IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2016 2137

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)
*Section 67 of the **Coroners Act 2008***

Inquest into the Death of:	Harley Robert Larking
Delivered On:	18 September 2020
Delivered At:	65 Kavanagh Street Southbank, Victoria, 3006
Hearing Dates:	25, 26, 27, 28, 29 March 2019 21 May 2019, 12 and 19 August 2019
Findings of:	Caitlin English, Deputy State Coroner
Counsel Assisting the Coroner:	Mr R Ajzensztat of Counsel
Representation:	Ms D Foy of Counsel Instructed by Ms J Moffatt of DTCH Lawyers For North Western Mental Health, Melbourne Health

Ms N Hodgson of Counsel

Instructed by Mr J Snowdon of General Counsel and Minter Ellison

For Northern Health

Ms T Lee of Counsel

Ms K Grinberg of Counsel

Instructed by the Victorian Aboriginal Legal Service

For Mr Larking's family

Ms E Gardiner of Counsel

Instructed by the Victorian Government Solicitor's Office

For Victoria Police

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BACKGROUND & CHRONOLOGY

1. I acknowledge the traditional owners of the land on which the Coroners court is situated, the Wurundjeri people of the Kulin nation and I pay my respects to their elders, past, present and emerging.

2. Harley Robert Larking was a Palawa and Nunga man. He was very close to his family. His mother, Annemarie Skratek, lived in Glenroy with his step-father, Terry Measures, and visited him daily when he was a patient at the Northern Hospital. He had an older brother, Andrew, and younger brother, Dylan, and was close to both his brothers and their families.

3. He was 23 years old at the time of his death on 13 May 2016. His mother had spent time with him on the evening of 12 May 2016 and said he '*seemed pretty good and seemed fairly happy.*'[1]

4. In 2011, Mr Larking started an apprenticeship as a chef at Charcoal Lane when he began to experience symptoms of psychiatric ill health.

5. Over time his symptoms worsened, and he began to experience auditory hallucinations and was diagnosed with substance induced psychosis and subsequently schizophrenia and then treatment resistant schizo-affective disorder.

6. In May 2012, he came under the care of North Western Mental Health Service (**NWMHS**). He was admitted to the psychiatric unit at the Northern Hospital and had numerous admissions in the inpatient psychiatric unit (**IPU**).

7. On 8 April 2016, Harley was admitted to the IPU at the Northern Hospital as a compulsory patient.

8. He was started on clozapine, which is within contemporary practice and guidelines for treatment resistant schizophrenia.

9. Mr Larking was on a graduated plan to transition from the Intensive Care Area (**ICA**) to the Low Dependency Unit (**LDU**). As part of that transition, he had supervised and unsupervised trial visits to LDU during May 2016.

10. On 13 May 2016, during a trial in the LDU, at approximately 12.10pm Mr Larking left the LDU by jumping the fence. Nursing staff telephoned Epping Police Station to advise that

[1] Coronial Brief (**CB**), 24.

Mr Larking was absent without leave and attempted to send a fax with a description of Mr Larking.

11. Between 2.30 and 2.45pm two rail inspectors at the Epping rail yards, 10 minutes by foot from Northern Hospital, noticed smoke coming from adjacent grassland. Metropolitan Fire Brigade attended at about 3.21pm and extinguished the fire.

12. Police attended the scene and confirmed the death of a young man who was later identified as Mr Larking. A black cigarette lighter and a small plastic milk bottle containing petrol residue were located at the scene.

CORONIAL INVESTIGATION

13. Mr Larking's death was reported to the coroner as it was the result of accident or injury and fell within the definition of a reportable death in section 4 of the *Coroners Act 2008* (Vic).

14. Mr Larking's death was also reported to the coroner as he was a compulsory patient pursuant to the *Mental Health Act 2014* (Vic) at NWMHS and thus he was a person '*in care*' at the time of his death, which made his death reportable.

15. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

16. A coronial brief was prepared which included statements from family members, medical staff as well as from the forensic pathologist and the neuropathologist who examined Mr Larking after his death.

17. As part of the coronial investigation, I sought advice from the Coroners Prevention Unit (**CPU**)[2] regarding the appropriateness of Mr Larking's mental health care and treatment. Following this advice, an expert report was obtained from Dr Stephen McConnell, consultant psychiatrist.

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[2] The Coroners Prevention Unit (**CPU**) was established in 2008 to strengthen the prevention role of the coroner. The unit assists the Coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations. The CPU also reviews medical care and treatment in cases referred by the coroner. The CPU is comprised of health professionals with training in a range of areas including medicine, nursing, public health and mental health.

Mandatory Inquest

18. As Mr Larking was a compulsory patient and 'in care' at the time of his death, an inquest is mandated by section 57(2) of the *Coroners Act 2008*.

19. The mandatory nature of the inquest recognises the special duty owed to those who die when in the care of the State, and the importance of an independent coronial investigation into the circumstances in which the death occurred.

20. For that reason, the scope considered at the inquest focussed on the role of the various institutions, such as the NWMHS, which was responsible for Mr Larking as an inpatient, and the procedures followed by hospital staff and police subsequent to his report as missing.

21. An inquest was held in March, May and August 2019. The inquest heard from 15 witnesses and, including submissions, ran for eight days.

22. Mr Larking's identity was not in dispute. The inquest considered the cause of his death and whether or not his death was intentional. The inquest also focussed on the circumstances of his death, namely his care in hospital immediately prior to his death, how he absconded and the procedures following his absconding.

23. The inquest scope was as follows:

    (a) The circumstances of Mr Larking's death on 13 May 2016, including how and when he absconded from the Northern Hospital, his activities after absconding and prior to death, and the manner in which he died;

    (b) The appropriateness of the clinical care provided to Mr Larking at NWMHS, including the decision for him to be trialled in the low dependency unit in May 2016, and the manner and adequacy of the monitoring to which he was subject prior to his absconding;

    (c) The extent to which the provision of health services to Mr Larking was culturally competent during the period of his admission prior to his death;

    (d) The manner and appropriateness of the response by NWMHS staff to Mr Larking absconding on 13 May 2016; and

    (e) The manner and appropriateness of the immediate response by Victoria Police to any reports of Mr Larking having absconded from the Northern Hospital on 13 May 2016.

24. The cause of death and manner in which Mr Larking died included a consideration of his intent at the time and whether his death was intentional.

25. Save for Mr Larking's cause of death, my consideration of the evidence and the matters in scope in this finding have been re-ordered to fit a linear narrative.

26. This finding does not purport to recite all of the evidence heard at Inquest, only that which is relevant to the statutory requirements, namely the identity, cause of death and circumstances as set out in section 67 of the *Coroners Act 2008*. The circumstances considered focus on the issues forming the scope of the inquiry at inquest.

27. The coroner also has a preventative role. The coroner is able to make recommendations and comments with a view to reducing the number of preventable deaths.

28. In the coronial jurisdiction facts must be established to the standard of proof which is the balance of probabilities.[3]

IDENTITY – SECTION 67(1)(a)

29. On 16 May 2016, Harley Robert Larking, born on 1 March 1993, was identified using fingerprint identification.

30. Identity is not in dispute and requires no further investigation.

CAUSE OF DEATH – SECTION 67(1)(b)

31. This section considers the evidence and advice of the forensic pathologist and his formulation of the cause of death. It also considers the investigation that took place at the scene of Mr Larking's death by specialist fire investigators, and the attempts by the coroner's investigator to trace Mr Larking's movements between leaving Northern Hospital and his death in grassland adjacent to the substation, including how he obtained petrol. The evidence was considered to determine whether Mr Larking's death was intentional.

Formulation of the cause of death

32. On 18 May 2016, Dr Malcolm Dodd, a Senior Forensic Pathologist practising at the Victorian Institute of Forensic Medicine, conducted an examination and provided a written report dated 22 September 2016. [4] In that report, Dr Dodd formulated that a reasonable cause of death was *'1(a) Effects of fire'*.

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[3] This is subject to the principles enunciated in *Briginshaw v Briginshaw* (1938) 60 CLR 336. The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

[4] Exhibit 1.

33. At the inquest, he gave evidence about his formulation of the cause of death and his observations at autopsy.

34. Dr Dodd identified soot particles in the laryngeal lumen, the voice box, but not in the trachea and bronchi, which he explained was a reflection of the fire being in the open air, making inhalation of soot less likely.[5] Dr Dodd could not distinguish whether the reddened trachea and bronchii was caused by irritation from breathing petrol vapours or from the inhalation of hot gas following ignition.

35. Within the stomach there was a strong smell of petrol,[6] which Dr Dodd described as '*surprising*.' He explained that whilst vapours can be inhaled and be smelt on the lungs, they appear '*very rarely in the stomach. So I was surprised that the contents of the stomach actually did smell – smell strongly of petrol*'. He explained it could mean one of two possibilities, either a certain amount of petrol was orally consumed, or it was from the inhalation of vapours.[7] Similarly, the detectable hydrocarbons in Mr Larking's blood could be from inhaling or ingesting petrol or from the inhalation of hot gas.[8]

36. Dr Dodd was not able to identify the primary site at which the accelerant was applied to the body, although he noted there was minimal facial injury.[9] Nor was he able to say the position Mr Larking was in when the fire started.[10] Dr Dodd indicated the burn distribution did not assist to determine whether Mr Larking had deliberately doused himself or spilt petrol.[11]

37. Dr Dodd was surprised by the absence of clothing, noting:

> *In a relatively small fire like this, in a[n] open environment, I would have expected if he was fully clothed, you would have quite a few remnants of clothing to be present. But all I could see in this case was maybe the remnants of a pair of underpants only.*[12]

38. Dr Dodd agreed it was possible Mr Larking may have ingested or inhaled some petrol and then lit a cigarette which then caught fire but stated, '*I have no way of proving that or anything else.*'[13] He went on to say that if there is volatile gases and a naked source of flame, '*you're*

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[5] Transcript (**T**), 57.
[6] T 58.
[7] T 59.
[8] T 86.
[9] T 63.
[10] T 69, Dr Dodd indicated he could only intuit an answer.
[11] T 88.
[12] T 71-2.
[13] T 90.

going to have a fire, or an ignition and the possibly underpinning causes of that are multiple.'[14]

39. In respect of the possibility of Mr Larking 'fire breathing', Dr Dodd noted there was not a great deal of thermal injuries around the facial region, '*no frank charring or burning to the lips*',[15] so if he had been doing that, the fire was not all over his face. Dr Dodd agreed that the gastric content could be consistent with inadvertent swallowing of petrol if Mr Larking had been attempting a circus trick like the fire breathing, which he had recently seen on television with his mother.[16]

40. Dr Dodd was of the view his findings were equally consistent with death being by suicide or misadventure, and there was nothing in the pattern of injuries that made it more likely for one over the other. Dr Dodd formed the view there were no apparent suspicious circumstances as there were no injuries to the body other than burning.[17]

41. I accept Dr Dodd's formulation of '*Effects of fire*' as the cause of death

Investigation of the scene

42. Rachel Noble, scientist with Victorian Police Forensic Services Centre, gave evidence at inquest. Her role is to investigate the cause and origin of fires and explosions. She conducted an investigation jointly with the Metropolitan Fire Brigade as is standard procedure when there is a death arising from a fire.

