IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2016 5581

FINDING INTO DEATH FOLLOWING INQUEST

Form 37 Rule 63(1)

*Section 67 of the **Coroners Act 2008***

INQUEST INTO THE DEATH OF ADAM LAUFER

Findings of:	Judge John Cain State Coroner
Delivered on:	26 July 2021
Delivered at:	Coroners Court of Victoria 65 Kavanagh Street, Southbank, Victoria, 3006
Inquest Hearing Dates:	2-4 June 2021
Counsel Assisting:	Ms Naomi Hodgson of Counsel instructed by Lindsay Spence, Principal In-House Solicitor
Family of Adam Laufer:	Mr Kevin Armstrong of Counsel
Chief Commissioner of Police:	Mr Paul Lawrie of Counsel instructed by Katherine Goldberg, Norton Rose Fulbright
Ambulance Victoria:	Ms Roslyn Kaye of Counsel instructed by Fiona Karmouche, Lander & Rogers

I, Judge John Cain, State Coroner, having investigated the death of Adam Laufer, and having held an inquest in relation to this death from 2-4 June 2021 at Melbourne, find that:

- the identity of the deceased was Adam Laufer born on 14 October 1984; and
- the death occurred on 24 November 2016 at LaTrobe Street Overpass, Docklands;
- from 1(a) multiple injuries sustained in a fall from a height

in the following circumstances:

BACKGROUND:

1. Adam, as his family wish him to be known, was born on 14 October 1984 to Maxine and Dr Eljas Laufer and was 32 years old at the time of his passing on 24 November 2016. Adam lived with his parents in Brighton.

2. Adam's father describes his major interests from his early teenage years as being an avid reader around all forms of sport, mostly but not exclusively football (both AFL and soccer), cricket, tennis, athletics and thoroughbred horse racing.

3. Adam completed his VCE at Wesley College, Prahran in 2002 and was accepted into a Bachelor of Arts at Victoria University and subsequently transferred across to a combined Bachelor of Arts/Bachelor of Law degree. Around 2006 Adam's father observed that Adam's attendance at University was inconsistent, his grades were falling, and his mental health was deteriorating.[1]

Medical History

4. Adam had a complex medical history and over time he had been under the care of various health professionals, psychiatrists and psychologists.

[1] Statement of Dr Eljas Laufer, Inquest Brief, p18.

5. Following these observations in 2006, Dr Laufer contacted colleague Professor Tong who facilitated a consultation for Adam with psychiatrist, Dr Tiller. Dr Laufer gave evidence that Dr Tiller informed him that Adam was extremely depressed and commenced him on an SSRI that after a short period resulted in Adam becoming acutely manic, refusing to cease taking the medication, and confining himself to his bedroom which he totally disorganised and effectively destroyed.[2] Ultimately Adam was arrested pursuant to the *Mental Health Act* and conveyed to Monash Hospital where he spent several weeks as an inpatient under psychiatric care.

6. Adam was released as a voluntary out-patient under the care of a private psychiatrist at the Albert Road Clinic, with Dr Cocks diagnosing Adam as suffering from bipolar depression given his clinical presentation and positive family history.[3] By this stage Adam was no longer attending University and was admitted at various stages as a voluntary inpatient into the Albert Road Clinic and then into the Delmont Hospital. Adam however absconded from the Delmont Hospital against medical advice and as a consequence was diagnosed with schizophrenia, placed under a Community Treatment Order (CTO) and treated with Risperidone.[4] Dr Laufer in both his written and oral evidence stated that he considered schizophrenia was a mis-diagnosis and that he believed that the correct diagnosis of Adam's condition was bipolar disorder.[5]

7. Over the ensuing decade Adam moved between psychiatrists, psychologists as well as multiple General Practitioners and he ultimately successfully appealed against the Community Treatment Order.[6] Dr Laufer gave evidence that as a consequence of the Risperidone, Adam's weight increased significantly resulting in Adam becoming reclusive staying in his room reading books, watching television or on the internet.[7]

8. At the time of his death, Adam did not have a current psychiatrist, but he was under the care of psychologist, Dr Jeffrey Edmonds. He wasn't taking any antipsychotic medication and according to his father, had not done so for about a year.[8] It appears from both the medical records and the witness statements, that Adam had little or no insight into his psychiatric illness.

