Coroners Act 1996
[Section 26(1)]

Western *Australia*

RECORD OF INVESTIGATION INTO DEATH

Ref No: 44/15

I, Barry Paul King, Coroner, having investigated the death of ***Mark Warton Bennett-Robertson*** *with an inquest held at* ***Perth Coroners Court*** *on* ***17 November 2015 and 20 November 2015****, find that the identity of the deceased person was* ***Mark Warton Bennett-Robertson*** *and that death occurred on* ***24 April 2013*** *at* ***Kings Park in Perth*** *from* ***ligature compression of the neck (hanging)*** *in the following circumstances:*

Counsel Appearing:

Mr J T Bishop assisted the Coroner
Ms J C O'Meara (State Solicitor's Office) appeared for the North Metropolitan Health Service

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INTRODUCTION

1. On 24 April 2013, Mark Warton Bennett-Robertson (**the deceased**) was found hanging at the entrance to the Tree Top Walk in Kings Park in Perth. He had last been seen alive at about 2.30 am that morning.

2. As the deceased was an involuntary patient under the *Mental Health Act 1996* at the time of his death, he was a 'person held in care' under section 3 of the *Coroners Act 1996*.

3. Section 22(1)(a) of the *Coroners Act 1996* provides that a coroner who has jurisdiction to investigate a death must hold an inquest if the death appears to be a Western Australian death and the deceased was immediately before death a person held in care.

4. An inquest to inquire into the death of the deceased was therefore mandatory.

5. I held an inquest into the deceased's death on 17 and 20 November 2015 at the Perth Coroners Court. The evidence adduced at the inquest comprised documentary evidence and oral testimony. The documentary evidence included an investigation report and associated attachments prepared by Detective Sergeant (now Sergeant) Kylie Simmons of the Western Australia Police.[1]

6. Oral testimony was provided by:

   a) Ms Charlotte Bennett-Robinson, the deceased's sister;[2]

   b) Sergeant Simmons;[3]

[1] Exhibit 1
[2] ts 46-47
[3] ts 41-46

c) Dr Muhammad Sarfaraz, a medical officer at Graylands Hospital (**Graylands**) at the time of the deceased's death;[4]

d) Dr Ancy John, a consultant psychiatrist at Graylands;[5] and

e) Dr Prabha Krishnan, a medical officer at Graylands.[6]

7. Under section 25(3) of the *Coroners Act 1996*, where a death investigated by a coroner is of a person held in care, the coroner must comment on the quality of the supervision, treatment and care of the person while in that care.

8. I have found that the supervision, treatment and care of the deceased was reasonable and appropriate in the circumstances.

THE DECEASED

9. The following background information about the deceased comes primarily from a detailed report prepared on 19 March 2008 by psychologists at The Psychology Centre at the University of Canterbury in Christchurch, New Zealand.[7]

10. The deceased was born in Christchurch on 3 August 1987. He had a younger sister and two older half-siblings. His father was a university lecturer and journalist.

11. Before he began to go to school the deceased had a number of head injuries that required medical attention. The injuries were likely caused from his adventurous climbing, though the most serious injury occurred when

[4] ts 4-24,
[5] ts 24-40
[6] ts 52-69
[7] Exhibit 1, Tab 16

he fell while running at full speed and hit his head on a door jamb. He had also injured his head as he grew older: twice while bike-riding, three times from fights, five times from rugby and three times following school.

12. The deceased was hyperactive and impulsive as a child. He would talk excessively and, at times, in inappropriate circumstances.

13. Until he was about eight years old, the deceased was bullied at primary school and was often in fights. When he was 14 he associated with a group of friends who drank alcohol and smoked cannabis. For about 18 months he would drink alcohol at school and smoke cannabis three times a week.

14. During his final years at high school the deceased behaved well in class, but his homework and written work were below what he appeared to be capable of achieving. He had several jobs during and following high school.

