IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2017 5543

FINDING INTO DEATH FOLLOWING INQUEST

Form 37 Rule 63(1)
Section 67 of the ***Coroners Act 2008***

Inquest into the Death of	Anthony Lansell Churches
Delivered On:	21 October 2020
Delivered At:	Coroners Court of Victoria, 65 Kavanagh Street, Southbank
Hearing Dates:	
Findings of:	Judge John Cain, State Coroner
Representation:	Donna Filippich, Legal Counsel, St Vincent's Hospital
Counsel assisting the Coroner:	Samantha Brown Principal In-House Solicitor In-House Legal Services

I, Judge John Cain, State Coroner, having investigated the death of Anthony Lansell Churches, and having held an inquest in relation to this death on 21 October 2020

at MELBOURNE

find that the identity of the deceased was ANTHONY LANSELL CHURCHES

born on 19 November 1946

and the death occurred on 1 November 2017

at Unit 14, 177 Power Street, Hawthorn, Victoria 3122

from:

1a CYANIDE TOXICITY

I find, under section 67(1) (c) of the **Coroners Act 2008** ('the Act') that the death occurred in the following circumstances:

BACKGROUND:

1. Anthony Lansell Churches (**Mr Churches**) was 70-years old at the time of his death and lived at Unit 14, 177 Power St in Hawthorn. Mr Churches lived alone, had few known friends and was estranged from his family. His unit in Hawthorn had been purchased by his mother, Peggy Scott, in 1975 so that he would have a place to live.[1]

2. Mr Churches had a history of unemployment and substance use.[2] He had come to the attention of police on several occasions between 1971 and October 2017 and had appeared in court in relation to offences involving drugs, assault and contravention of personal safety intervention orders (**PSIO**). On five occasions, he was sentenced to terms of imprisonment,[3] most recently on 31 October 2017.

3. Although he had no documented psychiatric history,[4] at the time of his death, Mr Churches was the subject of an Inpatient Assessment Order pursuant to section 29[5] of the *Mental Health Act 2014* (Vic) (**the MHA**) and had absconded from St Vincent's Hospital (**SVH**) where psychiatric assessment was to have occurred.

4. On 1 November 2017, Mr Churches was located deceased at his home.

[1] Coronial Brief [CB], Statement of Audrey Lansell.
[2] Ibid.
[3] CB, Mr Churches' Victoria Police LEAP record.
[4] CB, Statement of Janice Cheslin.
[5] The criteria for an Assessment Order appear in section 29 of the *Mental Health Act 2014* (the MHA). Assessment Orders are defined in section 28 of the MHA as orders made by a registered medical or mental health practitioner to facilitate the transfer of an individual to a designated mental health service for compulsory examination by an authorised psychiatrist to determine the need for treatment.

THE PURPOSE OF A CORONIAL INVESTIGATION

5. Mr Churches' death constitutes a '*reportable death*' under the *Coroners Act 2008* (Vic) (**the Act**), as he ordinarily resided in Victoria[6] and the death appeared to have been unexpected, unnatural, violent or the result of an accident or injury.[7]

6. At the time of his death, Mr Churches was a 'person placed in custody or care' as defined in section 3 of the Act because immediately before his death he was a patient detained in a designated mental health service within the meaning ascribed in the MHA.[8] There is no dispute on the available evidence that despite absconding from SVH, Mr Churches remained subject to an Inpatient Assessment Order and was therefore a 'person placed in custody or care'.

7. Mr Churches' designation as a 'person placed in custody or care' is significant. This is because the Act recognises that people in the control, care or custody of the State are vulnerable and therefore, irrespective of the nature of the death, requires the death to be reported to the coroner and so be subject to the independent scrutiny and accountability of a coronial investigation.

8. As an additional protection, until the insertion of section 52(3A) into the Act in November 2014, all deaths of people placed in custody or care required a mandatory inquest.[9] An inquest into Mr Churches' death was mandatory pursuant to section 52(2)(b) of the Act because he was a 'person placed in custody or care' and his death was not due to natural causes.[10]

9. The jurisdiction of the Coroners Court of Victoria is inquisitorial.[11] The Act provides for a system whereby reportable deaths are independently investigated to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.[12]

10. The expression '*cause of death*' refers to the medical cause of death, incorporating where possible, the mode or mechanism of death.