---

[2] Ibid, p18.
[3] Ibid, p19.
[4] Ibid, p19.
[5] Inquest Transcript 22.14-19; Statement of Dr Eljas Laufer, Inquest Brief, p20.
[6] Statement of Dr Eljas Laufer, Inquest Brief, p20.
[7] Ibid, p22.
[8] Ibid, p21.

9. Dr Pytharoullos provided a statement in respect of Adam's pattern of behaviour that he always believed that he had multiple physical ailments and requested multiple investigations and would persist until he could find a doctor to agree with him. Adam refused to discuss anything relating to his psychiatric illness and medications and attempts to discuss the possibility of psychiatric illness were refused by Adam.[9]

THE PURPOSE OF A CORONIAL INVESTIGATION

10. Adam's death constitutes a '*reportable death*' under the *Coroners Act 2008* (Vic) (**the Act**), as Adam resided in Victoria[10] and the death appears to have been unnatural and unexpected.[11]

11. The jurisdiction of the Coroners Court of Victoria is inquisitorial.[12] The role of the Coroner is to independently investigate reportable deaths to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.[13] Surrounding circumstances are limited to events which are sufficiently proximate and causally related 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 expression "*cause of death*" refers to the medical cause of death, incorporating where possible, the mode or mechanism of death.

14. For coronial purposes, the phrase "*circumstances in which death occurred*,"[16] 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.

---

[9] Statement of Dr Despina Pytharoullos, Inquest Brief, p120.
[10] Section 4 *Coroners Act 2008.*
[11] Section 4(2)(a) *Coroners Act 2008.*
[12] *Coroners Act 2008* (Vic) s 89(4).
[13] *Coroners Act 2008* (Vic) preamble and s 67.
[14] *Keown v Khan* (1999) 1 VR 69.
[15] *Coroners Act 2008* (Vic) s 69 (1).
[16] *Coroners Act 2008* (Vic) s 67(1)(c).

15. 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*" mandate.

16. Coroners are also empowered:

    (a) to report to the Attorney-General on a death;[17]

    (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;[18] 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.[19]

    These powers are the vehicles by which the prevention role may be advanced.

17. The Victoria Police assigned Senior Constable Lambros Ouzounis to be the Coroner's Investigator for the investigation into Adam's death. The Coroner's Investigator conducted inquiries on my behalf and submitted a coronial brief of evidence.

18. This Finding draws on the totality of the material obtained in the coronial investigation of Adam's death, that is, the Court File, the Coronial Brief prepared by the Coroner's Investigator, further material obtained by the Court, together with the transcript of the evidence adduced at Inquest and the closing submissions of Counsel.[20]

19. All coronial findings must be made based on proof of relevant facts on the balance of probabilities.[21] The strength of evidence necessary to prove relevant facts varies according to the nature of the facts and the circumstances in which they are sought to be proved.[22]

---

[17] *Coroners Act 2008* (Vic) s 72(1).
[18] *Coroners Act 2008* (Vic) s 67(3).
[19] *Coroners Act 2008* (Vic) s 72(2).
[20] From the commencement of the Act, that is 1 November 2009, access to documents held by the Coroners Court of Victoria is governed by section 115.
[21] *Re State Coroner; ex parte Minister for Health* (2009) 261 ALR 152.
[22] *Qantas Airways Limited v Gama* (2008) 167 FCR 537 at [139] per Branson J (noting that His Honour was referring to the correct approach to the standard of proof in a civil proceeding in the Federal Court with reference to section 140 of

20. In determining these matters, I am guided by the principles enunciated in *Briginshaw v Briginshaw*.[23] The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals or entities, unless the evidence provides a comfortable level of satisfaction that they caused or contributed to the death.