15. In 2007, when he was 19 years old, the deceased started studying at university. In 2008 he referred himself to The Psychology Centre for assessment of attention-deficit/hyperactivity disorder (**ADHD**) and specific learning disability. He was concerned that he was under-achieving at university due to problems with attention and motivation to complete his classwork. He was also binge-drinking alcohol, smoking 10 to 20 cigarettes a day, smoking cannabis weekly and drinking energy drinks. At times he would also go through periods of binge-eating.

16. The deceased reported to psychologists that he was often aggressive, including towards his sister Charlotte.

17. The clinical psychologists who assessed the deceased noted that his difficulties with impulsivity and inattention had been long-standing. Following interviews and psychometric testing, they concluded that the deceased 'could be diagnosed with Attention-Deficit/Hyperactivity Disorder – Combined Type', as well as 'Reading Disorder

and Disorder of Written Expression'. They noted that he was binge-drinking frequently, which could lead to problems if not stopped.

18. The psychologists recommended that the deceased undergo tuition for his reading disabilities and receive stimulant medications such as methylphenidate for ADHD, together with brief and limited therapy from a psychologist to learn specific skills.

19. The psychologists also noted that the deceased had been experiencing mood swings that would require further assessment if they became worse.

THE DECEASED COMES TO PERTH

20. In 2011 the deceased came to Western Australia in order to start a new life as a driller in the mining industry in Kalgoorlie. He ended up settling in the Perth metropolitan region where he became a car salesman.

21. In May 2012 the deceased's mother died. He returned to New Zealand and spoke at her funeral, but from about that time he began to have problems with conflict at work.[8] He went to a doctor who referred him to a psychiatrist, Dr Raymond P K Wu.[9]

22. The deceased saw Dr Wu on 20 August 2012. He described to Dr Wu non-specific symptoms of poor mental and cognitive functioning at work and difficulty in engaging with people and in organising his day to day life. He provided Dr Wu with a copy of the psychologists' report of 2008.

23. Dr Wu arranged for a SPECT scan of the brain, a urinary drug screen and serum and copper levels. The SPECT scan did not seem to indicate a defect consistent with ADHD, and the drug screen and blood tests were mostly

[8] Exhibit 1, Tab 14
[9] Exhibit 1, Tab 14

negative. The SPECT scan suggested that the deceased may have had anxiety.[10]

24. The deceased saw Dr Wu again on 17 September 2012. He requested a prescription of stimulant medication such as dexamphetamine. Dr Wu cautioned him against stimulant medication, but following a negative urine test prescribed 20 mg of dexamphetamine sulphate daily.[11]

25. On 26 November 2012 Dr Wu reviewed the deceased following the use of the dexamphetamine. The deceased was visibly improved in his mental functioning. He told Dr Wu that he had changed jobs and was now a supervisor. He alluded to problems with work conflict but did not report any problems relating to aggression or violence. Dr Wu renewed the prescription with two repeats.[12] Dr Wu did not see the deceased again.

SIR CHARLES GAIRDNER HOSPITAL

26. On the evening of 13 March 2013 the deceased was taken by police officers to the emergency department at Sir Charles Gairdner Hospital after being contacted by the deceased's father and flatmate, who both had had concerns about the deceased's recent behaviour.[13]

27. The deceased told a psychiatric registrar that he had used all his dexamphetamine prescription by January 2013 and that he believed he was the son of God. He said that he could start a nuclear war in Korea. He said that he had left his job two weeks previously.

28. The deceased was agitated and psychotic with disordered thought forms and poor insight, but he denied suicidal thoughts. The registrar reached the impression that the deceased could have a dexamphetamine-induced psychosis and was at risk of harming others, so placed

[10] Exhibit 1, Tabs 14 and 15
[11] Exhibit 1, Tab 14
[12] Exhibit 1, Tab 14
[13] Exhibit 1, Tab 12

the deceased under the *Mental Health Act 1996* as an involuntary patient to be reviewed by a psychiatrist in the morning. He prescribed the anti-psychotic drug olanzapine.

