McLelland. She was informed that due to lack of resources it was not possible to transport Sean to Bywong. S/C McLelland phoned and told Sean's father who subsequently let Sean know that this was the case. Sean was then seen walking back into his house from the front balcony at about 10:15pm. As already mentioned Sean was found by his mother under the rear veranda of their home at 10:35pm.

60. As I previously mentioned the issues examined at inquest related firstly to the decision making of the mental health professionals, including the emergency call services, that tried to assist Sean and secondly the actions of the NSWPF officers on 24 March 2011 who were involved with Sean. In order for this to occur an extensive brief of evidence was assembled by the officer in charge of the investigation into Sean's death and a large number of witnesses gave evidence at the inquest.

Issues relating to Sean's mental health care:

61. There was no dispute during the course of the inquest that following Sean being taken to Queanbeyan Hospital on 15 March 2011 it was appropriate, having regard to his history and presentation at the time, for him to have been made an involuntary patient in accordance with the provisions of the Mental health Act.
62. There was also no dispute that the CRC, as a mental health facility for adults with acute mental health conditions, was an inappropriate environment for an adolescent experiencing their first admission to a mental health facility.
63. The evidence that the nearest adolescent mental health facilities were at Campbelltown and Westmead was also uncontroversial as was the evidence that such facilities were not available in the Australian Capital Territory.
64. An issue of contention was, however, whether or not the decision on 23 March 2011 to change Sean's status from an involuntary to voluntary patient was appropriate. It was contended on behalf of the family that Sean should have remained an involuntary patient at the CRC until a bed became available at a specialist adolescent mental health facility and that him being granted leave from the CRC at the time it occurred was not appropriate and thus a factor that contributed to the circumstances that led to his death.
65. In considering this issue I had the assistance of evidence from Dr Gordon Elliot (Sean's treating psychiatrist), Dr Kim Ngo (a career medical officer at the CRC with training in psychiatry who cared for Sean during his admission), Associate Professor Michael Robinson (a consultant psychiatrist qualified on my behalf as Coroner to review Sean's care) and Dr Michael Giuffrida (a consultant psychiatrist qualified to review Sean's care on behalf of his family).
66. Dr Elliot gave evidence that on 23 March 2011 he, together with Dr Ngo, reviewed Sean's progress and that he formed the opinion that he no longer met the requirements for him to continue as an involuntary patient. He said: *'He wasn't pervasively depressed. There weren't any other criteria for a mentally ill person and even ignoring the legislation for a moment, you know. When we reviewed him Sean was bright reactive, he had plans for his future, he was looking forward to going home. In a practical sense this wasn't someone that I wanted to keep locked in a room.'*
67. Dr Ngo also gave evidence that she reached a similar conclusion.
68. Both doctors gave evidence that in coming to their conclusion they took into consideration the clinical information and observations that they, and other staff

of the CRC, had made that suggested that whilst Sean had been an in-patient there had been an improvement in his condition, the history that had become available to them during the time Sean had been admitted to the CRC, the fact that although Sean was expressing some continuing self-harm or suicidal ideation such expressions were unfocused, generalised, often fleeting and passive rather than being active in that no plan was involved. They also took into account their view that the CRC was not an appropriate facility for an adolescent for the reasons that have been previously identified.

69. Associate Professor Robertson gave evidence that in his opinion the conclusion reached by Dr Elliot and Dr Ngo was reasonable and that *'it was improbable that Dr Elliot could have enforced further stay in a highly inappropriate clinical setting.'*

70. Dr Giuffrida, who gave evidence concurrently with Associate Professor Robertson, formed a different opinion.

71. Associate Professor Robertson took the view, consistent with Dr Elliot and Dr Ngo, that allowing for Sean's comparatively improved mental state ongoing detention could not be justified as being the least restrictive option of safe care. Dr Giuffrida, on the other hand, considered that given his recent reported suicide attempt, the length of time Sean had reported other suicide and self-harm attempts and his two year history of depression, Sean should have remained as an involuntary patient. Dr Giuffrida considered that having regard to Sean's mental state history any improvement that was noticed during his time as a patient at the CRC may well have been illusory.