43. Ms Noble confirmed there was nothing from the evidence at the scene to suggest the involvement of a third party,[18] and it was her view there was nothing obvious from the scene to suggest someone was trying to ignite a campfire.[19]

44. Ms Noble described '*moderately evaporated petrol was detected in the bottle*' and explained this meant the petrol has had some form of evaporation and the hydrocarbons detected were consistent with this,[20] however there was no liquid in the bottle, '*The bottle was essentially empty.*'[21]

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[14] T 91.
[15] T 92.
[16] T 78.
[17] T 68.
[18] T101.
[19] T 103.
[20] T 111.
[21] T 113.

45. Although in her statement Ms Noble stated, '*I have concluded the fire started by the ignition of available materials which may have been poured on or over the deceased*', she conceded she was unable to say exactly how the petrol was applied.[22]

46. Elisabeth Andrew, firefighter and fire investigator at the Fire Investigation and Analysis Department, Burnley Complex, gave evidence. Ms Andrew investigates fires to determine their cause and origin and her Department assists the Victoria Police Forensic Unit.

47. In her report she stated, '*I conclude that the most probable cause of the fire to be self immolation, using the cigarette lighter and bottle of hydro-carbons located near the deceased.*' In her evidence she clarified she meant self-immolation could be either intentional or accidental.[23]

48. By classifying the fire as '*suspicious*' she meant it was deliberately lit, meaning a person may have used accelerants, as distinct from an accidental or electrical fire, but clarified it was not her role to determine the motive or intention behind why the fire had been lit.[24]

Investigation of Mr Larking's activities after absconding and prior to death

49. The coroner's investigator, Detective Senior Constable (**DSC**) Peter Anderson, gave evidence the most direct route from the Northern Hospital to where Mr Larking was found by foot was '*on average maybe 10 minutes.*'[25] It was apparent from the CCTV footage that Mr Larking had not taken the most direct route as he is captured walking along Howard Street when the most direct route would have been down Cooper Street.[26]

50. Although there was a possibility Mr Larking had walked through Epping Plaza, DSC Anderson did not obtain any CCTV footage from the Plaza's entrances.[27]

51. DSC Anderson's investigations had not been able to reveal Mr Larking's route or activities between leaving NWMHS at approximately 12.10pm and when he arrived at the grassland.[28] The CCTV footage collected by DSC Anderson indicated that Mr Larking arrived at the grassland area near the substation at about 1.53pm. Mr Larking appears to leave the site, and returns at 2.09pm. Smoke can be seen rising from the trees on the CCTV footage at 3.02pm.

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[22] T 112.
[23] T 128.
[24] T 129-130.
[25] T 757.
[26] T 768; Exhibit 79 CCTV footage.
[27] T 770.
[28] T 757.

DSC Anderson gave evidence he visited three petrol stations in the vicinity and was not able to ascertain from where and how Mr Larking obtained the petrol, the residue of which was located in the small plastic milk bottle at the scene.

52. DSC Anderson arrived at the scene of Mr Larking's death at approximately 3.49pm on 13 May 2016. He was made aware at about 9.40pm that a person missing from Northern Hospital may be Mr Larking, who had been reported missing by his sister-in-law to Epping Police station.

53. DSC Anderson formed the view that suicide was likely, so he did not request finger printing of the bottle or lighter found at the scene. DSC Anderson spoke with witnesses and as no-one had been seen in the vicinity '*we were of the opinion that it was more likely than not at that stage to be a non-suspicious death ...*'[29] DSC Anderson indicated that he was satisfied it was not a suspicious death, in that there was nobody else involved in Mr Larking's death.[30]

54. Although in his statement DSC Anderson was of the view that Mr Larking had taken his own life, after hearing the evidence at the inquest DSC Anderson was of the view Mr Larking's death could have been either from misadventure or suicide.

55. The evidence at inquest was not able to establish where Mr Larking went immediately after he left the hospital. It is unknown how he obtained the lighter or petrol in the small milk bottle located at the scene however I am satisfied the milk bottle itself came from the Northern Hospital. The route that Mr Larking took to reach the grassland area behind the substation is not known. The local service stations between the Northern Hospital and the scene of Mr Larking's death had no record from that day of either the purchase or theft of a small amount of petrol.

Intentional death or by accident or misadventure?

56. Mr Larking's psychiatrist, Dr Vaskar Chakraborty did not note suicidality as a risk factor during Mr Larking's admission to NWMHS. Dr Chakraborty described him as '*future focussed*' and '*he never actually commented on harming himself during the stay.*'[31] A Continuing Risk Assessment Management **(CRAM)** form in Mr Larking's medical records indicates an assessment was performed on 9 April 2016. Mr Larking's 'categorisation of risk

[29] T 774-5.
[30] T 776.
[31] T 333.

of suicidality and self-harm' were both ticked as '*low.*'[32] The same categorisation was recorded for a risk assessment on 1 May 2016.[33]

57. Following Mr Larking's death, Dr Chakraborty completed the MHA 125 Notice of death to the Chief Psychiatrist'[34] and answered '*No*' to the question of whether there was a '*strong indication of suicide.*' He maintained that view in evidence at the inquest.

58. Dr Stephen McConnell, a consultant psychiatrist, prepared an expert report for the coronial investigation. He was asked his opinion regarding whether or not Mr Larking took his own life. Dr McConnell stated:

> *... the more I reflected on my summary of the clinical notes it doesn't really make sense that it would have been a suicide attempt based on Harley's ... recent clinical profile before his death. Unfortunately I can't truly know myself, but the best I can say is on probability I think it's most likely it was misadventure or accident.*[35]

59. Dr McConnell also noted in his report, that:

> *He did not appear to have expressed or documented risk of having suicidal intent during the admission including in the last few days prior to and on the day of his death. Nor did he appear to have long-term significant pattern of deliberate self-harm or suicidal behaviours. In contrast, he appeared to have chronic risk of impulsive aggression towards others. Annemarie [Ms Skratek] says in her statement that on the evening of 12/5/16 she visited Harley and he 'seemed pretty good and seemed fairly happy.*[36]

60. There is a legal presumption against a finding of suicide. Suicide must be proved by evidence; it cannot be presumed just because it seems to be a likely explanation.[37] A finding that a person has deliberately taken his or her life can have long lasting ramifications for family and friends of that person. Any such finding requires clear and cogent evidence; suicide must be affirmatively proved to justify the finding. The certainty required is higher than on the balance

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[3232] T 197, Medical Records 868.
[33] T 197.
[34] Exhibit 28.
[35] T 660.
[36] CB 63.65; Exhibit 29.
[37] *Crown v Coroner for City of London, Ex parte Barber* [1975] WLR 1310.

of probabilities and requires positive evidence that the deceased intended to die through their own actions.[38]

61. The only direct evidence suggesting suicide in this case is the manner in which Mr Larking died. Dr Dodd used the formulation of '*Effects of fire*' as the cause of death, and witness Elisabeth Andrew, firefighter and fire investigator, in her report described the death as '*self-immolation*' however clarified in evidence this could be intentional or accidental and she had no way of telling which.

62. A recent report by the Koori Engagement Unit of the Coroners Court and the CPU using data from the Victorian Suicide Register indicated that of suicides by Aboriginal and Torres Strait Islander people, 62.3% had a diagnosed mental illness. The report also showed that suicide rates of Aboriginal and Torres Strait Islander people in Victoria are twice that of the state's non-Indigenous population, with young Indigenous Victorian's being most at risk. This evidence is not of a causal nature and is not proof in this case, but indicative of the extent of passings of Aboriginal and Torres Strait Islander people identified as suicides between 2009 and 2020.

63. Mr Larking had not expressed an intention to suicide or self-harm during his most recent admission at the NWMHS. There is evidence in the medical file that he was impulsive and took risks, such as somersaulting off a table in the ICA.[39]

64. I am not satisfied there is sufficient evidence to satisfy me that Mr Larking's death was an intentional act by him to end his life. There is no evidence of recent suicidal intent or expression in the medical records. The evidence of Mr Larking's treating psychiatrist, Dr Chakraborty, and the expert opinion of Dr McConnell supports this. Dr Dodd cannot point to any physical evidence from the scene to establish or support Mr Larking's intention. There is no evidence where the petrol was on his body. Dr Dodd was unable to distinguish between whether petrol had been ingested or inhaled, although the presence in the stomach was an unusual finding. There is no evidence as to how Mr Larking had come to have the petrol in the small milk bottle at the scene. Mr Larking's mother, Ms Skratek indicated that prior to his death, they had watched a television program together featuring people fire breathing.[40]

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[38] The principles in *Briginshaw v Briginshaw* (1938) 60 CLR 336.
[39] CB 30; Exhibit 24.
[40] CB 63.74 Second statement of Anne Marie Skratek dated 22 March 2019

65. Mr Larking was not able to access petrol and a lighter in the inpatient unit. He was in the ICA because of his high risks, poor decision making, and vulnerabilities, associated with his mental illness (the seriousness of which had resulted in his admission and commencement on high risk clozapine) which cannot be separated from what occurred after he absconded. The risks he had in the ICA could only increase after he had left.