---

[6] *Coroners Act* 2008 [the Act], section 4.
[7] The Act, section 4(2)(a). *Coroners Act 2008*
[8] Section 3 of the Act provides an exhaustive definition of a 'person placed in custody or care'.
[9] The Act, section 52.
[10] Section 52(3A) of the Act stipulates that a coroner is not required to hold an inquest in the circumstances set out in subsection (2)(b) if the coroner is satisfied that the death was due to natural causes.
[11] The Act, section 89(4).
[12] The Act, preamble and section 67.

11. For coronial purposes, the phrase '*circumstances in which death occurred*,'[13] refers to the context or background and surrounding circumstances of the death. Rather than being a consideration of all circumstances which might form part of a narrative culminating in the death, it is confined to those circumstances which are sufficiently proximate and causally relevant to the death.

12. It is not the role of the coroner to lay or apportion blame, but to establish the facts.[14] It is not the coroner's role to determine criminal or civil liability arising from the death under investigation,[15] or to determine disciplinary matters.

13. The broader purpose of coronial investigations is to contribute to a reduction in the number of preventable deaths, both through the observations made in the investigation findings and by the making of recommendations by coroners. This is generally referred to as the Court's "*prevention*" role.

14. Coroners are also empowered:

    (a) to report to the Attorney-General on a death;[16]

    (b) to comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice;[17] and

    (c) to make recommendations to any Minister or public statutory authority on any matter connected with the death, including public health or safety or the administration of justice.[18] These powers are the vehicles by which the prevention role may be advanced.

15. All coronial findings must be made based on proof of relevant facts on the balance of probabilities.[19] In determining these matters, I am guided by the principles enunciated in *Briginshaw* v *Briginshaw*.[20] 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 that they caused or contributed to the death.

---

[13] The Act, section 67(1)(c).
[14] *Keown v Khan* (1999) 1 VR 69.
[15] The Act, section 69 (1).
[16] The Act, section 72(1).
[17] The Act, section 67(3).
[18] The Act, section 72(2).
[19] *Re State Coroner; ex parte Minister for Health* (2009) 261 ALR 152.
[20] (1938) 60 CLR 336.

16. At the conclusion of my investigation, I was satisfied I was able to make findings about the deceased's identity, the cause of death and the circumstances in which death occurred, so this case was listed for inquest in accordance with the Act. The Inquest was a Summary Inquest – one conducted without oral testimony – as there were no evidentiary conflicts or discrepancies that would justify calling witnesses.

IDENTITY OF THE DECEASED PURSUANT TO S.67(1)(a) OF THE ACT

17. On the 6 November 2017, fingerprint analysis and comparison were undertaken, and a report prepared. Mr Churches was identified by fingerprint identification report dated 6 November 2017.[21]

18. Identity was not in dispute and required no further investigation.

MEDICAL CAUSE OF DEATH PURSUANT TO S.67(1)(b) OF THE ACT

19. On 3 November 2017, Forensic Pathologist Dr Essa Saeedi of the Victorian Institute of Forensic Medicine (**VIFM**) performed an external examination[22] of Mr Churches' body under the supervision of Professor Stephen Cordner also of VIFM. Dr Saeedi reviewed post-mortem computed tomography (**CT**) scans of the whole body, the Police Report of Death for the Coroner (Form 83),[23] a Section 27 Form[24] and medical records provided by SVH before providing a written report dated 21 March 2018.[25]

20. Among Dr Saeedi's anatomical findings were minor injuries mostly involving the upper and lower limbs as well as the right eye, some of which showed signs of healing and so were considered likely to have been sustained prior to Mr Churches' death; no skeletal injuries were evident on post-mortem CT.[26] None of the injuries identified were considered likely to have contributed to death.[27]

---

[21] Forensic Identification (Fingerprint) Report dated 6 November 2017.
[22] Given the suspicion that Mr Churches had died by ingesting cyanide, and the occupational health and safety risks associated with internally examining a deceased person in these circumstances, in accordance with the forensic pathologist's recommendation, the duty coroner did not order that an autopsy be performed.
[23] The Police Report of Death for the Coroner outlines the circumstances in which death occurred as these are understood immediately after the death has occurred.
[24] A 'Section 27 Form' is a form requesting that an autopsy be performed which, in Mr Churches' case was a form dated 2 November 2017 submitted by Victoria Police's Homicide Squad.
[25] CB, Medical Investigation Report of Dr Essa Saeedi.
[26] Ibid.
[27] Ibid.