72. Counsel for Sean's family have submitted that I would accept Dr Giuffrida's opinion and conclude that Sean should have remained an involuntary patient and not been given leave on 24 March 2011.

73. It is clear that assessing a patient's mental state for the purpose of determining whether or not a person's freedom should be taken from them is not a mechanical exercise. It is for the assessing practitioner to weigh up all the available information and make a judgement as to whether or not, in a particular situation, the requirements for involuntary admission were present. Doing so is more of an art than a science. Different practitioners looking at the same circumstances may reasonably come to different conclusions. This is the case here where three well qualified and experienced psychiatrists have differed.

74. I accept the evidence that Dr Elliot and Dr Ngo took into account all the available clinical and other information available and approached their task in a sensitive and professional manner and came to a conclusion that could not be said to be unreasonable.
75. I also accept that in their mind, having reached the conclusion that Sean could not be detained involuntarily any further, and in the face of Sean's desire to go home they were left in a situation where it was incumbent on them to not prevent him leaving the CRC, if that was what he wanted. Having reached the conclusion that they did it was proposed that Sean would be transitioned to care in the community and would initially have leave and if that went well he would be discharged from the CRC a week later.
76. In the circumstances, given Sean's youth, history and vulnerability, it was essential that Sean's leaving the CRC should be well planned and that risks that might arise following him leaving the security of the CRC be anticipated, and where possible, mitigated. Unfortunately while the CRC staff attempted to achieve this there were flaws in the attempt that the subsequent tragic events were to highlight.
77. Sean leaving the CRC occurred in the context of the unanimous view of the treating practitioners, and the consulting experts, that he was suffering significant mental health issues and that his best care would have been able to have been provided in a specialist adolescent mental health facility.
78. Had a bed in such a facility become available it would have been necessary, in the light of the conclusion that he could no longer be detained as an voluntary patient, for Sean to agree to be admitted as a voluntary patient. Had he not been prepared to agree then his further treatment would, unless there was a change in his mental state, would necessarily have been in the community.
79. A bed in such a facility, however, had not become available whilst Sean was a patient at the CRC and there was no certainty that one would become available in the immediate future. Indeed the evidence was that Sean's apparent mental state improvement made this less likely. His continuing care in the community would consequently need to be well thought out.
80. Effort was put into achieving this and a management plan was developed that all the experts agreed was comprehensive in terms of the availability of medical supervision whilst Sean was on leave. That plan included daily review by

clinicians and experienced mental health professionals provided through the Queanbeyan CAMHS.

81. Dr Giuffrida's agreed that the plan was appropriate as far as it went but was concerned that it did not emphasise the heightened risk of self-harm in the week following Sean leaving the CRC and the degree of supervision of him that was necessary following his return home.
82. Following Sean leaving the CRC he was driven home by Ms Debbie Godfrey (RN / Counsellor - CAMHS) and Ms Yvonne McAviney (Clinical Leader – CAMHS). Both Ms Godfrey and Ms McAviney gave evidence. On arrival at the Sean's home the management plan was explained to Sean's mother and father. Ms Godfrey and Ms McAviney's evidence was that they believed they had properly informed the family of all aspects of the discharge plan including the need to know where Sean was, what he was doing and ensuring that he was under adult supervision. I accept that they believed this to be so.
83. That Sean was to be the subject of parental supervision following him leaving the CRC was in fact an expectation of Dr Elliot. In his evidence Dr Elliot said that: *'I expected them (Sean's parents) to be at home, yes, and to be around Sean and to be aware that he had just come out of hospital and that if he did become agitated or aroused, they would ring the numbers that were made available to them and seek advice.'*
84. Such supervision was an essential aspect of the supervision of Sean that was necessary to mitigate the risks that were associated with Sean leaving the CRC. In the mind of Ms Godfrey and Ms McAviney that might have been done however subsequent events were to show that how Sean's carers were to become confused as to how to assist him when, as occurred late on 24 March 2011, he showed that he was not prepared to abide by the plan and they apparently did not identify the seriousness of Sean's decompensating mental state.
85. Julie King, in her statement of 1 July 2011, shows how the plan and its explanation on its face appeared to be adequate but not able to achieve its goals when challenged. Ms King clearly was a concerned mother and asked a lot of the questions that it was important to ask. In her statement she said: *'Upon reading the management plan, Paul and I expressed our concerns as to what support we would receive if Sean needed to be returned to mental health, especially what backup was available to us after hours. We stated that without backup, from mental health we were not prepared to have Sean home at that stage. We were*