29. On the morning of 14 March 2013 the deceased underwent a psychiatric review as planned. He was still exhibiting delusional beliefs. He maintained his denial of suicidal ideation on the premise of "singularity" because he was singular and many people would die if he died. The psychiatrist who reviewed him continued the olanzapine and noted that the deceased denied suicidal ideation, but because it was an issue within the deceased's delusional system, risk could shift dramatically should the delusional system change.[14]

30. On 15 March 2013 the deceased was reviewed again by a psychiatrist, who noted that the deceased was unable to be safely managed on an open ward, so was to remain an involuntary patient. That evening, a place was made available for him at Graylands and he was transferred there.

GRAYLANDS

31. The following details come from the Graylands file for the deceased.[15]

32. When the deceased arrived at Graylands at about 7.40 pm on 15 March 2013, he told the assessing clinician, duty medical officer Dr Suparare, that he was the son of God and was able to save the world, that the end of the world was coming on 26 December 2013 when a nuclear meteor was approaching and that he was chosen to prevent it. He said that he had lost his job because he shared his beliefs with his bosses and they all agreed that he should be released of his duties to fulfil his

[14] Exhibit 1, Tab 16
[15] Exhibit 1, Tab 16

mission on earth. He denied thoughts of harm to himself or others.

33. Dr Suparare made a diagnosis of schizophreniform psychosis with a differential diagnosis of paranoid schizophrenia. She admitted him into a locked ward as an involuntary patient and directed that he be observed every 30 minutes for unpredictable behaviour.

34. On 16 March 2013 the deceased was reviewed by the duty psychiatrist, Dr Victoria Pascu, who found that he was thought disordered and had affective psychosis with grandiose persecutory delusions. He spoke of different Earths and various dimensions. He repeated much of what he had expressed to Dr Suparare and said that everyone in the world knew about him. He had no insight into his condition.

35. Dr Pascu diagnosed the deceased with mania-like presentation – affective psychosis, with a differential diagnosis of dexamphetamine-induced psychosis or bipolar affective disorder. She confirmed his involuntary status and continued with the olanzapine as needed.

36. Over the next couple of days the deceased was polite, pleasant and co-operative on the ward, though he remained delusional.

37. On 18 March 2013 his sister Charlotte called Graylands. She told the social worker that she had spoken to the deceased that morning and that the plan was for the deceased to fly back to New Zealand upon discharge from Graylands. She said that she could help to arrange that, and could provide details of a mental health clinic in New Zealand near her home where the deceased's care could continue.

38. Dr John reviewed the deceased on 18 March 2013 and noted that he remained psychotic. He told her that he had used two to six dexamphetamine tablets daily instead of the prescribed one tablet. On that basis, Dr John

considered that the primary diagnosis was dexamphetamine-induced psychosis.

39. When Dr John reviewed the deceased on 19 March 2013 he appeared more settled. There was no evidence of depression or self-harm, but his psychotic delusions continued. On 21 March 2013 he was started on quetiapine and the mood stabiliser sodium valproate. The sodium valproate was tapered off after three weeks due to changes to his liver function tests and because the mood symptoms had resolved.[16]

40. By 30 March 2013, not only had the deceased's mood symptoms resolved, he had also been compliant with his medications and he was no longer expressing delusional ideas to staff. He was allowed to leave Graylands on 30 March 2013 and 1 April 2013 for escorted leave in the company of his aunt and uncle who lived in Perth.

41. On 5 April 2013 the treating team at Graylands met with the deceased's aunt and uncle and a friend of the deceased with whom he had lived prior to his admission to Graylands. His uncle mentioned that the deceased had delusional beliefs that his medications were going to kill him.[17] The deceased's aunt and uncle said that they were keen to help the deceased to obtain a replacement for his expired passport.

42. On the afternoon of 5 April 2013 the deceased went on unescorted ground access for half an hour without any problems despite maintaining the delusion about the world coming to an end. However, the next morning he went on unescorted ground access at about 9.00 am and failed to return.

43. The nursing staff discussed the deceased's failure to return with the duty medical officer, Dr Prabha Krishnan, who instructed that the deceased be declared absent without leave (**AWOL**) at 3.00 pm that day if he had not

[16] Exhibit 1, Tab 13
[17] Exhibit 1, Tab 16

returned by then. At about 3.40 pm police were notified that the deceased was a missing person.