21. Proof of facts underpinning a finding that would, or may, have an extremely deleterious effect on a party's character, reputation or employment prospects demands a weight of evidence commensurate with the gravity of the facts sought to be proved.[24] Facts should not be considered to have been proven on the balance of probabilities by inexact proofs, indefinite testimony or indirect inferences. Rather, such proof should be the result of clear, cogent or strict proof in the context of a presumption of innocence.[25]

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

22. On 13 December 2016, DNA testing conducted by Zoe Bowman, Molecular Biologist at the Victorian Institute of Forensic Medicine established the identity of the deceased as Adam.

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

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

24. On 2 December 2016, Dr Saeedi, Forensic Pathology Registrar at the Victorian Institute of Forensic Medicine performed an autopsy upon Adam's body. Post-mortem examination revealed multiple injuries predominantly involving the right side of the head, face, trunk, upper and lower limbs with associated fractures, internal bleeding, lacerations and contusions of internal organs.

25. Dr Saeedi formulated the cause of death as

1(a) **Multiple injuries sustained in a fall from a height**

26. Toxicological analysis of a post-mortem blood sample did *not* detect any ethanol, common drugs or poisons.

---

the *Evidence Act 1995* (Cth); *Neat Holdings Pty Ltd v Karajan Holdings Pty Ltd* (1992) 67 ALJR 170 at 170-171 per Mason CJ, Brennan, Deane and Gaudron JJ.
[23] (1938) 60 CLR 336.
[24] *Anderson v Blashki* [1993] 2 VR 89, following *Briginshaw v Briginshaw* (1938) 60 CLR 336.
[25] *Briginshaw v Briginshaw* (1938) 60 CLR 336 at pp 362-3 per Dixon J.

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

27. On the 24 November 2016 at approximately 8.00pm Adam walked along Spencer Street in the Melbourne CBD, from Southern Cross Railway Station towards Latrobe Street. He turned left into Latrobe Street and continued until he was above the railyards on the Latrobe St overpass. Adam waited there for a short time and then climbed over the overpass railing and jumped to the tracks below landing on his head and right side[26]. Adam passed away at the scene. Adam's conduct in climbing up over the bridge railing and jumping unassisted was seen by a number of eyewitnesses[27] as well as recorded on CCTV footage.

Events proximate to Adam's death.

28. At 12.36am on 23 November 2016, Officers from Bayside Police Station attended Cabrini Hospital, New Street, Brighton following reports that Adam had been standing outside the hospital for approximately one hour and had stated that he had an appointment tomorrow but had nowhere to go.[28]

29. Senior Constable Neave (S/Cst Neave) and Senior Constable Rakib (S/Cst Rakib) spoke with Adam who stated that he did not intend to go home that evening however would not disclose the reasons as to why. He further stated that he had a doctor's appointment at Cabrini Hospital the following morning. Despite S/Cst Neave encouraging Adam to return home or to go to a friend's or relative's house until the appointment, Adam remained adamant that he would not return home.[29],[30]

30. S/Cst Neave and S/Cst Rakib consulted each other and whilst they formed the opinion that Adam's behaviour was unusual, and they had some concerns regarding remaining out all night in the elements, they also concluded that Adam presented as calm and exhibited no delusional or erratic behaviour. They conducted a number of routine enquiries on the LEAP system that detailed his prior involvements with Victoria Police, including that Adam did suffer from mental health issues.

---

[26] Statement of Rachel Norman, Inquest Brief, p49.
[27] Ibid.
[28] Statement of S/Cst Neave, Inquest Brief, p51-52; Statement of S/Cst Rakib, Inquest Brief, p57-58.
[29] Ibid.
[30] Inquest Transcript, 114.16-22.