assured that the backup support would not be an issue as mental health at Queanbeyan Hospital were available to support us throughout office hours and that there was a 24 hour mental health hotline phone service available. After hours if we needed assistance with returning Sean to mental health, we were told to call police. At the time Sean was dropped off, I thought the plan was OK, and I understood that if we had any problems, we were to contact the police so that Sean could be readmitted to mental health.'

86. The need for a clear understanding of how to respond to the challenges of Sean's mental state variations became apparent when he decided that he did not want to remain under his parent's supervision and wanted to go to his friend's home for the night. This gave rise to the NSWPF involvement in the events that preceded Sean's death.

Issues relating to involvement of NSWPF

87. The NSWPF has an important role in the care of persons with mental health conditions. There are two relevant provisions of the Mental Health Act 2007 that underpin that important role. Those sections are section 22(1)(a), which gives, in certain defined circumstances, police officers the power to apprehend a person who appears to be mentally ill or mentally disturbed and take that person to a mental health facility for assessment and section 49, which gives police officers the power to apprehend a person and take them to a mental health facility when requested to do so by an authorised medical officer.
88. It was submitted on behalf of the family that the response of police to the events on the evening of 24 March 2011 as they unfolded was inadequate and involved a number of critical missed opportunities that, had they been acted upon differently, may have changed the course of that evening and prevented Sean's death.
89. The first involvement of the NSWPF on 24 March 2011 was a telephone call by Sean's mother to S/C Lancaster at 8:47pm. During this call Julie King told S/C Lancaster that Sean's *'behaviour was escalating'* and that she had been advised by the CRC that *'he needed to be returned to the Queanbeyan Hospital for reassessment'*. Julie King also gave S/C Lancaster the contact person at the CRC so that they could verify the information as to Sean's mental health condition.
90. S/C Lancaster's evidence at the inquest confirmed content of the call. She made a short note of the call at the time. S/C Lancaster gave evidence that she did not doubt the information given to her by Julie King concerning the need for Sean to

be returned to the CRC and that had she continued to look after the matter she would have arranged for a 'CAD job' to be put on to look for Sean so that when found he might be assessed to determine *'if he should be scheduled under the Mental Health Act.'*

91. Bradley Luttell, as I have already mentioned, was a friend of Sean. He had been speaking to Sean on the phone that evening. It was Brad's home that Sean wanted to go to that evening. As a result of the conversation he had with Sean, Brad became concerned for his welfare and phoned the police. He spoke to S/C Papanicolaou who had dealt with Sean on 11 March 2011 when he had been scheduled
92. During the call S/C Papanicolaou gave evidence that she recalled Brad saying that the words Sean was using raised alarm bells for him and that he was concerned Sean *'might do something stupid.'*
93. S/C Papanicolaou thought that her conversation with Brad occurred about 9.30pm however on the evidence available I am satisfied that it occurred earlier and about the time S/C Lancaster spoke to Julie King.
94. Because she had previously dealt with Sean on 11 March 2011 it seems that S/C Papanicolaou assumed responsibility for further police action concerning Sean that evening. It would also seem that S/C Lancaster's handover to S/C Papanicolaou was limited and some information, including the name of the contact at the CRC and the fact that the CRC nurse had suggested Sean should be taken to the CRC or Queanbeyan Hospital for reassessment, was not given.
95. Having spoken to Brad S/C Papanicolaou then phoned Sean and spoke to him.
96. S/C Papanicolaou confirmed that Sean did not want to go home and that he wanted to go to Brad's home for the night. S/C Papanicolaou suggested that Sean go home and that she would try to arrange for a police car to take him to the Luttell residence. It was S/C Papanicolaou evidence that during the course of her conversation she found Sean to be calm, forthcoming and happy with the proposal that had been suggested.
97. Shortly after S/C Papanicolaou's conversation with Sean his mother phoned him. This would appear to have been at 8:56pm. Julie King states Sean indicated that he was on his way home and that *'the police had told him they would take him to Brad's place.'* Sean did return home to await the lift he believed he had been promised by S/C Papanicolaou.