66. In the absences of suspicious circumstances and evidence of sufficient weight to establish intention, I am satisfied on the balance of probabilities Mr Larking's death was the result of accident or misadventure.

THE CIRCUMSTANCES IN WHICH THE DEATH OCCURRED - SECTION 67 (1)(c)

67. This section will consider the scope in the following order.

(a) The first part considers Mr Larking's clinical care at NWMHS, the decision for him to be trialled in the Low Dependency Unit and his monitoring prior to absconding;

(b) The second part examines the response by NWMHS staff following his absconding. There was a concession made by NWMHS that the policies related to patients absconding were ambiguous and that staff were unaware of them;

(c) The third part considered the response by Victoria Police to Mr Larking's absconding. There was significant dispute about the phone call and contents made from ICA NWMHS to Epping Police station following Mr Larking's absconding;

(d) The fourth part examines how Mr Larking absconded over the fence. This considered Northern Health's role as having responsibility for the building and facility; and

(e) The fifth part considers whether the provision of the mental health services for Mr Larking by NWMHS were culturally competent.

Mr Larking's clinical care in NWMHS

68. NWMHS services 1.4 million people and is the largest mental health provider in Victoria.

69. Although Northern Health operates the Northern Hospital, the mental health unit, NWMHS is operated by Melbourne Health. This means care must be taken when referring to hospital staff or NWMHS staff as they are employed by different entities. Northern Health is responsible for the premises, such as the buildings and the facility where NWMHS is situated.

70. The ICA of NWMH admits a maximum of five patients, and the LDU admits a maximum of 20 patients.[41] The ICA is usually staffed with two nurses on the morning shift, two nurses in the afternoon shift and a nurse who has a 'late' shift which covers part of the morning and afternoon shift.

Diagnosis and treatment

71. Mr Larking was admitted to the ICA on 8 April 2016. Mr Larking's psychiatrist, Dr Chakraborty, described the evolving nature of his illness and the difficulties with diagnosis.

72. At 13 May 2016, Mr Larking had a working diagnosis of schizoaffective disorder. People suffering from schizophrenia usually experience mainly psychotic symptoms, schizoaffective disorder comprises both psychotic symptoms as well as affective symptoms from time to time, such as elevated mood, racing pulse and decreased sleep.

73. Dr Chakraborty described Mr Larking as treatment resistant, meaning he did not respond to trials of at least two anti-psychotic medications. He met the criteria for clozapine treatment and was being gradually titrated up.[42]

74. Dr McConnell, a consultant psychiatrist who prepared an expert report for the coronial investigation, stated:

> *It is appropriate that Harley was started on clozapine, which follows contemporary practice and guidelines for treatment resistant schizophrenia and related conditions.*[43]

75. When he was asked about Mr Larking having been on clozapine for two weeks, Dr McConnell commented:

> *... that's still in the earliest beginnings of ... maximal or optimal improvement that eventually will occur. So, at two weeks, it's still in, you know, what's called a titration phase, so where the dose is being gradually built up ... you can take many months to...really get best benefit from clozapine.*[44]

[41] T 174, Ms Neale referred to 'swing room' whereby the LDU can have 21 patients but 'that rarely happens.'
[42] T 315.
[43] CB 63; Exhibit 29.
[44] T 650.

Trials in the Low Dependency Unit

76. During his admission Mr Larking had been moved to the LDU on 15 April and moved back to ICA on 23 April following increased agitation and a Code Grey. From 1 May 2016 he was having escorted or supervised periods in the LDU every day (except 3 May) until 13 May. Mr Larking was assessed on a daily basis as to whether he should have a visit to the LDU.

77. Dr Chakraborty described Mr Larking as showing early signs of improvement on clozapine,[45] and although his escorted leave had been cancelled, supervised trials to the LDU were continued in the spirit of the recovery model and the least restrictive option. He explained this helped to engender hope and gives patients a sense of autonomy and to acknowledge their wishes with respect to treatment. He explained that Harley had been in the ICA of the ward for quite a long time, and it was very evident by statements like:

> *"He felt caged in there, like an animal" and it was very apparent, the way he was expressing his distrust there. So ... we did believe that ... giving him that latitude of freedom and an inclination of greater freedom to come, would really improve our therapeutic relationship, which is a treatment modality by itself. And hence, we incorporated the least restrictive option in the spirit of that recovery model. However, I understand it's always a balance between clinical reasonable judgment and incorporating the wishes and to that, I understand, we did cancel the outside leaves, but still continued with the trials, because we believed it would be too punitive to take that out from him.*[46]

78. On 9 May 2016, Mr Larking had a trial in the LDU supervised by Ms Hannan, Aboriginal Liaison Officer. In the clinical progress notes Ms Hannan noted Mr Larking had said to her, he '*could jump the fence right now if i really wanted to but im not guna* (sic)'.[47]

79. The medical record shows that on 10 May 2016, Mr Larking had a supervised visit in the LDU for 30 minutes from 4.15 to 4.45pm and then spent a further half an hour with his mother in LDU that evening. On 11 May, Mr Larking had a supervised LDU visit.

80. On 12 May 2016, Mr Larking had an unsupervised trial in the LDU from 12.45 until 5.30pm, with 30-minute observations.[48] The CRAAM Revised Risk Assessment in the medical records

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[45] T 365.
[46] T 317-318.
[47] T 318; Exhibit 30; Medical record 829.
[48] T 262-263; Exhibit 12.

dated 12 May 2016 at 10.40am[49] recorded Mr Larking as an ICA patient rated as medium risk of absconding, agitation, disorganisation, and aggression, with an overall assessed level of risk and engagement as medium.

Chronology of 13 May 2016

81. At 7.00am on 13 May 2016, ICA nurse Sumi Sathiyamoorthy commenced work in the ICU with nurse Gary Lansell, who was from the bank staff.[50] There were five patients in the ICA. That day there was no late shift nurse for the 10 am to 6.30pm shift. The absence of a 'late shift' nurse meant the ICA was short staffed.

82. Mr Larking was woken at 10.00am and was reviewed by his treating team, comprising the consultant psychiatrist, Dr Chakraborty, a medical officer and Ms Sathiyamoorthy. Ms Sathiyamoorthy described Mr Larking as pleasant during the review and that he answered all questions. Each patient in the ICA has a daily clinical review by the medical team and nursing staff. For indigenous patients, the Aboriginal mental health liaison person can attend those meetings, however it is not compulsory.[51]

83. The CRAAM Revised Risk Assessment in the medical records was dated 23 May 2016 at 12.00pm.[52] It recorded Mr Larking as an ICA patient rated as a low risk of absconding, however his overall level of risk was medium.[53]

84. Ms Sathiyamoorthy advised that in assessing risk, Mr Larking's history was considered, '*But day by day, because of medications and all that, their mood change.*'[54] On 13 May 2016, '*his mood was ... more pleasant and cooperative, and ... he didn't mention any auditory hallucinations or perceptual disturbance on that interview.*'[55]

85. Following his review, Dr Chakraborty made the decision for Mr Larking to be trialled in the LDU, to commence at 11.00am with 30-minute observations. He described the decision regarding the frequency of observations as follows, '*risk assessment is a dynamic process ... a real time dynamic process rather than just a static instruction.*'[56] Further, he noted that when

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[49] Digital medical records 865.
[50] Bank staff means he was employed by Melbourne Health to fill in as required in various psychiatric units managed throughout Melbourne by Melbourne Health.
[51] T 193.
[52] Dr Chakraborty's evidence this date was an error and should have been 13 May 2016.
[53] Exhibit 27.
[54] T 235.
[55] T 236.
[56] T 327.

ICA patients go to the LDU on trials they are always on at least medium risk.[57] Ms Sathiyamoorthy was responsible for the observations, which she completed at 11.00am, 11.30am and 12.00pm. Although Ms Sathiyamoorthy was tasked to do observations whilst Mr Larking was in LDU, as the ICA was short staffed, she returned to her duties there.

86. Ms Sathiyamoorthy gave evidence that the treating team was aware the ICU was short staffed but '*Harley wanted to'* go to the LDU, and had been '*agitated,*' and she agreed it was important to '*consider what the patient wants to do.*'[58]

87. Ms Sathiyamoorthy knew Mr Larking's risk of absconding was 'high' and that she could closely observe him for risk to himself or others. She knew he had previously absconded but had come back.

88. The record of the treating team review on 13 May 2016 stated that Mr Larking:

> *... understands consequences of AWOL, and is agreeable to stay in LDU if transferred. Hence it was agreed to have extended trials and transfer if doing well.*
>
> *According to last clinical review, plan was to organise family meeting early next week to discuss about discharge process.*[59]

89. The observations included engagement. At 11.30am Mr Larking was in the courtyard, not interacting with other patients and Ms Sathiyamoorthy asked him, '*Are you OK*' and he indicated, '*Yes, I am OK.*'[60] At 12.00pm she observed him in the lounge, with other patients watching TV, and asked, '*How are you?*' and he replied, '*Yes, I'm fine.*' In evidence she explained that as they were short staffed, she did not spend more time with him.[61]

90. The CRAAM Consumer Engagement form[62] records Harley as being in the courtyard at 11.00am and 11.30am; in the lounge at 12.00pm and noticed missing by one of the doctors at 12.10pm.[63] Ms Sathiyamoorthy recorded on the nurse engagement form as the observations were made.[64] Since Mr Larking's death, there is a new version of the nurse engagement form,

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[57] T 330.
[58] T 230-231.
[59] Exhibit 18, Medical Record 786. Entered by Dr Chakraborty 14 May 2016 at 10.31am.
[60] T 214 Ms Sathiyamoorthy's evidence was he indicated he was OK by 'sign language.'
[61] These observations were noted in the CRAM engagements and observation document Exhibit 12.
[62] Digital medical records 872.
[63] Digital medical records 865.
[64] T 156-7. The nurse engagement record used when Mr Larking was trialling in the LDU is at p 233 of the CB and the new version is at CB 223.

with headings, 'Principle concern' and 'Intervention plan' so that the risks that are clear on admission have an intervention plan, rather than in a safety plan on a separate document.