21. Toxicological analysis of post-mortem blood samples detected only cyanide (>10mg/L).[28] Cyanide was also detected in one of the two exhibits seized by police at the scene.[29]

22. Dr Saeedi observed that cyanide exposure can occur by inhalation, ingestion or via skin contact. Cyanide prevents the uptake of oxygen by cells and interferes with its use in the body, producing anoxia and eventual death. Cyanide toxicity mainly affects the heart and brain, leading to cardiac arrhythmias and convulsions.[30]

23. Given the paucity of injuries, the toxicological findings and their consistency with the reported circumstances, Dr Saeedi concluded that the cause of Mr Churches' death was '1*(a) Cyanide Toxicity*'.[31]

24. I accept Dr Saeedi's opinion as to the medical cause of death.

CIRCUMSTANCES IN WHICH DEATH OCCURRED PURSUANT TO S.67(1)(c) OF THE ACT

Dispute with neighbour

25. Mr Churches had been in dispute with a neighbour, Andrew Nielson (**Mr Nielson**), who lived at Unit 15 177 Power St Hawthorn (**Unit 15**). The dispute started after a disagreement about the use of the common areas in the apartment block. This dispute escalated, and resulted in Mr Neilson reporting to police that he felt threatened and unsafe and ultimately to police applying for a PSIO on behalf of Mr Nielson.[32]

26. The PSIO initially granted by the Magistrates' Court prohibited Mr Churches from being at or within 2 meters of Unit 15. This condition was breached on several occasions and subsequently, an application to vary the terms of the PSIO was made and granted. The first variation prohibited Mr Churches from being at or within 5 meters of Unit 15. After this condition was contravened, further variations were made to prohibit Mr Churches from being

[28] Ibid. Cyanide is a swift-acting, potentially deadly chemical that can exist in various forms. Blood concentrations of cyanide in fatalities attributed to ingestion of cyanide range from 0.4 to 320mg/L, with an average of 37mg/L.

[29] Cyanide was detected in a fluid sample found in a brandy bottle located in Mr Churches' bedroom (Exhibit 2). Cyanide was not detected in a fluid sample taken from a drinking bottle located in the same place (Exhibit 1).

[30] CB, Medical Investigation Report of Dr Essa Saeedi. The forensic pathologist noted that without a full autopsy medicolegal issues that may arise at a later date may not be able to be adequately addressed.

[31] Ibid.

[32] CB, Statement of Andrew Neilson.

within 50 metres and, finally, 200 meters of Unit 15.[33] The effect of this PSIO was to make it impossible for Mr Churches to live at his unit.

27. On Tuesday, the 31st of October 2017, Mr Churches was arrested for contravening the PSIO. He was charged and conveyed to the Melbourne Magistrates Court.[34] Upon entering a plea of guilty to breaching the PSIO, Mr Churches was sentenced to five days' imprisonment,[35] with three days of that sentence reckoned as already served.[36] He was due to complete his prison sentence on 1 November 2017.[37]

Mental health assessment

28. On 1 November 2017, during a routine physical health assessment at the Melbourne Custody Centre (**MCC**) where he was serving his sentence of imprisonment, Mr Churches commented to the nurse that he was going to kill himself upon his release from custody.[38]

29. The nurse requested that a Forensicare mental health clinician further assess Mr Churches prior to his release from MCC.[39]

30. Jan Cheslin, a Registered Psychiatric Nurse (**RPN**) employed by Forensicare, attended MCC to perform a mental health assessment. Mr Churches presented as 'co-operative … calm and easy to engage' but stated that he had 'nothing to live for' and intended to end his life.[40] RPN Cheslin determined that Mr Churches required further mental health assessment and possible treatment and met the MHA criteria for an Inpatient Assessment Order. RPN Cheslin completed the MHA 101 Assessment Order form noting:

> *Mr Churches has clearly stated he will 'commit suicide' on release from police custody. - Reports not having opportunity whilst in cells – Mr. Churches appears to have clear plan and intent to suicide. In my opinion requires further mental health assessment and possible treatment.*[41]

---

[33] CB, Statement of Jess Maddock.
[34] CB, Statement of Senior Constable Luke Penhalluriack.
[35] CB, Schedule to Warrant to Imprison Mr Churches relation to Case Number H13021831.
[36] Though not entirely clear from the materials before me, it appears that the three-day period of imprisonment already served by Mr Churches occurred following his remand in custody in about September 2017.
[37] CB, Victoria Police Sentence Calculation Request.
[38] CB, Appendix G.
[39] CB, Appendix G
[40] CB, Statement of Jan Cheslin.
[41] CB page 274, MHA 101 Assessment Order dated 1 November 2017.

31. Mr Churches was transported by ambulance to SVH's Emergency Department (**ED**), arriving at about 12.30pm. Mr Stephen Buckland, the ED's mental health clinician received a handover from RPN Cheslin prior to Mr Churches' arrival and upon having an initial conversation with him found to be 'calm and cooperative' and detected no imminent risk that Mr Churches would abscond.[42]

32. Mr Churches was triaged, and at about 2.05pm was reviewed by ED Registrar Dr Jana Gerlach.[43] A general medical examination was performed, and routine pathology tests ordered during which Mr Churches stated that he would ingest potassium cyanide if he were to go home.[44] Dr Gerlach consulted with Mr Buckland and was advised that Mr Churches should be assessed by the Psychiatric Registrar as soon as possible.[45]

33. Based on his presentation, Mr Churches was placed in a high visibility cubicle within the ED. Dr Gerlach did not believe that 'one-on-one' nursing observation, sometimes referred to as 'specialling', was required though she noted that a 'Code Grey' response should be initiated should Mr Churches attempt to leave."[46]

34. At 3.40pm, Mr Churches could not be located within the high visibility cubicle. ED staff attempted to find him and made enquiries with Security staff who, in turn, viewed CCTV footage and confirmed that he had absconded. Mr. Churches was reported to police as missing and SVH staff completed and sent to Fitzroy Police station two forms: Personal Physical Description (VP L10) and Missing Person and Risk Assessment (VP L18). No Apprehension of Patient Absent Without Leave (MHA124) (**MHA 124**) form was completed.[47]

Attendance at 177 Power Street Hawthorn

35. At approximately 4.20pm on 1 November 2017, Mr Nielson saw Mr Churches return to his unit and contacted Boroondara Police to report that by doing so he had contravened the PSIO.[48]

---

[42] CB, Statement of A/Professor Peter Bosanac.
[43] CB, Statement of Dr Andrew Walby.
[44] Ibid.
[45] Ibid.
[46] Ibid.
[47] CB, Statement of A/Professor Peter Bosanac.
[48] CB, Statement of Andrew Nielson.

36. At about 5.10pm, in response to Mr Neilson's call, a Police unit from Boroondara was tasked to attend Mr Churches' home.[49]

37. At around 6.20pm, Senior Constables (**SC**) Penhalluriack and Stamatakos arrived at 177 Power Street Hawthorn. Once there, the D24 operator advised that Mr Churches was an involuntary psychiatric patient who had absconded from SVH. Further enquiries were made by police and it was ascertained that Mr Churches had threatened to kill himself by ingesting potassium cyanide.[50]

38. SCs Penhalluriack and Stamatakos tried to engage with Mr Churches by knocking on his door and calling out to him. SC Penhalluriack turned off the gas to the unit to reduce the risk of self-harm.[51]

39. At approximately 6.50pm, Boroondara patrol supervisor Sergeant (**Sgt**) Rooney arrived at the scene with a jemmy bar with which police tried, unsuccessfully, to force entry to the unit.[52]

40. Sgt Rooney, SCs Penhallurack and Stamatakos heard movement inside the unit and Mr Churches say that he was going to kill himself.[53]

41. At about 7.25pm, the Critical Incident Response Team (**CIRT**), Metropolitan Fire Brigade and Ambulance Victoria were requested to attend and were quickly on scene.[54]

42. Between 8.20pm and approximately 9.15pm, the CIRT members endeavoured to engage with Mr Churches and gain access to his unit. The actions undertaken included smashing windows and banging loudly on the front door. Oleoresin Capsicum grenades were also deployed to elicit some response from inside the unit.[55]

43. At about 9.30pm, the decision to force entry to the premises was made and, upon entering, Mr Churches was located, deceased, lying on the bed in the main bedroom.[56]

---

[49] CB, Statement of SC Penhalluriack.