31. Ultimately the Officers concluded that Adam's presentation failed to meet the requisite threshold pursuant to s351 *Mental Health Act 2014*, that is Adam neither appeared to have a mental illness nor was there evidence available that he needed to be apprehended to prevent serious and imminent harm to himself or another person.[31]

32. Senior Constables Neave and Rakib then departed Cabrini Hospital leaving Adam at the location. During the routine enquiries conducted on the LEAP system S/Cst Neave had located a telephone number for Dr Eljas Laufer which he subsequently contacted approximately 12.46am. S/Cst Neave gave evidence that Dr Laufer informed him that Adam must have suffered a psychotic break and requested the Officers to transport Adam home in the divisional van.[32] However S/Cst Neave informed Dr Laufer that they had already departed Cabrini Hospital and were no longer in a position to assist. S/Cst Neave indicated to Dr Laufer that they had no legal authority to force Adam to be conveyed home or to hospital against his will in the circumstances.[33],[34] In light of Dr Laufer expressing that Adam had suffered a psychotic break, S/Cst Neave indicated further to Dr Laufer the importance that Adam attend his doctor's appointment the following morning as well as the possibility of Dr Laufer contacting the Crisis Assessment Team.[35]

33. Dr Laufer arrived at the Cabrini Hospital within approximately 15 minutes however was unable to locate Adam. He subsequently drove through the streets of Brighton and the Bayside suburbs into the early hours of the morning without locating Adam.[36]

34. Later that morning on 23 November 2016 Adam attended the consulting rooms of rheumatologist A/Professor Ryan at the Cabrini Hospital. The exact timing of this attendance is unclear as Adam arrived without an appointment and neither A/Professor Ryan nor his Practice Manager recorded the time.[37] A/Professor Ryan observed that Adam's speech was delusional and that he was referring to radiation zones around his house and cosmic voices. There was no opportunity to make a full assessment of Adam's mental state as he departed the waiting room after a short period of time. The Practice Manager contacted Mrs Laufer who attended to pick Adam up, and who gave evidence that Adam left with Mrs Laufer in a compliant manner.[38] Dr Laufer however indicates that once outside, Adam refused to return home with Mrs Laufer and instead walked off indicating that he was going to see Dr Edmonds.[39]

---

[31] Statement of S/Cst Neave, Inquest Brief, p51-52; Statement of S/Cst Rakib, Inquest Brief, p57-58.
[32] Statement of S/Cst Neave, Inquest Brief, p51-52.
[33] Inquest Transcript 48.16-19; 48.24-27.
[34] Inquest Transcript 112.22-113.14.
[35] Inquest Transcript 48.28-49.
[36] Statement of Dr Eljas Laufer, Inquest Brief, p23.
[37] Statement of A/Professor Ryan, Inquest Brief, p45; Statement of Kerry Lawson, Inquest Brief, p47.
[38] Statement of Kerry Lawson, Inquest Brief, p47.
[39] Statement of Dr Eljas Laufer, Inquest Brief, p24.

35. That same day Adam also attended a consultation with his GP Dr Pytharoullos who indicated she did not perform a formal mental state assessment as Adam declined them or became upset if attempts were made to perform them. During the consultation Adam stated that the reason his parents never believed him about his ailments and thought he had a psychiatric illness was because they were controlled by the illuminati. This was of concern to Dr Pytharoullos as it suggested further psychotic symptoms in addition to Adam's usual delusions. She then discussed with Adam that she was concerned about his mental state however he denied any suicidal ideation on direct questioning and was calm but requested an appointment for the following day for further discussion. Further Adam also informed her that he had a referral from another doctor to see a new psychiatrist, Dr Chris Corcos, a week later. Dr Pytharoullos stated that Adam never presented with any suicidal ideation, rather with irrational fears of various physical illnesses and wishing those to be treated.[40]