44. The next day at about 3.30 pm police officers returned the deceased to Graylands. The deceased told medical staff that he had left Graylands because he felt that nothing was wrong with him and he did not want to take medication. He had gone to Scarborough beach and had found a piece of rope which he had used to compress his neck in order to asphyxiate himself and cause soul nurturing and grey matter neurogenesis. He strongly denied any thoughts of self-harm.

45. After walking on the beach for several hours, the deceased returned to his unit on the afternoon of 7 April 2013. His friend notified the police, who picked the deceased up and returned him to Graylands.

46. The deceased was returned to the locked ward and placed on 60 minute observations. His dosage of quetiapine was increased and he was continued on olanzapine. He kept a low profile and displayed no psychotic symptoms. On 9 April 2013 he denied any psychotic symptoms and said that his belief that he was the son of God was a delusion.

47. On 11 April 2013 Dr John reviewed the deceased to determine whether his involuntary status should continue. She found him pleasant and polite but guarded. His insight remained poor and did not believe that he needed medications or to be in Graylands. However, he was compliant with medications.

48. Dr John determined that his involuntary status would continue to ensure that he received medication in a safe environment. She noted a plan to discharge him from a secure ward if his aunt was to accompany him to New Zealand. She also directed that the deceased could have escorted leave in order to obtain a photograph for renewal of his passport.

49. On 13 April 2013 the deceased was allowed escorted day leave with his aunt as foreshadowed. He returned after lunch without any issues having arisen. He kept a low profile upon returning and told nursing staff that he felt that he was getting better and that returning to New Zealand would be the best thing for him at that stage.

50. Over the next two days the deceased isolated himself from staff and other patients. He was guarded: superficially polite, but reluctant to engage in meaningful conversation.

51. When seen by Dr John and Dr Sarfaraz on 16 April 2013 the deceased asked to be moved to an open ward. He appeared co-operative and promised to be compliant with his medication.

52. Dr Sarfaraz spoke to the deceased's aunt about the deceased's coming discharge. She indicated that the deceased's new passport would take at least 10 days and that she had no room to accommodate him in her house if he were to be discharged before he went to New Zealand.

53. The deceased, his aunt and uncle and the treating team understood that, after arriving in New Zealand, the deceased would go to live with his father and sister in Christchurch.[18]

54. On 17 April 2013 the deceased was engaging more with staff, and was laughing and having a joke, but he was still guarded.

55. On Thursday 18 April 2013 the deceased was seen by Dr John. He wanted to discuss the discharge options. He said that he had no problems with sleep or appetite, but he was still guarded about his psychiatric symptoms. Dr John arranged for a meeting with the deceased and his aunt on Monday 22 April 2013. She told the deceased that all discharge options could be discussed then.

[18] Exhibit 1, Tab 11

56. On 18 April 2013 the deceased went out twice on escorted ground access without any problems. In the afternoon he told nursing staff that he was no longer having delusions and admitted that he was unwell when he was first admitted to Graylands. He said that he needed to come to Graylands to get better.

57. On Friday 19 April 2013 Dr Sarfaraz transferred the deceased to an open ward after assessing him as a low risk to himself and others.[19] One reason for his decision to do so was to gauge his compliance with his treatment plan once discharged.[20] A transfer checklist summary sticker attached to the integrated progress notes directed that the deceased be observed every 30 minutes for absconding for one day.

58. Also on 19 April 2013, the deceased's aunt called the Graylands social worker to arrange to take the deceased out for a few hours on Saturday and Sunday. She told the social worker that she thought the deceased would be better off in an open ward because he was becoming irritable in a closed ward. She would have liked the deceased to stay with her until his passport was ready, but she did not have room, so she thought that transferring him to an open ward was a good alternative.

59. While on the open ward on 19 April 2013 the deceased appeared appropriate when staff engaged him. He walked around the grounds, reported every 30 minutes and was compliant with his medication.

60. At about 8.45 am the next day, the deceased left Graylands with his aunt and returned at midday. He appeared settled and spent time walking around the hospital grounds.