[51] CB, Statement of SC Penhalluriack.
[52] CB Statement of Sergeant Lisa Rooney.
[53] CB, Statement of SC Jim Stamatakos (who stated over police radio that he had observed Mr Churches through the bedroom window at 7:20pm).
[54] CB, Statement of Sgt Rooney.
[55] Ibid.
[56] CB, Statement of Leading SC Andrew Nickson.

COMMENTS

44. Pursuant to section 67(3) of the Act, I make the following comments connected with the death:

Management of Mr Churches by St Vincent's Emergency Department

45. In accordance with the SVH Psychiatric Triage and Emergency Department Mental Health Guidelines (**ED Mental Health Guidelines**) the role of the ED Mental Health (**EDMH**) clinician is to provide 'mental health triage, assessment services, advice and/or liaison' to certain types of consumers who present to the ED.[57] The ED Mental Health Guidelines do not articulate the role of the EDMH clinician with regards to patients who are already subject to an Assessment Order under the MHA.

46. In this instance, Mr Buckland receipted Mr Churches under the MHA, triaged him, provided ED staff with a copy of the mental state examination and risk assessment conducted by RPN Cheslin, and liaised with Psychiatric Triage. Mr Buckland did not conduct any mental health or risk assessments himself. Although this appears to be a missed opportunity to potentially identify Mr Churches' risk of absconding, I do not find that it contributed to his death. A thorough assessment had been conducted four hours earlier to place Mr Churches on the Assessment Order and Mr Buckland and ED staff were consequently fully aware of Mr Churches' intention to suicide when he returned home. Notwithstanding a lack of formal risk assessment, Mr Churches was placed in a highly visible bed in the ED and a plan was implemented to initiate a Code Grey should he attempt to abscond.

47. Pursuant to SVH's ED Mental Health Guidelines, the EDMH clinician has a responsibility to monitor waiting times for mental health consumers within the ED[58] and to notify management if a consumer has been in ED for 12 hours.[59] Mr Churches had only been in the ED for three hours before he absconded, therefore there was no obligation on Mr Buckland to escalate this waiting time to management. Three hours is not an unreasonable amount of time to wait for a mental health assessment particularly given Mr Churches' calm presentation, lack of psychotic symptoms and stable mood. Under the MHA, Mr Churches was required to be examined by an authorised psychiatrist 'as soon as practicable', but within 24 hours after arriving at a designated mental health service.[60]

---

[57] St Vincent's Hospital Psychiatric Triage and Emergency Department Mental HealthGuidelines, page 4.
[58] St Vincent's Hospital Psychiatric Triage and Emergency Department Mental HealthGuidelines, page 4.
[59] St Vincent's Hospital Psychiatric Triage and Emergency Department Mental Health Guidelines, page 5.
[60] Section 36 MHA.

48. A mental health assessment of Mr Churches upon his arrival at the ED may have helped inform risk management and potentially reduced the risk that he would abscond.

49. I note that in response to Mr Churches' death, SVH reviewed and amended its ED Mental Health Guidelines to ensure compulsory patients receive a mental health assessment on arrival at the ED. In his statement, Associate Professor Bosanac, SVH's Director of Clinical Services, did not specify if this refers to a standard mental health assessment conducted by the EDMH clinician or the legally required examination by an authorised psychiatrist.[61] Regardless, this is a constructive amendment to the ED Mental Health Guidelines.

50. It is not clear exactly when Mr Churches was last seen by ED staff. Statements provided by SVH staff suggest that Mr Churches was last observed in his cubicle at 3.30pm though who made this observation was not stated and the medical records provide no clarification. That said, Mr Churches was not subject to a formal visual observation schedule,[62] nor was specialling considered clinically indicated, therefore staff were not required to monitor him or document observations at specific times.