98. S/C Papanicolaou subsequently spoke to Julie King and Jennifer Luttell about the proposed transportation of Sean the Luttell residence and obtained their agreement to the proposal. Julie King says that she was not comfortable with the arrangement. In her statement on 1 May 2011 she said that she *'was not happy with (the arrangement to take him to Brad's) but if that's all police would do I was OK with it.'* S/C Papanicolaou does not agree that Julie King expressed this concern. It is not, however, necessary for my purposes to determine whose recollection is more accurate as the proposal did not come to fruition.

99. Having spoken to Julie King and Jennifer Luttell S/C Papanicolaou discussed the proposal with S/C McLelland who was her supervisor. S/C Papanicolaou was informed that police did not have the resources available to transport Sean as proposed.

100. S/C McLelland then phoned Paul MacWilliam and advised him that police would not be able to transport Sean to the Luttell residence due to the unavailability of resources. Paul MacWilliam relayed the information he had been given by S/C McLelland to Sean. It was after this that Sean was last seen walking back into his home. It is reasonable to infer that Sean reacted to the information he had been given with disappointment.

101. As I have already mentioned the representative of Sean's family have argued that failures on the part of the police contributed to the circumstances in which Sean's death occurred. It is suggested firstly that had S/C Papanicolaou been given all the information available to S/C Lancaster she may have approached her interaction with Sean in a different way and sought to have contacted so that his mental state could be assessed. As it was her action was focused on trying to arrange transport for him. It is assumed that had his mental state been assessed by police at the time he might have been able to be apprehended and taken to a hospital for assessment.

102. I do not accept that this was the case. I am satisfied that having spoken to Sean, even though for a short period, S/C Papanicolaou reasonably came to the conclusion that the issue of concern was not his welfare but where Sean would stay for the night. It may well be that had police been able to transport Sean to his friend's home he would not have taken the action he subsequently did. It is however unfortunate that S/C Papanicolaou appears to have raised Sean's expectations without being able to fulfil those expectations.

103. It is also suggested by the representative of Sean's family that S/C McLelland also had sufficient information available to him to require that police resources be made available to address the concerns for Sean's welfare. I do not consider that it is necessary for me to analyse this issue in detail. S/C McLelland gave evidence at the inquest. His evidence was that in his mind the issue was not one of concern for Sean's welfare but something more akin to a *'domestic argument'*. He said that the possibility of a concern for Sean's welfare *'didn't cross my mind.'*

104. It is trite to note that police are not trained mental health professionals. They do receive some training to assist them in dealing with persons with mental health conditions. That training was described by a number of witnesses and can be described as being 'basic' or 'limited.' That is why where a person is suspected of being mentally ill or mentally disordered and consequently a danger to themselves or others police are required to take them to a hospital for assessment. Their training, as far as it goes, appears to prepare them to deal with persons in an acute mental health situation rather than a more subtle decomposition of mental state that, if anything, Sean appears to have been experiencing.

105. In the circumstances, notwithstanding that S/C McLelland was aware of various aspects of Sean's history, I do not consider that his response was inappropriate and in particular I am satisfied that the circumstances as understood by S/C McLelland did not reasonably give rise to the likelihood of the provisions of section 22, Mental Health Act being enlivened.

106. Notwithstanding this the evidence was that S/C McLelland did respond and in fact went looking for Sean but was unable to locate him. Had he been able to locate Sean and been able to speak to him he may have formed a different opinion however he did not locate him and what might have happened had he done so is a matter for speculation.

107. The last involvement of the police prior to Sean's death appears to have been by Constable Nathan Marks in a telephone call with Linda from the Mental Health Line (MHL). Before dealing with this incident it is necessary to examine the involvement of the MHL personnel in the events that led to Sean's death.