61. However, while the deceased was with his aunt on 20 April 2013, she disclosed to him that his father had

[19] ts 9-10 per Sarfaraz, M
[20] Exhibit 1, Tab 11

sent an email in which he explained that he may not be ready to have the deceased live with him as he may not be able to cope. She went on to tell the deceased that her husband, the deceased's uncle, had a house in Palmerston North on the North Island of New Zealand and that he was happy for the deceased to live with him. The deceased purported to be happy about the change of plans, but his aunt could see that he was affected by it.[21]

62. The deceased's last observation for risk of absconding was made at 3.00 pm that afternoon.[22]

63. In the evening of 20 April 2013 the deceased told a nurse that he had relapsed because he had stopped taking his prescribed medications. He said that he intended to go back to New Zealand upon discharge. The nurse noted that the deceased was appropriate when engaged.[23]

THE DECEASED GOES MISSING

64. On Sunday 21 April 2013 the deceased was not sighted on his ward after about 10.00 am. The Graylands grounds were searched and nursing staff contacted his aunt, but he was not located. At 2.30 pm nursing staff contacted the duty medical officer, Dr Krishnan, who directed that the deceased be declared absent without leave and that the police be contacted if the deceased did not return by 6.00 pm that evening.[24]

65. A nurse had also contacted the deceased's sister Charlotte to inform her that the deceased had gone missing. The nurse told her of the plan to wait until the evening meal time to see if he returns before declaring him AWOL. Charlotte said that the deceased was not the type of person to return for a meal and that searching should commence immediately.[25]

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[21] Exhibit 1, Tab 11
[22] Exhibit 1, Tab 16
[23] Exhibit 1, Tab 16
[24] Exhibit 1, Tab 16
[25] ts 21-22 per Sarfaraz, M

66. The deceased's father heard about the deceased's disappearance from Charlotte. He called Graylands at about 4.15 pm and told a nurse that the deceased was likely to go to a wilderness area or the beach rather than to the city or a built-up area.[26]

67. The deceased was declared absent without leave that evening at 7.20 pm. Police searched for him without success at his home and at beaches from Trigg to Fremantle, including Cottesloe, Swanbourne and Floreat, over the next two days. They tried calling his phone in order to determine its location, but he had left it at Graylands.

68. On Monday 22 April 2013 the deceased's aunt attended Graylands to meet with Dr John and Dr Sarfaraz as planned. The deceased's aunt informed the doctors about the day leave on Saturday 20 April 2013 and about the change of plans for the deceased to go to Palmerston North to stay with his uncle.

69. The doctors and the deceased's aunt called the deceased's father, who said that he had received an email from the deceased on Saturday indicating that the deceased was upset about him not taking the deceased back. He said that it was a misunderstanding and that he was absolutely ready to take the deceased back and to support him. He said that he had emailed the deceased back to give him assurances to that effect.[27]

70. Unfortunately, it seems that the deceased never received his father's return email.[28]

71. At about 7.00 pm on 23 April 2013 Graylands received a call from the Inner City Mental Health Service to say that the deceased had turned up at a Highgate church. Police were notified, but by the time they attended, the deceased

[26] Exhibit 1, Tab 16
[27] Exhibit 1, Tab 16
[28] Exhibit 1, Tab 13

was no longer there. Police officers searched the area but did not find him.[29]

72. I infer that the deceased had gone to one of the churches in Highgate and had appeared to someone connected to the church to be delusional. That person then obtained the deceased's name and contacted the Inner City Mental Health Service to report that the deceased was at the church. The Inner City Mental Health Service would have access to a data bank of current mental health patients, so would have been able to determine that the deceased had absconded from Graylands.