51. Mr Churches was placed in a highly visible bed to enhance observation. Dr Gerlich had, appropriately, considered one-to-one supervision of Mr Churches during her review. Her clinical decision that specialling was not required was reasonable in the circumstances and at the time that decision was made. Although Mr Churches could be considered at significant risk of suicide (with a developed plan and high-lethality means apparently available at home), he did not exhibit other risk factors commonly associated with absconding such as a disorganised mental state, aggression, alcohol or substance use, poor co-operation, a stated intention to leave, or a known history of absconding. There is limited research on risk factors for absconding from EDs and no reliable validated assessment tools. Assessment therefore involves clinical judgement and looking for markers for absconding in a patient's clinical presentation along with any available corroborative or historical information.

52. SVH ED does not have a bed or area in which patients can be held securely or against their will.[63] A Behavioural Assessment Room (**BAR**) exists for patients who exhibit disruptive and/or aggressive behaviour and present a risk to the safety and security of staff and other patients. It would not have been appropriate to place Mr Churches in the BAR as he was calm and cooperative. Similarly, it would not have been appropriate to utilise a restrictive

---

[61] CB, Statement of A/Prof Paul Bosanac.

[62] A/Prof Peter Bosanac advised in his statement that the Risk Assessment Guideline and Category of Observations Guideline are applicable to the Mental Health Acute Inpatient setting and not the ED.

[63] CB, Statement of Dr Andrew Walby.

intervention, given that pursuant to the MHA restrictive interventions such as seclusion or bodily restraint are only to be used 'after all reasonable and less restrictive options have been tried or considered and have been found to be unsuitable'.[64] Mr Churches' placement in a highly visible bed with general observations was a reasonable plan given his apparent cooperation and calm presentation.

53. It is nonetheless concerning that Mr Churches was able to leave a highly visible bed and the hospital without anyone in the nursing station observing him. There is no value in placing a vulnerable patient in a highly visible bed if there is not consistent and continuous observation. I note SVH's Director of Emergency Medicine Dr Andrew Walby's comment that between 2pm and 4pm is the busiest period of the day with staff changeover and a large number of people moving through ED.[65] Mr Churches appears to have opportunistically absconded from ED during this time.

54. Since Mr Churches' death, in the 2018/2019 State Government Budget, SVH received funding to develop an ED crisis hub for people needing urgent mental health treatment.[66] The aim of the ED crisis hub is to relieve pressure on emergency departments due to increasing numbers of mental health presentations, and to ensure patients who present with acute mental health issues receive fast-tracked specialist treatment. At the time of the inquest, the specifics of the crisis hub's operation had not been clarified.[67] Implementation of the crisis hub innovation, and its contribution to the management of emergent psychiatric patients, will be watched with interest.

SVH's Notification to Police that Mr Churches had absconded from the ED

55. Although SVH staff responded promptly to Mr Churches' disappearance from the high visibility cubicle once it was appreciated, as noted above, only two of the three forms used by designated mental health services to notify police that a compulsory patient has absconded were completed. A/Professor Bosanac conceded that this omission meant that staff had only complied 'in part' with the applicable Absent and Absconded Patient Policy.[68]

---

[66] See Media Release: https://www.premier.vic.gov.au/wp-content/uploads/2018/05/180510-New-Mental- Health-Hubs-To-Treat-More-Victorians-Sooner .pdf
[67] CB, Statement of A/Prof Bosanac dated 4 June 2018.
[68] CB, Statement of A/Prof Peter Bosanac. SVH's Absent or Absconded Patient Policy requires a 'phone call to the section Sergeant … to inform the Police of a missing person' and that the 'appropriate forms' be completed and emailed/faxed to the Police. Three forms are listed in the policy are: a Personal Physical Description form (VP L10), a Missing Person & Risk Assessment form (VP L18), and an Apprehension of Patient Absent without Leave form (MH124).

56. It is not clear whether the failure by SVH staff to complete the MHA124 was due to a lack of awareness of, or a lack of compliance with, the policy. A/Professor Bosanac advised that ED staff 'will be reminded of the need to complete the MHA124 for patients who abscond who are under the MHA'.[69]

57. The MHA124 is the document that authorises police to apprehend the named person and take him or her to a designated mental health service. The MHA124 also includes a section in which important information that will assist with apprehension may be recorded. Among the prompts provided on the form are the urgency of apprehension and an address where the person may be found.[70] Indeed, in the case of patients subject to compulsory treatment under the MHA, there would appear to be little value in completing any form other than the MHA124 as it captures all the information required in the other two forms *and* provides opportunity to convey urgency of response. Without the MHA124, although Fitzroy Police were aware that Mr Churches was an involuntary patient and suicidal, police were **not** aware of the need for an urgent response.