Decision for LDU trial on 13 May 2016

91. In contrast to Ms Sathiyamoorthy's evidence, Dr Chakraborty indicated he was not aware of the staff shortage in ICA on 13 May 2016. However, he stated it would not have altered his decision for Mr Larking to be trialled in the LDU, '… *because [it] seems [s] too punitive just because of staff shortage ... withholding somebody's trials, when there are no other indications.*'[65]

92. Dr McConnell discusses the dilemma in decision making regarding an LDU trial: on the one hand, being in the ICA allowed for further improvement in Mr Larking's mental state given he had only been on clozapine for two weeks, on the other hand, he strongly desired to be in the LDU and the exacerbation in his distress that may be the result of refusal. Dr McConnell was not of the view that the risk of absconding (without a high risk of either suicide or violence to others) should be a major reason to keep a more restrictive level of care. Further, he noted Mr Larking's regular pattern when absconding over the years had been to return home and then be safely returned to the ward.[66]

93. In Dr McConnell's expert report, he stated:

> *It is documented that there was a staff shortage on the 13/5/16. In my view when deciding on the most appropriate ward environment for a patient, multiple sources of input need to be taken in to account including from medical and nursing staff. Other factors apart from the patient's clinical presentation need to be considered eg ability to safely monitor and support the patient, ward dynamics with other co-patients etc. Given the staff shortage on the 13/5/16 it may have been prudent to delay further trials of unsupervised visits in LDU until the usual staffing levels had been reinstated.*[67]

94. The evidence from clinicians caring for Mr Larking demonstrates the 'dilemma' referred to in Dr McConnell's expert evidence. In his report he stated:

> *I understand the dilemma faced in decision making when attempting to balance the 2 opposing needs of nursing Harley for an adequate period of time in ICA to allow for potential of further improvement in his mental state (given he had only been on*

[65] T 326.
[66] CB 63.65.
[67] CB 63.66.

clozapine for about two weeks) versus respecting Harley's strong desire to be nursed in LDU (ie to support treatment of Harley in the least restrictive environment.)[68]

95. Dr McConnell was asked to explain his statement that '*I do not believe that absconding without concerns about associated acute high level risks should be a major reason to keep a person in more restrictive levels of care ...*'[69]

96. In his evidence he expanded on this, given the physical limitations of the LDU:

> *That comment was very much based on my own clinical experience ... due to similar physical deficiencies in hospitals where I work at where they're not well designed to reduce absconding risk ... it's such a regular concern, absconding, that if we tried to reduce that risk by keeping people in ICA only, I see it again and again that the person's clinical state, even on Clozapine, starts actually going backwards or deteriorating further.*[70]

97. In Dr McConnell's view, in the absence of high-level risk factors,[71] the risk of absconding should be given lesser weight in the balance of maintaining a patient in ICA. Mr Larking's history of absconding and going home and returning to hospital was a pattern of behaviour indicating a lower risk associated with absconding.

98. Dr McConnell was of the view it was a reasonable decision to gradually transfer Mr Larking to the LDU. He had recommendations about nursing observations that they not be predictably every half hour and that the ICA nurse not be the one responsible for observations in LDU as it meant the nurse was unable to have regular informal awareness of his whereabouts between the formal observation times.

99. Dr McConnell stated:

> *My opinion is that the speed and ease with which Harley could abscond over the fences had the most significant contribution to him eventually being in an unsupervised situation outside of the ward that gave him the opportunity to die.*[72]

100. I accept Dr McConnell's evidence that the decision by medical staff to trial Mr Larking in the LDU was reasonable. The staff had to work within the physical limitations of the LDU

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[68] CB 63.65; Exhibit 29.
[69] CB 63.65.
[70] T 651.
[71] High level risk factors such as the high risk of suicide or violence to others.
[72] CB 63.69; Exhibit 29.

environment. The evidence of risk posed by the ease with which Mr Larking could scale the courtyard fence and abscond was a risk balanced against the detriment to his treatment of refusing his trials in the LDU, which were important incremental steps towards his discharge and recovery.

101. Dr McConnell concluded:

> *In my opinion, it is unrealistic to expect that nursing staff could have prevented Harley from absconding from LDU when he had such ready access to means of absconding. The other alternative would have been to continue nursing Harley in ICA but this was becoming increasingly distressing for Harley. Furthermore I note that Harley was not experiencing suicidal ideation or intent during his admission on 13/5/16 when he died therefore ongoing nursing in ICA was not clearly indicated.*[73]

102. In his evidence Dr McConnell stated he had considered nine points to come to the conclusion the decision to continue the trial in the LDU was reasonable, but with the benefit of hindsight '*... that the staff numbers were down ... that's the only bit that sticks out in the decision making for me.*'[74]

103. Mr Larking was improving on clozapine and was communicating his frustration at being locked in the ICA. Most of the trial periods were between one and two hours with the longest being on 12 May 2016 when he was there between 12.45 pm and 5.30pm, also on 30-minute observations which appeared to go well.

Conclusions on the evidence

104. I am of the view the evidence supports a finding that the decision to trial Mr Larking in the LDU on 13 May 2016 was reasonable. This coincides with the opinion of his treating psychiatrist, Dr Chakraborty, and the expert, Dr McConnell, despite his misgiving about the staff shortage. Although Ms Sathiyamoorthy returned to the ICA between observations, there was other nursing staff in the LDU, and Mr Larking was familiar with the LDU and known to the staff there. I am of the view that observations and monitoring were reasonable, but I note that Dr McConnell was of the view that variable timing of observations was preferable. I intend to make a recommendation in accordance this, that observations be done at variable

[73] CB 63.70; Exhibit 29.
[74] T 693.

times so that patients cannot easily predict the routine, especially where a patient is known to be a high absconding risk.

Events immediately following Mr Larking's absconding

105. This part examines the response by NWMHS staff following his absconding. There was a concession made by NWMHS that the policies related to patients absconding were ambiguous and that staff were unaware of them.

106. There were a number of facts in issue. These centred around whether NWMHS staff followed correct NWMHS procedure when a compulsory patient absconds, by calling family, calling police, filing out the correct forms, and faxing the appropriate forms to police. The staff were closely questioned about their knowledge of the appropriate NWMHS policies.

107. Ms Gardiner, Counsel for Victoria Police, conceded that a phone call from NWMHS ICA had been made to Epping Police Station on 13 May 2016 however it was a fact in issue as to what was communicated during the call and whether the call constituted a 'missing person report.'

108. On day four of the inquest, Ms Foy, Counsel for NWMHS, made a concession on behalf of NWMHS that the policy 'NWMHS Missing patient/Absconded patient,'[75] '*is ambiguous and misleading with respect to the timelines for action, and the instructions and communications and follow up with Victoria Police*'[76] and was being revised as a matter of priority. She also acknowledged the deficiencies in the knowledge and awareness of NWMHS staff of the policy and procedures in such matters and advised the Inquest that NWMHS is implementing compulsory staff education program in how to respond to missing persons. Further, NWMHS is in communication with Victoria Police, examining technological options to '*enhance communication and the accuracy of that communication by clinical staff to the Victoria Police.*'[77]

109. This concession followed the production of a memo during the inquest written by Paul Kelly, Director of Operations at NWMHS, dated 18 February 2013 (**the Kelly memo 2013**).[78] The memo details the requirements of staff at NWMHS when notifying Victoria Police of missing persons to note the name and number of the police officer to whom the report was made in the patient's record, to ensure facsimile numbers for police stations are in the speed dial of the

[75] Exhibit 9.
[76] T 457.
[77] T 458.
[78] Exhibit 49.

IPU facsimile machine and for the NWMHS staff member making the report to police to ensure the facsimile reaches the intended recipient.[79]

110. Sergeant Turney from Epping Police Station explained the Kelly memo 2013 came about, '*In regard to lack of information being reported in regard to persons being reported missing from the Northern Hospital Psychiatric ward.*'[80]

111. Dr Kurt Wendelborn, Director of Clinical Services at NWMHS at the time of Mr Larking's death, was unaware of this memo and confirmed it was not part of policies sent to the court in his statement dated 4 December 2017.[81]

112. John Dermanakis, the Area Manager for NWMHS since 2014, gave evidence NWMHS operates across 32 sites and its intranet has approximately 380 policies and over 200 forms. He was unable to confirm whether the Kelly memo 2013 was part of the 380 policies on the NWMHS intranet.[82] Mr Dermanakis indicated the Kelly memo 2013 was currently being revised into a policy, as a matter of urgency.[83]

113. The NWMH 'Missing patient/absconded patient' guidelines do not reflect the content of the Kelly memo 2013.

114. Mr Dermanakis confirmed that both the 'NWMH Missing patient/absconded patient' guidelines and the 'The Missing person' flowchart were ambiguous and contradictory.[84]

115. In summary NWMHS conceded its policy and procedure surrounding absconding patients was ambiguous, that staff needed training about the policies and procedures, and that work was underway to better communicate with Victoria Police about absconding patients.

116. In light of the concession by NWMHS and the inconsistent and unclear nature of the policies, I intend to make a recommendation that the policies at Melbourne Health as they relate to missing/absconded persons be reviewed and rationalised so that they are written in plain English, are consistent across facilities and are clear regarding steps required to be followed.

[79] Exhibit 49.
[80] T 739.
[81] Exhibit 45.
[82] T 639.
[83] T 642.
[84] T 638.

The relevant NWMHS policies and procedures when a patient absconds

117. The principal documents that set out the NWMH guidelines for absconding compulsory patients are contained in the 'NWMHS Missing patient/absconded patient' guidelines[85] and the 'The Missing Patient – RMH Satellite Sites.'[86] 'The Missing Patient' is a chart detailing action to be taken at 15-minute intervals when a patient is suspected missing. When read together the policies suggest the missing compulsory patient is to be reported missing to police within 15 minutes and a Form 124 sent to police.