73. At about 2.30 am on 24 April 2013 the deceased was seen by security guards who were guarding the war memorial at Kings Park for Anzac Day. He walked past them and continued towards the water gardens.[30]

THE DECEASED IS FOUND DEAD

74. At about 6.45 am on 24 April 2013 a horticulturist at Kings Park was doing rubbish collection at the Forrest carpark. A jogger waved him down and told him that someone had apparently killed themselves at the Tree Top Walk.[31]

75. The horticulturist went to the Tree Top Walk entry and found the deceased hanging by the neck with twine attached to a railing behind a bench seat. The deceased was obviously dead.[32]

76. Police officers and ambulance paramedics attended. A paramedic certified that the deceased had died. Police officers found a key in the deceased's pocket that appeared to be from Graylands. The police officers contacted Graylands and searched the police databank to

[29] Exhibit 1, Tab 16
[30] Exhibit 1, Tab 9
[31] Exhibit 1, Tab 10
[32] Exhibit 1, Tab 10

obtain a driver's licence photo confirming the likely identity of the deceased.[33]

77. A registered nurse at Graylands formally identified the deceased later that day.[34]

CAUSE OF DEATH

78. At the request of the deceased's father, a full post mortem examination was not conducted.

79. On 30 April 2013 forensic pathologist Dr J McCreath conducted an external post mortem examination of the deceased's body and found a ligature and a ligature mark around the neck.[35]

80. A toxicological analysis of the deceased's blood detected a therapeutic level of olanzapine and the presence of quetiapine metabolite.[36]

81. Dr McCreath formed the opinion that the cause of death was consistent with ligature compression of the neck (hanging).[37]

82. I find that the cause of death was ligature compression of the neck (hanging).

HOW DEATH OCCURRED

83. Hanging in the circumstances in which the deceased was found indicates that the deceased caused his own death with an intention to do so. There is no basis to find that he would have done so had he not been in a delusional state caused by his mental illness. That notion is consistent with the fact that the toxicological analysis

[33] Exhibit 1, Tab 7
[34] Exhibit 1, Tab 2
[35] Exhibit 1, Tab 4
[36] Exhibit 1, Tab 5
[37] Exhibit 1, Tab 4

indicates that the anti-psychotic drug quetiapine was not present in the deceased's blood and the likelihood that his psychosis re-surfaced as the drug decreased from the time of his last dosage on 20 April 2013.

84. In the circumstances, I am satisfied that, while the deceased's mind was disturbed, he formed an intention to end his life and hanged himself with a ligature and compressed his neck, which caused his death.

85. I find that death occurred by way of suicide.

COMMENTS ON THE TREATMENT, SUPERVISION AND CARE OF THE DECEASED

86. It is clear on the evidence that the deceased experienced a debilitating mental illness characterised by psychotic delusions, and that his mental illness led to his death.

87. In my view, there are two main issues that arose in the inquest that deserve comment:

a) the decision to transfer the deceased to an open ward on 20 April 2013; and

b) the apparent delay on 21 April 2013 in declaring the deceased absent without leave and notifying police that he was missing.

Transfer to an open ward

88. The decision to transfer the deceased to an open ward was made by Dr Sarfaraz. He said that he made that decision because the deceased had been allowed escorted leave with his family who reported improvement, he was considered to be no risk to himself or others, his aunt had said that he had become, understandably, irritable in the locked ward, the open

ward would be therapeutic for him and there would always be nursing staff there to look after him.[38]

89. In some regards, the evidence suggests that the decision was surprising. In particular, the deceased's psychiatrist Dr John stated that a decision to transfer a patient from a closed ward to an open ward is usually a major decision in relation to which she would expect, in general, discussion with the consultant psychiatrist.[39] No such discussion took place.

90. In addition, Dr John had indicated in the integrated progress notes (**the notes**) that the plan was to discharge the deceased from a secure ward if the deceased's aunt was accompanying him to New Zealand.[40] Dr John said that she made that entry in the notes because she wanted the deceased to have that kind of support due to his age and because this was his first episode. She said that she did not think of transferring him to an open ward.[41]

91. Notwithstanding the fact that Dr Sarfaraz had not discussed with Dr John the decision to transfer the deceased to an open ward, in looking at the notes and how the deceased presented, Dr John could not say that the decision to transfer him was not rational. However, because of what ultimately happened, it was difficult for her to say whether it was a reasonable decision.[42]

92. She said that medical officers are entitled to make such decisions and that, in the circumstances of the deceased's presentation, she could understand why Dr Sarfaraz made the decision he did.[43]