108. As previously mentioned the MHL was recommended to Sean's parents as part of the management plan developed for Sean a source of advice in dealing with Sean especially if they had concerns for his welfare. There were two calls

made to the MHL on the evening of 24 March 2011. I will examine each of these calls.

109. The first call was made by Julie King just before 7.30pm and lasted for about 16 minutes. She spoke to Frieda. The transcript of that call formed part of the evidence. An examination of that conversation shows that Julie King was concerned about Sean's wish to go to a friend's home for the night. Ms King specifically indicates that she did not think that Sean would harm himself. The support provided by Frieda in the circumstances appears to have been appropriate. This is the first involvement the MHL had with Sean. While the call was occurring Frieda opened a file and took the history provided by Julie King.

110. It is unfortunate that the CRC did not provide the MHL with information as to Sean's situation especially as its availability was part of the support outlined in the leave management plan.

111. The second call was made by Paul MacWilliam a little before 10.15pm. He spoke to Linda. The call lasted a little over 10 minutes. This call appears to have occurred shortly after S/C Mclelland's conversation with Sean's father advising him that police would not be able to transport Sean to Brad's home.

112. Once again the transcript of the call was available as evidence in the proceedings. The issues also concerned Sean's wish to go to his friend's home for the night with the addition of his reaction to the police apparently reneging on their promise to take him there. Mr MacWilliam is questioned about the possibility of Sean self-harming or harming someone else and Mr MacWilliam is uncertain as to the situation.

113. The transcript shows that during the course of the conversation Linda seeks to identify whether or not there is a need for some intervention to assist Sean. The conversation with Mr MacWilliam concludes with Linda stating that she would follow the matter up with the police. As agreed Linda phoned the Queanbeyan Police Station and spoke to Constable Marks.

114. The conversation between Linda and Constable Marks was available for review. Constable Marks's questioning of Linda during the conversation clearly seeks to identify whether or not there was a basis for concluding that Sean, or someone else, was at risk. At one point he specifically says *'If there is any – if there is concern that he is harming himself, well something like that or intending on harming someone else obviously we have got grounds to go around there.'* Linda was not able to provide such information.

115. I am satisfied that the evidence available shows that Linda acted in an appropriate manner when she followed up the matter with the police having been given the information provided to her by Paul MacWilliam. I am also satisfied that Constable Marks correctly concluded that on the information provided by Linda police did not have a basis to seek to apprehend Sean. Having regard to the time that this conversation occurred, it would seem that even if such a basis had been available it was likely to have been too late.

116. A further issue raised by those representing Sean's family was the appointment of Leading Senior Constable Rikki Gerbich as officer responsible for the investigation of Sean's death.

117. The issue was that LSC Gerbich was an officer within the same command as the other officers who had an involvement with Sean and his family on 24 March 2011. It was suggested that it would have been more appropriate for an officer from another command to have been allocated that role as being in the same command might have affected, consciously or unconsciously, his ability to undertake the role.

118. This criticism shows a misunderstanding of the role of an OIC in a coronial investigation. The OIC is undertaking their investigation on behalf of the coroner. The OIC is subject to direction by the coroner as to how the investigation is to be undertaken. In addition, in cases such as this one, the coroner has the assistance of the Crown Solicitor and counsel assisting appointed by the Crown Solicitor's Office. Should an OIC not be undertaking their function appropriately I, as Coroner, would have no hesitation to have him or her removed from the role because it is my responsibility to ensure that the requirements of the Coroners Act 2009 are fulfilled and that deaths are properly investigated.

119. Fortunately, in this case, there was no need for me to take such action. I am satisfied that LSC Gerbich undertook his duties diligently and in a professional manner and that all inquiries he was asked to undertake were attended to.

Section 82 Recommendations

120. Sean's death was a tragedy. After all tragedies it is important to look at the circumstances in which they occur and try and see if they could have been prevented. There is no doubt in this case that Sean's mental health care would have been better assisted by him having access to specialist adolescent mental health facilities. Had that been available his death might not have occurred.

121. Sean being granted leave for the CRC was, I have found, appropriate in the circumstances. The management plan developed to support him during that leave was appropriate in what it provided for however it is clear that once Sean indicated that he was not going to comply, there was inadequate planning as to how to respond.