118. The Procedures in the 'NWMHS Missing patient/absconded patient' guidelines require for the absence of a compulsory patient (summarised):

(a) a search within the first hour a patient is identified as missing;
(b) an attempt to locate by contacting family;
(c) completion of a risk assessment;
(d) a report to consultant psychiatrist;
(e) a report of the absence to police and for involuntary patents completion of a MHA 124;
(f) completion of a missing person report;
(g) notification to police if patient is located or returns;
(h) entering the incident on Riskman;
(i) document in the clinical file a detailed summary of process and outcomes; and
(j) to notify family.

119. The contents of the Kelly memo 2013 have been detailed above.

What happened when Mr Larking absconded

120. At 12.10pm, Ms Sathiyamoorthy returned to the ICA and was standing near the staff area when an unknown doctor said that someone from the Northern Psychiatric Unit (**NPU**) had jumped the fence in the courtyard. Ms Sathiyamoorthy checked the LDU and noted Mr Larking was not there. A patient head count noted he was not on the ward. Security staff were asked to check the hospital grounds. The nurse in charge, Frank Kavanagh, was advised, as was the Nurse Unit Manager and Mr Larking's treating team.

[85] Exhibit 9; CB 217.
[86] Exhibit 15.

121. Ms Sathiyamoorthy stated she called Mr Larking's mother but there was no answer. She then called his brother, Andrew, advised him and asked if he could let NWMHS know if Mr Larking attended his mother's place.

122. Ms Sathiyamoorthy prepared an incident report in Riskman on the computer at the nurse's station. Next to her, Gary Lansell called the Epping Police Station and made a missing person report. Ms Sathiyamoorthy stated she was within earshot when this call was made.

123. At this point it appears from the evidence that many of the requirements in the 'NWMHS Missing patient/absconded patient' guidelines had been completed.

Telephone call to police

124. There was significant dispute about the phone call and its contents made from NWMHS to Epping Police station following Mr Larking's absconding.

125. NWMHS interrogated its phone records and established that on 13 May 2016 at approximately 1.20pm, a telephone call with the duration of one minute and 22 seconds was made from ICU to Epping Police Station.

126. Nurse Gary Lansell gave evidence that he made the telephone call to Epping Police Station to report Mr Larking as missing. He had noticed he was missing when he went to wake him for lunch, but was told he was in the LDU and had decamped.[87] Following the call to Epping Police station he relayed the conversation to Clinical Nurse Manager NPU1, Clare Neal, and Ms Sathiyamoorthy, words to the effect, that the call had been brief and that the police officer he spoke to had not asked the usual questions.[88]

127. He also started to fill in a form that Ms Sathiyamoorthy handed him which was MHA 120, not the stipulated MHA 124. In the following minutes he then faxed three pages[89] through to Epping Police Station. He could not recall whether the fax machine displayed or printed a transmission report.[90] Mr Lansell stated that nobody told him that day that the fax had not gone through.[91] The attempt to fax material occurred at 1.20pm, however the fax did not transmit, and this was not noted by NWMHS staff until after they were contacted that evening by Victoria Police.

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[87] T 550.
[88] T 543.
[89] Exhibits 55B and 55C.
[90] T 544.
[91] T 580.

128. Mr Lansell had no recollection of having seen the NWMH Missing Patient/Absconded patient policy,[92] nor the policy, 'The Missing Patient.'[93]

129. Mr Lansell did not recall receiving training about the relevant procedures for absconding patients at NWMH.[94]

130. Mr Lansell had not seen the Kelly memo 2013,[95] which detailed the process for the 'Notification of Missing Persons to Victoria Police.'

131. In cross examination by Counsel for Victoria Police, Mr Lansell confirmed the following:

(a) He made his first statement two years after Mr Larking's death after being shown the telephone records that a call was made from ICU to Epping Police Station, and in that statement there were no details about the contents of the call;

(b) The call to Epping Police station lasted one minute and 22 seconds. He had made one missing person's report previously;

(c) He had not seen the Kelly memo 2013,[96] therefore, he did not take the name or number of the police officer and did not confirm the facsimile reached its intended recipient;

(d) He had no recollection that there was a recorded message on the Epping Police station number with options, which took about 30 seconds;

(e) He was not able to recall details of the telephone call to police, such as whether he asked his colleagues what Mr Larking had been wearing;

(f) He could not recall when he obtained the information contained on the fax header about what Mr Larking was wearing;

(g) He said the first fax he attempted to send '*went through skewed*' so he sent another one;[97]

(h) He agreed he filled out the incorrect form MHA 120,[98] which is not the correct form for a compulsory patient who is absent without leave. He explained that Ms Sathiyamoorthy handed him that form saying, '*We need to start preparing this*,' and someone said, '*Just write 'AWOL' and fill in the next one,' which I did.*';[99]

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[92] Exhibit 9.
[93] Exhibit 15; T 553.
[94] T 554.
[95] Exhibit 49.
[96] Exhibit 49.
[97] T 570.
[98] Exhibit 56.
[99] T 570.

(i) He stated one of the Forms he filled in was MHA 124 (but not Exhibit 13). He was not able to explain why it was signed by Ms Sathiyamoorthy, not himself.;

(j) He stated: '*I can recall filling it in but I have no, you know, recollection of not doing it. My only recollection is one of doing it*';[100]

(k) He agreed the staffing shortage on the day put him under '*a great deal*' of pressure;[101] and

(l) He agreed that the approach he took to making the missing person's report was compromised because of that pressure.

132. Ms Sathiyamoorthy gave evidence she was sitting next to Mr Lansell when he made the phone call to Epping police station to report that Mr Larking was missing. She stated, '*All I can remember ... normally police asking lot of questions but this time they said, just fax the information and then put the phone down.*'[102]

133. She stated she had a conversation with Mr Lansell afterwards when he said the effect '*That's weird*' as usually police ask a lot of questions but instead they said to just fax the information.[103]

134. In Ms Sathiyamoorthy's first statement dated 15 July 2016, there is no mention of her being in 'earshot' of Mr Lansell when he made the call to police.

135. Ms Sathiyamoorthy agreed there was no reference to her completing the Riskman report in her first statement, nor that a fax was sent to Epping Police station. She was unable to recall when she became aware that the fax had not gone through to the police station.[104]

136. Ms Sathiyamoorthy was taken to the 'The Missing Patient'[105] guideline, which requires police notification within 15 minutes of a patient going missing.[106]

137. Ms Sathiyamoorthy noted in Mr Larking's medical record that he had '*AWOL'd the unit, was not present at 13.00*' and '*Reported to police and rang.*'[107]

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[100] T 571.
[101] T 571.
[102] T 223.
[103] T 223.
[104] T 254.
[105] Exhibit 15.
[106] T 243; Exhibit 15.
[107] Exhibit 17 (Progress notes from the Medical record at 833); T 254.

138. The Associate Nurse Unit Manager, Frank Kavanagh, gave evidence in his statement he heard Gary Lansell call the police and confirmed he was with him when he had called the police.[108]

139. Although Mr Kavanagh was aware of the general procedure when a person absconded, such as calling police and family and '*doing the Riskman*', he was unaware of where the policies and procedures were written down[109] such as Exhibit 9, 'NWMHS Missing patient/absconded patient' guidelines. Mr Kavanagh had worked at NWMH for 11 years and stated he had had training, '*It would have been a long time ago, I don't remember.*'

140. Mr Kavanagh confirmed it was policy that when a report was made to police about someone absconding, the police name and badge number of the police officer spoken to should have been recorded in the patient's record.[110] It was also policy that the facsimile transmission confirmation to police would be attached to a patient's file.[111]

141. In his expert report, when commenting on improving communication to the police about Mr Larking absconding, Dr McConnell stated:

> *Practical and achievable include promptly sending the fax of the missing persons notification, checking it has been sent on the fax machine, and then confirming by telephone to the police that it has been received (with documentation of time of call and name of the police officer that this was confirmed with.)*[112]

142. This advice appears to affirm the contents of the Kelly memo 2013.

143. Although Mr Kavanagh was vague about particular names of policies, he had a fair idea of the process and procedures applicable when a compulsory patient absconded.

Response by Victoria Police to Mr Larking's absconding

144. Brad Turney was the Sergeant at Epping Police Station on 13 May 2016. He commenced work at 3.00pm and became aware of a possible deceased male at approximately 3.15pm. At 7.00pm he called Northern Hospital and established that Mr Larking was a compulsory inpatient who had gone absent without leave earlier that day. He asked why Epping Police Station had not been notified and was advised by 'Portia' she thought someone had called. His evidence was

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[108] T 273; Exhibit 20.
[109] T 284.
[110] T 296.
[111] T 297.
[112] CB 63.68; Exhibit 29.

there was no record of a call from NWMHS or any *Mental Health Act* paperwork from the hospital. He asked for details of the contact which were not forthcoming.

145. Sergeant Turney stated:

> *It is standard practice that when a patient goes missing from the Northern Hospital Psychiatric Ward, staff on the ward contact Epping Police and report the person as missing. From that point police will initiate and [sic] immediate investigation as to the missing person whereabouts.*[113]

146. Sergeant Turney checked with a number of morning and afternoon shift police officers on 13 May 2016 and no one said they had received the call with information that Mr Larking was missing from NWMHS. There was no further evidence from Victoria Police as to why the call was not recorded, nor evidence of any further internal investigation about it.