36. Sometime around 6.30pm Adam attended a consultation with psychologist Jeffrey Edmonds, who gave evidence that

> *Adam came in for his session and spoke about a number of non-essential topics, though he kept looking at my desk in a peculiar manner. He also complained about the lights being too bright. When asked whether he was experiencing psychotic symptoms, he flatly replied that he was not. At the very end of the session he asked me to accompany him to the ED to hold his hand while he died of supposed physical ailments he felt he had. Adam always suffered from body and illness delusions, and felt that this was his last day … … I told him that I would not be accompanying him and to email me how he was the next day, as that is always what he did in the past. He was very upset about my decision, but not aggressive. Before this, I asked him 3x in different ways whether he was a suicidal risk, which he denied. When I closed the door, he hit the window open-handed but then walked away. I then saw Adam walk slowly down the alley … … He appeared calm*.[41]

37. At 8.56pm Adam attended the Austin Hospital Emergency Department complaining of bowel problems. He was seen by a triage nurse and assessed as a category 5 however departed prior to being seen by medical staff.

[40] Statement of Dr Despina Pytharoullos, Inquest Brief, p120-121.
[41] Statement of Jeffrey Edmonds, Inquest Brief, p48.

38. Just before 1.00am on Thursday 24 November 2016 a taxi responded to a job via the dispatcher and attended Austin Hospital to convey Adam home to Brighton. Upon arriving at the hospital Adam indicated to the taxi driver that he didn't have any money to pay the fare however he would pay when he reached the destination. This arrangement was not acceptable to the taxi driver resulting in Adam calling his father and a subsequent conversation occurring where Dr Laufer confirmed with the taxi driver that he would cover the entire fare. The taxi driver recalled in respect of Adam that nothing seemed out of the ordinary apart from the fact that he was scruffy looking however was calm. Upon arriving at the Brighton address, Adam immediately left the taxi and walked into the residence without waiting for Dr Laufer who subsequently attended and paid the fare.[42]

39. In Dr Laufer's opinion Adam appeared inappropriately elated by contrast to the events of the previous day and was somewhat manic in contrast to his previous very depressed state. Adam proceeded to shower, wash and dry the clothes that he had been wearing, redressed in a hooded cotton jacket, tracksuit pants and bright orange sneakers and around 3.20am departed the residence against Dr Laufer's urging.[43]

40. Adam walked from Were Street via Hanby Street to Dendy Street and then onto Hampton Street. Dr Laufer followed Adam in his vehicle and called Triple Zero on three separate occasions (3:35:52am, 3:37:55am and 3:49:43am), reporting variously that Adam was psychotic and suffering from schizoaffective disorder, was having a mental breakdown and highly paranoid, however that Adam was not violent, had never been violent towards police and that Adam needed to be transported by Ambulance Victoria to Monash.[44]

41. In response to the multiple Triple Zero calls, dispatch jobs were broadcast requesting the attendance of both Victoria Police and Ambulance Victoria.

42. S/Cst Neave and Senior Constable Ashton (S/Cst Ashton) were working the Bayside night-shift divisional van (SBY311) in the early hours of Thursday 24 November 2016 and responded to the broadcast. They arrived at Hampton Street a short distance north of Dendy Street at 3.51am.[45] Upon their arrival they observed Adam walking along the footpath being followed by Dr Laufer in his vehicle.

[42] Statement of Mohit Sharma, Inquest Brief, p43.
[43] Statement of Dr Eljas Laufer, Inquest Brief, p25.
[44] Event Chronologies E1611179421, E16112410150 & E16112410164, Inquest Brief, p161-175.
[45] ePDR Form for SBY311 23/11/2016 23:00 – 24/11/2016 07:00, Inquest Brief, p157.