122. Examples of those inadequacies included the fact that Sean's parents did not know that they were expected to maintain supervision of him, there was no precision as to the role of the CRC, who had the best understanding of his mental health issues, in supporting them if a crisis developed after hours, although the MHL was designated as an afterhours support for Sean's parents it was not given information as to his mental health issues and consequentially when Julie King phoned them had to open a file for Sean for the first time and finally the police were not provided with information as to Sean's circumstances which would no doubt have assisted them in responding to the requests for assistance on the evening of 24 March 2011.

123. The representative of Sean's family has sought to identify a range of inadequacies in the response of CRC staff and police officers to the issues that developed on the evening of 24 March 2011. They have proposed some 23 recommendations that they submit I should make in accordance with Section 82. These proposed recommendations fall into a number of categories which I will deal with in turn.

124. Proposed recommendations 13 to 23 are of a general kind dealing with the provision of mental health services and are directed to NSW Health. NSW Health was not a party in the proceedings and it is not my practice, nor I understand that of Coroners in general, to make Section 82 recommendations to parties or organisations that are not parties in the proceedings. I therefore do not propose to make the recommendations suggested.

125. Proposed recommendations 1-12 deal with matters associated with police procedures and training. The NSWPF has, for various reasons submitted that the proposed recommendations are either already part of police policy and procedure or unnecessary. I accept that this is the case and do not propose to make the recommendations suggested.

126. Proposed recommendation 10 deals with the manner in which incidents such as the death of Sean are investigated on behalf of the Coroner. I have already

discussed this issue above. For the reasons identified in that discussion I do not propose to make that recommendation.

127. In his submissions Counsel Assisting also proposed a number of recommendations that I might consider making in accordance with Section 82.

128. Four of those proposed recommendations were addressed to the Southern NSW Local Health District (the LHD) of which the CRC forms part.

129. The representatives of the LHD subsequently indicated that two of the proposed recommendations had been accepted a third substantially accepted and the final proposal was the subject of discussions between the LHD and the other government agencies involved.

130. The LHD has also provided a number of proposed amendments to its procedures that it is hoped will improve the response of the LHD to situations involving patients with mental health conditions. I am satisfied that the issues raised by Counsel Assisting have been responded to appropriately by the LHD and that it is not necessary for me to make the recommendations proposed. The LHD is to be commended for the efforts that it has made to improve the provision of care to patients in this regard.

131. The final recommendation proposed by Counsel Assisting was directed to the NSWPF. It was also substantially adopted by the representatives of Sean's family. The proposal related to the wording of the NSW Handbook. The response of the NSWPF was that the proposed recommendation was unnecessary. As I have already said I do not consider that it is necessary to make the recommendation proposed.

Conclusion

132. Sean's death was a tragedy. The evidence available shows that although his conduct from the time he decided he wanted to go to his friend's home for the night was challenging and that created concerns for his parents they did not believe that he was likely to harm himself. Being told that the police were not able to take him to his friend's home appears to have caused him distress. At about 10.10pm his father saw him walk from the front balcony into his home. His father then phoned the MHL seeking advice and that call was followed up by a call from Linda at the MHL to the police. Whilst this was occurring, and in the 25 minutes that elapsed between his father seeing him walk away and his mother finding him, Sean took the action that resulted in his death. He was a young person with complex mental health issues. His action appears to have been an

impulsive response to the disappointment of not being able to go to his friends for the evening.

Section 75

133. As mentioned where a finding is made that a death is self-inflicted a report of the proceedings is prohibited unless the Coroner makes an order permitting the publication of the report. A Coroner may make such an order if he or she is of the opinion that it is desirable in the public interest to permit such a report.

134. During the inquest no application was made by any party to prohibit the publication of the evidence led in the proceedings. In addition on 30 September 2013 the representative of Sean's family indicated that there would be no objection to my making an order permitting a report being published following the delivery of my findings.

135. Having regards to the issues raised by Sean's death I am of the opinion that it would be desirable in the public interest to permit a report being published and I therefore propose to do so.

Paul MacMahon
Deputy State Coroner
13 August 2014