147. Sergeant Turney explained in the case of a compulsory inpatient who leaves the psychiatric ward without permission, it is the responsibility of Northern Hospital staff to contact police and provide as much information as possible to facilitate police successfully locating the missing person prior to potential harm occurring:

> *Reporting is initiated by Northern hospital staff calling the Epping police station and reporting the missing person. Police obtain as much information as possible from the caller in regard to the missing person, complete missing person reports, including the missing person risk assessment and notify supervisors directly via phone and patrol units via on air police communications (Integraph). ...*
>
> *In the case of an involuntary psych patient being reported missing, Northern Hospital Psych ward staff should fax to the Epping police station documented confirmation that the missing person is an involuntary psych patient and can be arrested under section 352 of the Mental Health Act when located.*[114]

148. Sergeant Turney stated that the phone call about a missing patient is sufficient to trigger police investigation without the paperwork. '*If they call us and tell us an involuntary patient has gone AWOL we take it in good faith that that's the truth ... so we'll initiate the investigation without the paperwork ...*'.[115]

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[113] CB 55; Exhibit 71.
[114] CB 63.2-63.3; Exhibit 72.
[115] T 703.

149. Sergeant Turney gave evidence that the fax system was about to be replaced with a secure email system between Northern Hospital and Epping Police Station, which was trialed in May 2019.[116] A phone call was still required with the relevant information but the documents were to be sent via a secure email.

150. The Northern Hospital telephone records established a phone call was made to Epping Police station on 13 May 2016 at 1.20pm of one minute and 41 seconds duration. Sergeant Turney believed the recorded options from when the call was first answered took about 30 seconds. Based on his '*25 years' experience in policing'* he did not believe one minute and 11 seconds was adequate time to communicate sufficient information to enliven a police response other than obtaining '*the reporting person's name and the missing person's name and that would be about it.*'[117]

151. Sergeant Turney was asked to comment whether it was likely Mr Larking could have been located given the call to police from NWMHS was made at about 1.20pm and the fire in which Mr Larking died was located by passers-by at approximately 3.00pm. He was asked the likelihood of whether police would have patrolled the area where Mr Larking was found thus avoiding the tragic outcome. Sergeant Turney answered it would depend on the availability of policing units and the priority of the job (compared to higher priority jobs) so a police unit could have patrolled the vicinity of Northern Plaza and Northern Hospital checking bus stops and train stations, but the grassland near the electrical substation where Mr Larking was found would have required a foot patrol and more specific information to prompt a search there.[118]

Form MHA 124

152. In the document 'NWMHS Missing patient/absconded patient'[119] it states at (f):

> *Reporting and documenting the absence to the police for compulsory patients or consumers identified as at risk – for the purpose of apprehending the patient and returning the patient to the designated mental health service for ongoing treatment ... Completion of the MHA 124, Apprehension of patient absent without leave.*

153. The *Mental Health Act 2014* Apprehension of Patient absent without leave form (MHA 124) dated 13 May 2016 (no record of time is required on this form) was signed by Nurse

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[116] T 705.
[117] T 738.
[118] T 741-2.
[119] CB 218.

Sathiyamoorthy. It is incomplete. The sections not filled out include what type of order Mr Larking was subject to at that time, any identifying information, including what clothing he was wearing, and information to assist with apprehension, including urgency, addresses, typical behaviours, communication strategies, known risks, triggers and medical considerations.[120]

154. The form required to be sent to police is MHA 124, however Mr Lansell unsuccessfully tried to fax a MHA 120 to police.[121] MHA 120 is for '*Leave of absence for a compulsory patient*', and on it was recorded, '*AWOL at 12 o'clock*', signed by Gary Lansell.

155. Although Mr Lansell attempted to send the incorrect Form, the fax header contained specific information about Mr Larking:

> *Good afternoon. Our patient Harley Larking has gone AWOL from NPU1. This was reported at 13.20 this afternoon to a member of your staff at Epping station. Harley is a 23 year old *(Caucasian male). He is 179 cm tall and of heavy build. He has dark brown hair cut in a sbas style. He has hazel coloured eyes and a fair/olive complexion. *(He is of Aboriginal heritage.) He is wearing a black hooded top, dark coloured tracksuit pants and runners.*[122]

When to contact police

156. The flow chart on 'The Missing Patient', [123] states police are to be contacted between 0 and 15 minutes of a compulsory patient absconding.

157. Clare Neale, the clinical manager nurse for NPU where Mr Larking was admitted, explained the difficulties when a patient absconds but is known to return of their own accord:

> *... a person may have a history of leaving and coming back to the unit ... that may be brought into question the time frame around ... us contacting the police may differ and we may ... seek advice through the consultant about how we respond or the immediacy of us responding to that in notifying the police.*[124]

158. Ms Neale explained that the timing of contacting police may be affected if staff see someone leaving and know them to be an acute risk, when contact would be immediate, as compared

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[120] Digital medical records 96.
[121] T 181; CB 274.
[122] Exhibit 55C.
[123] Exhibit 15.
[124] T 163.

with not seeing someone leave and knowing something about their absconding behaviour, and that a high-risk patient who had thoughts of harm to self or others would require an immediate response.

159. Ms Neale was also of the view that following Mr Larking's absconding, staff took steps to advise police '*as per protocol,*' in accordance with the NWMH guidelines.[125]

Conclusions about the evidence following Mr Larking absconding

160. A physical search was made of the NWMHS for Mr Larking.

161. Ms Sathiymoorthy called Mr Larking's mother (unsuccessfully) and also his brother, Andrew, to whom she did speak.

162. The nurse in charge, the nurse unit manager and Mr Larking's treating team were all advised he had absconded.

163. The telephone call was made from NWMHS ICA to Epping Police Station.

164. I am satisfied by the evidence of Mr Lansell, Ms Sathiamorthy and Mr Kavanagh that Mr Lansell made a missing person report by telephone to Epping Police Station on 13 May 2016.

165. Although Mr Lansell's memory of the call was imperfect, and he did not make a written note of who he spoke to as required pursuant to the Kelly memo 2013, the call to Epping Police station reporting Mr Larking missing was clearly made, as verified by three witnesses, who, although their evidence was vague, their credit was not impugned.

166. Further, Mr Lansell recorded the details of the call he made to Epping Police station in the handwritten message on the fax header to police, written at the time, but not successfully sent.[126]

167. I disagree with Sergeant Turney's opinion '*from 25 years' experience as a police officer*' that a telephone call of one minute and 12 seconds duration was insufficient time to communicate to police the basic details that a compulsory patient named Harley Larking had absconded from the NWMHS at Northern Hospital. The estimate of the length of time needed to communicate important details by telephone is not a subject matter requiring expertise. Sergeant Turney has been unable to establish which officer from his station took the call from

[125] T 16.
[126] Exhibit 55C.

Mr Lansell and why the information communicated, even the bare minimum that Mr Larking was a compulsory inpatient who had absconded, was not acted upon.

168. I find that although NWMHS staff were unfamiliar with the relevant NWMHS policies regarding procedures for absconding patients, their evidence established, they were experienced sufficiently to know basically what to do regardless of being able to cite the exact policies and the correct forms.

169. NWMHS staff were unaware of the Kelly memo 2013 regarding the notification of missing persons to Victoria Police to note the name and number of the police officer to whom the report was made in the patient's record, to ensure facsimile numbers for police stations are in the speed dial of the IPU facsimile machine and that the NWMH staff member making the report to police ensure the facsimile reaches the intended recipient. Frank Kavanagh was aware of this requirement despite not being able to cite the relevant policy.

170. I find that NWMHS staff did not check the facsimile had been sent, but, as acknowledged by Sergeant Turney, the failure of the paperwork should not have been fatal to a police investigation.

171. I am satisfied the NWMHS did report Mr Larking as missing to Epping Police Station and the police officer who took the call did not communicate and action that information appropriately. This represents a failure to action a missing person report response by Victoria Police.

172. I am not of the view however this constituted a missed opportunity, as it appears from Sergeant Turney's unchallenged evidence that it was highly unlikely given Mr Larking's whereabouts, although only 10-minute walk from Northern Hospital, he would have been located by routine police patrols.

173. According to Dr Wendelborn, the NWMHS internal review did not identify the process of faxing information to Victoria Police as deficit. In my view it is reasonable to expect there would be a basic checking process for fax transmissions in such circumstances; a process that is found in most workplaces that have a document control system in place.

174. In light of the concession by NWMHS about the lack of knowledge by staff about important policy and procedure such as the missing/absconding person policy, even though I have found they knew basically what to do, I intend to make a recommendation that a training program be implemented to educate staff, including bank staff , about those policies, to ensure staff are

able to take the required and appropriate action in reporting to external agencies to minimise risk to the patient.

175. At the time of hearing the evidence was inconclusive as to whether the electronic transmission process to replace the facsimile between NWMHS and Epping Police Station had been implemented so I intend to make a recommendation that an electronic transmission process be implemented to replace the facsimile system which existed at the time of Mr Larking's death.

176. Although Mr Larking's mother estimated in her statement that since February 2016 he had absconded approximately five times and returned home, and was then subsequently returned to NWMHS by his family, Sergeant Turney's evidence was that the LEAP records indicated Mr Larking had only been recorded once as a missing person by Victoria Police.[127]

177. The evidence of Ms Neale also illustrates the difficulty with discretion, particularly with a patient such as Mr Larking who had a history of absconding but of regularly returning. I am of the view the boundaries of when patients are to be reported to have absconded, particularly compulsory patients, are too porous. As a result I intend to make a recommendation so that all compulsory inpatients absent without leave for more than 15 minutes are to be reported as missing to police.

How Mr Larking was able to abscond from the Northern Hospital and the risk posed by the courtyard fence

178. This part examines the history of abscondments over the fence including by Mr Larking, the awareness of the risk and Northern Health's responsibility for the building and facility.

179. Mr Dermanakis, Area Manager for NWMHS, believed he first became aware that patients were able to jump over the fence in about April 2015. At that time, Victoria Police expressed concern to NWMHS about an increase in the number of absconding patients from NWMHS, namely 33 over the preceding 72 days.

180. Riskman is a computerised reporting system used by Victorian hospitals to identify all incidents and risks, so any attempt to abscond or actual absconding by a patient should be entered on the system.

[127] T 741.