43. Paramedics Steven Allen and Zoe Welsh (BN418) responded to the Ambulance Victoria broadcasts, acknowledging the job at 3.39am. Whilst they arrived at the initial broadcast location at 3.47am, they had difficulty locating Adam, Dr Laufer and Victoria Police requesting updated location details at 3.58am that, once provided, enabled them to arrive on-scene approximately 4.03am.[46]

44. The interaction between Adam, Dr Laufer, Senior Constables Neave and Ashton and Paramedics Allen and Walsh was the focus of the evidence at Inquest and is discussed later in this Finding.

45. Whilst the exact time is unknown, following this interaction Adam departed in a taxi that had been requested by Senior Constables Neave and Ashton on his behalf. The taxi driver gave evidence that when questioned whether Adam was able to pay the fare the Police Officer indicated that he had. The taxi driver described Adam as very quiet throughout the journey that ended when he dropped Adam at the taxi rank at the corner of King and Bourke Streets. Adam attempted to pay for the fare with a card that was declined and the taxi driver then left, indicating '*I didn't want to fight and argue and left him there*'.[47]

46. Little is known in respect of Adam's whereabouts between arriving in the Melbourne CBD around 5.00am or thereabouts and the tragic events that transpired some fifteen hours later at the Latrobe Street overpass.

47. What is known is that during the morning Jeffrey Edmonds called Dr Pytharoullos expressing concerns in respect of Adam's mental state however indicated that Adam had left yesterday's consultation peacefully and did not feel the need to call the CATT team. They agreed that given Adam had an appointment with Dr Pytharoullos later that day that the CATT team was not warranted at this point in time.[48] Adam failed to attend his appointment with Dr Pytharoullos and was sent a text message as well as attempts were made to reach him by telephone.[49]

[46] ERTCOMM Event Register E16112410147, E16112410150 & E16112410164, Inquest Brief, p128-135.
[47] Statement of Gaiver Aptourahman Ali, Inquest Brief, p494-495.
[48] Statement of Dr Despina Pytharoullos, Inquest Brief, p121.
[49] Ibid, p121.

48. At some time during the day Adam attended the office of Jeffrey Edmonds, although it was not possible for a consultation to be arranged at short notice. The record notation reported that Adam was pleasant, calm and was just sitting and waiting and walking around looking bored. Adam was informed that whilst a consultation was unavailable, Mr Edmonds would email him later that day (which he did at 4.22pm).[50]

49. Late in the afternoon Mrs Laufer received a telephone call that was an attempt at a reverse charge from Adam, however upon accepting the reverse charge and pressing '9' on her telephone there was no response at the other end.[51]

Scope of the Inquest

50. At a Directions Hearing held before Coroner Michelle Hodgson on the 6 November 2019, the Inquest Scope was determined, pursuant to section 64(b) of the *Coroners Act 2008*, as follows:

    (a) How did Adam present to Dr Eljas Laufer, the Police members and Ambulance Paramedics on 24 November 2016?

    (b) What assessments were performed on Adam at this time, and what conclusions were drawn about those assessments?

    (c) What information was communicated between the Police members and Ambulance Paramedics about Adam's presentation on 24 November 2016?

    (d) What information did Ambulance Paramedics rely upon to determine to leave the scene on 24 November 2016?

    (e) What information did the Police members rely upon to determine that it was appropriate for Adam to leave the scene in a taxi on 24 November 2016?

[50] Medical Records of Adam Laufer, Melbourne Counselling, Clinical Psychologist Jeff Edmonds.
[51] Statement of Dr Eljas Laufer, Inquest Brief, p29.

51. The inquest heard evidence from:

    (a) Dr Eljas Laufer (Adam's Father)

    (b) Senior Constable Dane Neave, Victoria Police

    (c) Senior Constable Bennett Ashton, Victoria Police

    (d) Ambulance Paramedic Zoe Welsh

52. On application by Ambulance Victoria, I excused Ambulance Paramedic Steve Allen from giving evidence on medical grounds. The evidence supporting Paramedic Allen's application to be excused was provided to all Interested Parties following which the application was not opposed. I draw no adverse inference from Paramedic Allen's absence.