93. Dr John also noted that Dr Sarfaraz was spending a lot of time with the deceased and perhaps had a very good

[38] ts 9 per Sarfaraz, M
[39] ts 35 per John, A
[40] Exhibit 1, Tab 16
[41] ts 28 per John, A
[42] ts 32 per John, A
[43] ts 35 per John, A

therapeutic relationship with him. She thought that Dr Sarfaraz really trusted him and thought that he was going to stay in the ward.[44]

94. Dr John said that there was nothing in the notes to indicate that the deceased would abscond and end his life.[45]

95. It is also important that the apparent trigger for the deceased to abscond was his understanding that he would not be returning to his father's house to live. This information was not available to Dr Sarfaraz.[46]

96. In relation to Dr Sarfaraz' trust of the deceased, the deceased's sister Charlotte Bennett-Robertson told the inquest that she believed that the deceased had misled Graylands staff. She said that the deceased was extremely intelligent and could be charming and deceptive. She said that in her telephone conversations with him, he was still delusional, whereas the notes seem to indicate that he was improving. She believed that he was misleading the staff in order to get to New Zealand where he could have more freedom.[47]

97. Ms Bennett-Robertson's concerns were put to Dr Sarfaraz and Dr John. Dr Sarfaraz said that there was a time when the deceased was superficially engaging: courteous but hiding his anxiety and agitated. Dr Sarfaraz said that he did not think that the deceased would have been able to deceive him. He said that the deceased would have had partial insight but poor judgment and that transfer to an open ward was part of his treatment.[48]

98. Dr John said that she was aware that at times the deceased was not being open and honest about his mental problems. She was looking for that possibility

[44] ts 29 per John, A
[45] ts 38 per John, A
[46] ts 11 per Sarfaraz, M
[47] ts 46 per Bennett-Robertson, C
[48] ts 13-14 per Sarfaraz, M

and accordingly wrote 'Guarded about psychiatric symptoms' in the notes for 18 April 2013.[49]

99. Several nurses had also made entries in the notes about the deceased's superficiality and guarded presentation. The last such entry was made by an enrolled nurse on 17 April 2013. Over the same period, the notes indicate that the deceased was not displaying psychotic symptoms.

100. In my view, the evidence indicates that Dr Sarfaraz' decision was reasonable when viewed in foresight. While it is possible that the deceased was presenting as more lucid than he actually was, there was no indication that he did not, in fact, wish to return to New Zealand or that he was at risk of self-harm. There is no reason, even in the deceased's delusional system, why he would abscond in order to go to New Zealand.

101. The deceased was considered to be little or no risk to himself, he was clearly improving with apparent insight into his condition, he reported having no further delusions, he was compliant with his medication, he was going on escorted leave for relatively long periods without problems, he was engaging with others, and his aunt, who saw him regularly, supported the transfer to an open ward.

102. As Dr John said, those were the circumstances of the transfer, and she could understand why Dr Sarfaraz took that decision.[50]

Delay in notifying police

103. The decision to wait until after 6.00 pm before declaring the deceased absent without leave and notify police that he was missing was made by the duty medical officer, Dr Krishnan.

[49] Exhibit 1, Tab 16
[50] ts 35 per John, A

104. Dr Sarfaraz was critical of the delay. His view was that there may have been a different outcome if the police had been notified earlier given that the deceased had been seen in Highgate. He also said that the policy at Graylands was for duty medical officers to notify police as soon as a patient absconded if that was directed by the form transferring a patient to an open ward.[51]

105. When it was pointed out to Dr Sarfaraz that the sighting of the deceased at a Highgate church did not occur until two days after the deceased's absconded, he accepted his error, but maintained that police should have been notified earlier in accordance with the protocol.[52]

106. Dr Krishnan said that he could not recall the event but that he was aware of the usual situation where a patient apparently absconds. He said that it is a common occurrence; it happens almost every day or every other day.[53] There is a standard procedure, though each case is assessed on its merits.[54]