181. The evidence at Inquest demonstrated a discrepancy with the Riskman entries and in cross examination it was clarified that not all instances of absconding or attempts were entered in Riskman. For example, the medical records revealed that on 22 April 2016 Mr Larking jumped the fence but returned straight back to the ward.[128] Mr Dermanakis confirmed that in such an instance, '*a Riskman is generally not completed ... We would not class this as absconding if he has immediately returned to the unit.*'[129]

182. The medical records revealed Mr Larking's mother had reported to medical staff on 26 July 2015 that he had told her he was going to '*jump the fence*' and she asked staff to '*keep an eye on him.*'[130] This was not recorded in Riskman, and neither was another incident when Mr Larking did jump the fence on 8 June 2015 and went to his brother's house in Craigieburn, from where his mother returned him to hospital.[131]

183. There was significant evidence about disparity between instances of absconding and attempts to abscond entered on Riskman and the absconding reported to the Epping Police Station. The disparity poses a risk as the inaccurate data obscures the extent of attempts to abscond and absconding. I intend to make a recommendation that the reporting practices on Riskman be reconciled and that compulsory inpatients who abscond for more than 15 minutes are reported to the police and entered in Riskman.

184. In response to Victoria Police's concerns regarding the number of patients who had recently absconded from NWMHS, a meeting took place on 1 April 2015 between Victoria Police and NWMHS.[132] As a result of the meeting, John Kelly, Director of Operations for NWMHS, asked his facilities manager to attend a site meeting with the Associate Nurse Unit Manager, and an engineer officer from Northern Health to provide a recommendation about the fencing.

185. Mr Kelly advised there were process impediments to having the fence altered. These included accessing sources of funding, the capital funding approval process, building approval (including a revised design), Health Purchasing Victoria Guidelines in respect of procurement requiring accredited contractors, the requirement for at least three quotes, and planning for the demolition and construction without disrupting the operations of the unit. He stated the Health Department guidelines regarding mental health facilities are silent about the height of fences,

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[128] T 594.
[129] T 594.
[130] T 598.
[131] T 599.
[132] T 473, Reference was made to 33 absconders from the Northern Psychiatry Unit in the first 72 days of 2015.

so the advice of the engineering officer and discussions with Northern Health determined the new height. In addition, constructing a new fence had to be planned so that patients still had access to the courtyard.

186. Although the issue had been raised by Victoria Police in April 2015, the courtyard fence had not been replaced by the time of Mr Larking's last abscondment and subsequent death. When asked about the level of priority assigned to the task, Mr Kelly stated '*I believe everyone was working as they could to get the fence progressed in a[s] soon as possible time*,'[133] but he could not recall whether there was a discussion about the level of urgency for the task, and neither were there temporary measures put in place to reduce the risk of absconding in the meantime and there were no measures taken to mitigate the risk of the fence.[134]

187. The liaison committee of Northern Health and NWMHS minutes indicate a purchase order for the fence works to go ahead was raised on 28 April 2016, and the meeting minutes from 30 May 2016 indicate the works were scheduled to occur within four to six weeks.

188. Dr Wendleborn, Director of Clinical Services at NWMHS at the time of Mr Larking's death, was aware that during 2015-2016 it was possible for a patient to jump over the fence in the LDU courtyard.[135] He was aware that a number of patients had jumped over the fence and absconded in that way. He noted that Northern Health, and not Melbourne Health, was responsible for the buildings and facility. Dr Wendelborn confirmed that the new courtyard walls are 1200 mm, or four feet higher than the original fence. [136]

189. Dr Wendelborn was asked why NWMHS would allow a situation to exist whereby patients could easily abscond by climbing the courtyard fence. He agreed with the hypothetical example, if there was a hole in the fence, '*I would certainly be keen for it to be addressed.*'[137] He advised the height of the fence in the courtyard was being, '*actively considered ... in the pro's and con's of ... changing the fence line.*'[138]

190. Mr Lansell gave evidence that it was generally considered by the nurses that the fence in the LDU was considered to be 'short,' in that patients were able to climb over it.[139]

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[133] T 478.
[134] T 459-460.
[135] T 415.
[136] CB 63.21 Exhibit 45
[137] T 422.
[138] T 434.
[139] T 556.

191. Dr McConnell stated:

> *There is significant documentation around the processes involved in starting building works to change the fences in the psychiatric unit courtyards that were the major sites for Harley and others to easily abscond from the ward. My opinion is that the speed and ease with which Harley could abscond over the fences had the most significant contribution to him eventually being in an unsupervised situation outside of the ward that gave him the opportunity to die.*[140]

192. Dr Chakraborty agreed with Dr McConnell's assessment and the difficulties preventing Mr Larking from absconding due to his *'long standing ability to abscond throughout his other admissions in the previous three to four years.'*[141]

193. It is not my role to decide when the fence should have been repaired or replaced however it was clearly a known risk for patients to abscond by April 2015.

Conclusions about the evidence

194. The height of the fence in the courtyard was a known risk to management of Northern Health and NWMHS as early as 2015, if not before, that the staff and senior staff of NWMHS were well aware of it. Increasing the height of the fence was not contrary to maintaining a least restrictive environment. The height of the fence, as Dr McConnell pointed out, was an 'enabler' for Mr Larking to leave the unit. His family was well aware of him leaving the hospital using this method. Although there was awareness of the risk, there was no evidence of steps taken to ameliorate or lessen the risk.

195. If the height of the fence had been actioned earlier Mr Larking would not have been able to abscond in the manner in which he did, so I regard the delay in repairing or replacing the fence was a missed prevention opportunity. He may well have found another way to abscond. By being able to abscond he was able to put himself at risk of harm by accident or misadventure, which was realised in this case by his death by the effects of fire.

196. Mr Dermanakis' was evidence was that he searched Riskman between 20 July and 31 December 2018. The data for NPU1 indicated six patients had absconded during that

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[140] CB 63.69; Exhibit 29.
[141] CB 63.69; and T 335.

period, but no indication they had absconded over the new LDU courtyard fence. The data for NPU2 indicated three patients had absconded, one had accessed the fence via a light pole.[142]

197. The evidence bears out the likelihood that absconding via the fence has been reduced by the new fence and the commensurate reduction in numbers of patients absconding.

198. I intend to make a recommendation that when risks in the physical environment are identified it is incumbent on Northern Health, as entity responsible for the buildings and facilities, to take timely action to ameliorate the risk.

Culturally competent mental health services

199. This part considers the extent to which the provision of health services to Mr Larking were culturally competent during the period of his last admission to NWMHS immediately prior to his death.

200. Dr Wendelborn gave evidence about the cultural supports provided to Mr Larking.

201. Dr Wendelborn had previous experience as a psychiatrist in New Zealand where all services are provided founded on the principle of bi-culturalism. As the lead psychiatrist in a Pacific Island mental health service in Wellington he described his understanding of the meaning of cultural competence in the health care setting:

> *It enjoins you to be sensitive to the other core cultural ... ideas, values ... and concepts that that person might have, and to take those into account ... in your general approach to that person ... and might include the way that you conduct an interview, the rituals that you observed ... things like that ... but also in how you think about the care and provision provided thereafter.*[143]

202. NWMHS covers the areas of Darebin and Whittlesea, which has the largest per capita aboriginal population in greater Melbourne. The NWMHS document 'Balit Marrup' is an Aboriginal social and emotional wellbeing framework for 2017-2027, described by Dr Wendelborn as driving and cementing cultural awareness in care and services generally.

203. Wadamba Wilam is a service run in conjunction with the Victorian Aboriginal Health Service, Northern Area Mental Health service, NEAMI and the Uniting Church to support aboriginal clients with a mental illness with intensive outreach support.

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[142] T 587.
[143] T 440.

204. At NWMHS, Michelle Hannan was the aboriginal mental health liaison worker on the ward.[144] Wadamba Wilam staff involved with Mr Larking's care were Grady Walsh, a psychiatric nurse from the Victorian Aboriginal Health Service, Dr Jarrod Lewis, the Aboriginal liaison psychiatric registrar, Mr Adam Burns, a senior nurse and Tamara Lovett a mental health worker. '*So all of those people were working alongside the larger clinical team in providing care to ... Harley ...*'.[145]

205. Dr Chakraborty's statement referred to the involvement of the Aboriginal liaison worker in Mr Larking's care:

> *... supervised trials to the low dependency section of the ward were continued, in the spirit of the recovery model and least restrictive treatment option. He initially had supervised trials for two days with the Aboriginal liaison officer. He came back to the high dependency area on request and engaged well with the aboriginal liaison officer.*[146]

206. In acknowledging the importance of cultural support, Dr Chakraborty stated:

> *... when a person goes into the LDU after a long time in the ICA, there is an element of uncertainty that we have to sit with them, hence the rational for the supervised trial. Now, this is not something that is routinely done in the NPU ward and this is something I did out of extra precaution for Harley in particular and also that he was Indigenous in background, I wanted to provide some cultural importance at this so we had the Indigenous worker actually escorting him and supervising him over trials.*[147]

207. Dr Chakraborty also pointed to aspects of Mr Larking's larger management plan, such as daily reviews by medical staff, daily risk assessments, occupational therapy,

> *... having the Indigenous services like Wadamba Wilam involved and providing him with as much of a culturally safe environment as possible. Indigenous liaison worker, the provision of PR and medications ... So, I believe there was a safety framework ... that we had as part of the management plan though it didn't have a formalised form there.* [148]

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[144] As Ms Hannan had passed away no statement or evidence was available.
[145] T 410.
[146] CB 30; Exhibit 24.
[147] T 321.
[148] T 332.

208. Ms Lovett made a statement and gave evidence at the Inquest. Ms Lovett was the Aboriginal social wellbeing officer at Wadamba Wilam. She first met Mr Larking at a home visit on 30 March 2016 and when he was re-admitted to NWMHS on 8 April 2016. On 24 April 2016 she attended multiple meetings at the hospital about Mr Larking's treatment. These included a meeting about his refusing to have the blood tests that are required with clozapine treatment, and a discussion with the treating team in a clinical review around electroconvulsive treatment (**ECT**) and a meeting with *'Jared, Grady and Shell (Michelle Hannan)'* where Ms Lovett expressed her concerns that Mr Larking was not getting enough cultural support at NPU. She and Adam Burns (senior clinician at Wandamba Wilam) continued to visit Mr Larking on the ward and discussed the LDU trials that they were supporting him with. Ms Lovett last visited Mr Larking on 12 May 2016.[149]

209. When asked about her concerns about Mr Larking's cultural support, Ms Lovett explained she was of the view the clozapine treatment should be given more time, and that:

> *... Michelle was the only other Aboriginal person who was ... present for Harley's care and I didn't feel like there had been enough of an input from aboriginal services or people or respected people into his treatment.*[150]

210. Ms Lovett explained she felt Mr Larking needed more support to ensure he understood what was being said to him, making sure that she was available to support him for any trials, and advocating for him.