58. The available evidence suggests that the best opportunity to prevent Mr Churches' death was for police to intercept him between the time his departure from the ED was reported at about 3.50pm and when he entered his unit at 4.20pm. SVH was invited to respond to this proposition[71] and did so in the following terms:

> *… [i]f it is suggested that not completing the MHA 124 Form and only completing the VP Form L10- Person Physical Description and the VP Form L18A Missing Person and Risk Assessment form, somehow hindered or did not fully enable [an] attempt to intercept Mr Churches before reaching his home, then there is no evidence before the court to (on the basis of the material known to St Vincent's) form such a conclusion.*[72]

59. It is not possible to say that had police understood the urgency of the situation that they could have apprehended Mr Churches prior to his arrival at his unit. However, completion of the MHA124 with information about the urgency of the matter would have provided an opportunity for police to prioritise their response.

60. At the time Mr Neilson reported the presence of Mr Churches at his unit, Boroondara Police were not aware of his compulsory status nor his suicide risk and did not respond with urgency. By the time SC Stamatakos and SC Penhalluriak attended at the unit they had obtained that

---

[69] Statement Associate Professor Peter Bosanac.
[70] Apprehension of Patient Absent Without Leave (MHA124).
[71] Correspondence from the Court to SVH dated 26 August 2020.

information. An earlier attendance by Boroondara Police at Mr Churches' home would not have prevented his death: he was alive when police arrived and remained so until at least 7.20pm.[73] Mr Churches refused to engage with police or to allow them entry to his home.

Police response and attendance at 177 Power St Hawthorn

61. The police's response to Mr Neilson's report that Mr Churches had contravened the PSIO by returning home at about 4.20pm on 1 November 2017, including their attendance at the apartment block at 6.20pm and escalation of the incident to the CIRT were reasonable and appropriate in the circumstances.

62. I find that the steps taken to gain entry to the premises, particularly given the risks associated with potential exposure to cyanide, were also reasonable and appropriate.

FINDINGS AND CONCLUSION:

63. Having held an inquest into the death of Anthony Lansell Churches, I make the following findings, pursuant to section 67(1) of the Act:

    (a) The identity of the deceased was Anthony Lansell Churches, born on 19 November 1946;

    (b) Mr Churches intended to take his own life and the death occurred on 1 November 2017 at Unit 14 of 177 Power St Hawthorn, Victoria, from Cyanide Toxicity;

    (c) That the death occurred in the circumstances set out above.

64. I convey my sincerest sympathy to Mr Churches' family.

65. I order that this finding be published on the Internet.

---

[72] Correspondence from SVH's Legal Counsel to the Court dated 4 September 2020.

[73] CB, Statement of SC Stamatakos (who stated on the police radio that he had observed Mr Churches through the bedroom window at 7:20pm).

RECOMMENDATIONS

Pursuant to section 72(2) of the Act, I make the following recommendation connected with the death:

1. That St Vincent's Health conduct a review of training programs (induction training for new ED staff and periodic training for ongoing ED staff) and any associated materials (hard copy and online) to ensure that they include comprehensive guidance about the response required in the event that a compulsory psychiatric patient absconds and highlights the importance, purpose and use of the MHA124 form when notifying police.

2. That St Vincent's Health consider the introduction of measures to improve observation of patients at risk of absconding from the ED during the afternoon change of shift (2pm-4pm).

3. That St Vincent's Health provide an update about implementation of its mental health crisis hub including a comment on anticipated (or actual) improvements to patient supervision, absconding risk minimisation or other aspects of mental health management in the emergency department, and how these will be monitored and evaluated.

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

Mr Churches' family

Chief Commissioner of Police

St Vincent's Health

Chief Psychiatrist

Coronial Investigator

Signature:

Judge John Cain
State Coroner

Date: 21 October 2020

NOTE: Under section 83 of the **Coroners Act 2008** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an inquest. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.