107. In assessing what to do in the case of a missing patient, Dr Krishnan said that the main issue is the risk to the patient. He would look at the events that led to the absconding, the patient's history and whether there was any documented risk. If the patients had indicated that he or she wanted to harm another person or himself or herself, police would be contacted.[55]

108. If there is no risk or immediate management plan as far as the treating team is concerned, patients would normally be given some time to return before being declared AWOL because a lot of patients at Graylands go out of the grounds on weekends and are delayed in returning.[56]

[51] ts 16 per Sarfaraz, M
[52] ts 19-21 per Sarfaraz, M
[53] ts 58 per Krishnan, P
[54] ts 54 per Krishnan, P
[55] ts 54 per Krishnan, P
[56] ts 55 per Krishnan, P

109. On the basis of the notes, Dr Krishnan understood that he had spoken to ward staff, who looked at risk assessments and communicated to him that they were not too concerned about the deceased. The deceased had never mentioned self-harm and had been compliant in the open ward where patients with high risks are not usually placed.[57]

110. When asked about any practical difficulties that might occur if police were notified about every patient who went missing, Dr Krishnan said that, if police were notified about every patient who was not sighted on an hourly check, police would be notified five to 10 times a day. For that reason, he said, it was not practical.[58]

111. Contrary to Dr Sarfaraz' evidence, at the time of the deceased's disappearance, the policy in place at Graylands governing the procedures that applied in the event of a patient absconding did not require that police be notified immediately.[59]

112. Rather, the policy then in place required the ward coordinator to be informed and the ward area and the grounds to be searched. The ward co-ordinator would then inform the patient's doctor or the duty doctor, who would consult with nursing staff to undertake a risk assessment and advise nursing staff how to proceed. Nursing staff would then document the time the patient was last seen, the doctor's decision, the actions taken and the persons notified. Prior to declaring the patient AWOL, a Brief Risk Assessment (**BRA**) was to be completed by medical staff or nursing staff.

113. Apart from the completion of a BRA, the notes indicate that the requirements of the policy in place at the time were followed.[60]

[57] ts 55-56 per Krishnan, P
[58] ts 54 per Krishnan, P
[59] Exhibit 2
[60] ts 61-66 per Krishnan, P

114. Following the deceased's death, the policy at Graylands applying to absconding patients was modified to require the immediate notification of police where there is documented evidence that the patient is at risk.[61]

115. Though the deceased was assessed to be at low risk of self-harm or harm to or from others, he was considered a moderate risk of absconding and psycho-social issues at the time of his disappearance.[62]

116. As I understand it, the current policy would require that police be notified if a patient in the same situation absconded. This is so because a patient who absconds is at risk of his or her mental state changing as a result of the lack of medication. It seems to me that the deceased's act of suicide was consistent with that scenario.

117. In the circumstances, it appears to me that the decision to delay notifying police of the deceased's disappearance was reasonable on the basis of the information available at the time. The delay was a matter of hours rather than days, so it is not possible to conclude that it had a bearing on the deceased's death.

118. Because of the amendment to the relevant policy at Graylands, there is no need for any comment or recommendation in relation to the pre-existing policy.

CONCLUSION

119. The deceased died at his own hands, but in my view it was his mental illness that caused his death. The tragedy to him and his family is a terrible reminder of how destructive severe mental illness can be.

120. While in hindsight it appears that the deceased's death could have been averted had he been kept in a closed

[61] Exhibit 3
[62] Exhibit 1, Tab 16

ward, in foresight the transfer to the open ward and the cessation of observations was reasonable. That conclusion is supported by the principle of providing mental health patients with 'the best care and treatment with the least restriction of their freedom and the least interference with their rights and dignity' as was enshrined as an object of the *Mental Health Act 1996*.[63]

121. I have no doubt that the medical and nursing staff at Graylands acted in what they considered in their professional judgment to be in the best interests of the deceased.

122. I am satisfied that the standard of supervision, treatment and care of the deceased while he was an involuntary patient was reasonable and appropriate in all of the circumstances.

B P King
Coroner
2 March 2016

[63] s5(a) *Mental Health Act 1996*