211. Ms Lovett did not believe either the nursing staff or the treating team doctors were culturally competent in their interaction with Mr Larking. [151]

212. Ms Hannan had instigated cultural formulation meetings for Aboriginal patients on the ward for staff to attend. Ms Lovett described them as looking at:

> *... different aspects of somebody's health, not just focussing on the ... emotional and physical health of a client. It would look at more the spiritual, the cultural, the connection to country ... connection to language and land, and connection to family and community and sort of would be more of a holistic approach to healthcare, as opposed to just a treatment to an illness.*[152]

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[149] Exhibit 54.
[150] T 506.
[151] T 516.
[152] T 517.

The meetings were open to everyone in the treating team and those caring for the patient. Ms Lovett stated they were not well attended by staff. Ms Lovett was of the view the meetings should be compulsory for staff, '*... it is important if you want a more culturally supportive treatment for the client.*'[153]

213. Ms Lovett's evidence was that she did not always feel welcome when attending the NPU to visit aboriginal clients,[154] that she faced resistance when trying to enter the NPU and was told a couple of times that she could not go in. She also stated she felt her contributions were not valued by the treating team. Ms Lovett's evidence included an explanation of the difficulties faced by individual aboriginal workers in a hospital, she described:

> *... working in a ... very westernised clinical space and being the only Aboriginal person who's come from, you know, a very different way of looking at things, it can be very hard when you're – in a sense, culturally isolated.* [155]

214. Ms Lovett was taken to the 'principles' in the Balit Marrup report. She gave evidence that in her view, aside from there being an Aboriginal liaison officer and Wadamba Wilum involved, evidence of staff embedding into the way they treated Harley through connection to culture, family and community, '*was fairly limited.*'[156] There was no cultural safe space in the NPU. [157]

215. When asked about Dr Wendelborn's evidence about the cultural competence and cultural safety at NPU Ms Lovett stated:

> *I don't feel as though one aboriginal mental health liaison officer ... it's not enough ... it's just not adequate ... you need more people ... like maybe nurses or registrars that are actually indigenous or aboriginal ... who actually have a better understanding of the trauma that people have faced in their life.*[158]

216. Mr Dermanakis, when asked about Ms Lovett's evidence, explained that no-one is allowed to simply walk into the ICA:

> *We would expect that any person that wanted to enter the ICA would have a conversation with the ICA nurses at that time to ascertain what's happening within*

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[153] T 518.
[154] T 519.
[155] T 522.
[156] T 524.
[157] T 526.
[158] T 528- 529.

that part of the unit and to make sure that it is safe for them to enter and safe for everyone else.[159]

217. Mr Dermanakis stated at the time Mr Larking was a patient, NWMHS was the only Victorian public mental health service inpatient unit that had an Aboriginal mental health liaison officer.[160]

218. Ms Neale gave evidence that at the time Mr Larking was on the unit, there was an Aboriginal mental health liaison officer, Michelle Hannan, allocated to the unit who would assist with communications between him and clinical staff,[161] however she was not aware of training given to nursing staff at NPU about culturally safe clinical practice.

219. Ms Sathiyamoorthy indicated in her 14 years as a nurse, she had attended training four or five times relating to cultural communication with Aboriginal patients.[162]

220. The ANUM, Mr Kavanagh, could not recall having had training in cultural safety with respect to engaging with Aboriginal patients,[163] and at the time he gave evidence was still working as the head nurse at NPU. Although he was aware of the Aboriginal mental health liaison officer, he never engaged with her, or had training from her, and was not aware of any training from her offered to staff.

221. Dr Chakraborty was aware that Ms Hannan had developed 'formulation reviews' for indigenous patients. He described these as:

> *... empowering the staff and the doctors to build up on a cultural formulation for the indigenous people I particular, so Michelle who was our indigenous worker would actually help us build on the cultural formulation which was an aid on top of the usual clinical formulation and then do we tailor treatment depending on the cultural needs is what was discussed.*[164]

222. Dr McConnell noted in his report that Ms Lovett commented in her statement that she did not believe enough support, time or cultural support had been provided to Mr Larking at NPU, or that information had been explained to him in a way that he would understand. His mother, Ms Stratek, stated she did not think doctors listened to her or Mr Larking about his medication.

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[159] T 633.
[160] T 634.
[161] T 170.
[162] T 244.
[163] T 286.
[164] T 376.

Dr McConnell noted the importance of mental health services to invite families to express their concerns about loved ones, and clearly documents attempts to do this.[165]

223. The evidence at the inquest was that at the time Mr Larking was an inpatient, NWMHS was the only Victorian public mental health service inpatient unit that had an Aboriginal mental health liaison officer on staff. Although this seems extraordinary, for this NWMHS is to be congratulated.

224. Evidence from Dr Wendleborn and Dr Chakraborty indicates they were very supportive of and recognised the importance of a culturally responsive treatment environment for Mr Larking.

225. However, the evidence from Ms Lovett indicated it is not sufficient for senior staff to be aware and supportive of the importance of cultural connection. That attitude must permeate the entire workplace and the evidence strongly suggested that staff (as opposed to senior management) were not familiar with either Ms Hannon's role and had not received recent and regular training about cultural competence in clinical practice. Ms Lovett's evidence reflected her firsthand experience of Mr Larking's mental health treatment and indicated that even with a policy framework such as Balit Marrup, and support of senior staff, Aboriginal cultural competence and connection to culture was not embedded in the provision of mental health care. Therefore I intend to make a recommendation that training in cultural competence in mental health clinical practice be implemented for all NWMHS staff and regularly repeated so that there is understanding by all staff of the benefits to the Aboriginal patient and their family from involving Koori Workers, and promoting culturally informed treatment.

226. In light of NWMHS being the only public mental health service inpatient unit in the State (at the time of the Mr Larking's death) to have an Aboriginal mental health liaison officer on staff, I also intend to recommend the Office of the Chief Psychiatrist review other public mental health services, that may not have an Aboriginal mental health liaison officer, with a view to encouraging the embedding of the principles and practice of cultural competence in the provision of mental health services to Aboriginal and Torres Strait islander patients.

[165] CB 63.63-63.64.

RECOMMENDATIONS

Pursuant to section 72(2) of the *Coroners Act 2008*, I make the following recommendations:

To the Director, Melbourne Health:

1. That policy and procedures for the monitoring of involuntary patients are reviewed to be in line with the Department of Health 2013 *Nursing observation through engagement in psychiatric inpatient care,* with particular focus on any predictability of the frequency, timing and duration of nursing observations and the requirements for contemporaneous documentation of the observations.
2. That a secure electronic transmission process be implemented to replace the facsimile system (which existed at the time of Mr Larking's death) so that North Western Mental Health Service can initiate and complete a missing patient notification to Epping Police Station by telephone and contemporaneously in writing.
3. That North Western Mental Health Service enter both actual and attempted absconding instances in Riskman and reconcile instances of absconding with the records of Victoria Police to determine areas for clarification including when to record incidents of absconding by compulsory patients in Riskman.
4. That North Western Mental Health Service specify that in circumstances where a compulsory inpatient absconds for more than 15 minutes (and in the absence of the treating psychiatrist's contemporaneously documented rationale otherwise), that Victoria Police are notified, and the instance and its outcome are recorded in Riskman.
5. That the policies at Melbourne Health as they relate to missing persons be reviewed and rationalised so that they are written in plain English, are consistent across facilities and clear regarding steps required to be followed and in what timeframes.
6. That staff be regularly trained about those policies (such as the missing/absconded person policy) and regular audits are undertaken to ensure North Western Mental Health Service is confident their staff are taking the required and appropriate action in reporting to external agencies to minimise risk to the patient.
7. That North Western Mental Health Service implement Aboriginal cultural competency training for all inpatient psychiatric staff that includes a focus on working with Koori workers, how to facilitate their role within the unit, develops an understanding of the benefits to the Aboriginal patient and their family from involving Koori Workers, and promotes culturally informed treatment planning.

To the Director, Northern Health:

1. That the system for responding to identified environmental risks to patients in the psychiatric units include prioritising of corrective or ameliorating actions and in circumstances where the risks are not managed in a timely way, require escalation to the governing body.

To the Office of Chief Psychiatrist

1. That the Office of the Chief Psychiatrist review other public mental health service inpatient units that may not have an Aboriginal mental health liaison officer, with a view to encouraging the embedding of the principles and practice of cultural competence in the provision of mental health services to Aboriginal and Torres Strait Islander patients.

FINDING AND CONCLUSION

1. I find that Harley Robert Larking died on 13 May 2016 from the effects of fire in circumstances described above.

2. I convey my sincere condolences to Mr Larking's family for their loss.

3. In light of the current Royal Commission into Victoria's mental health system, and Mr Larking's family's submission, I propose to include the Royal Commission on the distribution list.

4. Pursuant to section 73(1) of the Coroners Act 2008 I direct this finding be published on the Internet in accordance with the rules.

5. I direct that a copy of this finding be provided to the following:

Anne Marie Skratek, Senior Next of Kin (care of the Victorian Aboriginal Legal Service)

Northern Health (care of Minter Ellison)

North Western Mental Health (care of DTCH Lawyers)

Victoria Police (care of the Victorian Government Solicitor's Office)

Office of the Chief Psychiatrist

The Royal Commission into Victoria's mental health system

Senior Constable Peter Anderson, Victoria Police, Coroner's Investigator

Signature:

CAITLIN ENGLISH

DEPUTY STATE CORONER

DATE: 18 September 2020