How did Adam present to Dr Eljas Laufer, the Police members and Ambulance Paramedics on 24 November 2016?

Adam's Presentation to Dr Eljas Laufer

53. Dr Laufer's initial telephone call to Triple Zero was at 3.35am and in that, and two subsequent calls, the call-taker recorded being informed that Adam was '*psychotic*', '*schizoaffective dx*', '*has had mental breakdown*', '*demeanour – passive aggressive*', '*behaving bizarrely*' and '*highly paranoid*'.[52]

54. Dr Laufer in a written statement gave evidence that upon the initial arrival of Police members, he informed them that '*Adam suffers from long standing bipolar depression of 10 years duration and in the last 24 hours has had an acute relapse. He has become psychotic, delusional and paranoid according to my own observations of his sudden change in behaviour and this is also the opinion of A/Professor Peter Ryan whom he consulted at around midday yesterday and recommended that he requires urgent hospitalisation in a psychiatric unit because of his paranoid delusional state*'.[53]

[52] ERTCOMM Event Register E16112410147, Inquest Brief, p128-130.
[53] Statement of Dr Eljas Laufer, Inquest Brief, p25.

55. At Inquest Dr Laufer was specifically questioned in respect of his observations of Adam that evening and it was put to Dr Laufer by Counsel Assisting that '*you didn't observe anything in his behaviour that was then present for the others to see that would have been, in your experience, to be demonstrative of him being acutely psychotic and unwell*' to which Dr Laufer replied '*apart from him walking backwards as the police came, trying to – shining the flashlight on his mobile phone at me and failing to take photographs, which was indicative of paranoia, something he'd never ever done before, which I suspect police saw, nothing apart from that*'.[54]

Adam's Presentation to the Police members

56. Upon their arrival S/Cst Neave recognised Adam from his interaction that had occurred the prior evening.[55] During the following interaction S/Cst Neave primarily spoke with Adam whilst S/Cst Ashton primarily spoke with Dr Laufer, separated by some distance. Dr Laufer estimated that distance to be some 15-20 metres.[56],[57] In evidence S/Cst Neave indicated that the separation of parties was intentional as '*it is pretty common that we want to speak to people individually to get their versions without them cutting over the top of one another*'.[58]

57. S/Cst Neave in a written statement gave evidence that '*Adam stated he could not live with his father any longer and that he was overbearing and controlling and used Adam's mental health history to attempt to control him … … Adam told me that he no longer wished to reside with his parents. I asked him what his plan was and he said he would find one nights accommodation in the city and would then attempt to arrange longer term lodgings elsewhere. I asked him how he would pay for this and he stated that he received payments from Centrelink*'.[59] It was however abundantly clear to S/Cst Neave that Adam was neither willing to be transported to hospital or participate in any form of voluntary assessment.[60]

[54] Inquest Transcript, 38.14-24.
[55] Statement of S/Cst Neave, Inquest Brief, p53.
[56] Statement of Dr Eljas Laufer, Inquest Brief, p26.
[57] Inquest Exhibit #2, Hand-drawn sketch by Dr Eljas Laufer.
[58] Inquest Transcript, 139.22-25.
[59] Statement of S/Cst Neave, Inquest Brief, p53-54.
[60] Inquest Transcript, 93.27-94.2.

58. In S/Cst Neave's assessment, '*Adam presented himself calmly and followed the conversation without issue. He exhibited no delusions, erratic behaviours or other obvious signs of mental health issues … … his explanation appeared rational and he was capable of expressing himself clearly*'.[61]

59. Prior to Adam leaving, S/Cst Neave had a conversation with S/Cst Ashton regarding their respective conversations with Adam and Dr Laufer, with S/Cst Neave conveying to S/Cst Ashton what Adam had told him.[62]

Adam's Presentation to Ambulance Paramedics

60. Paramedic Steve Allen in a written statement gave evidence that upon his arrival he observed a police officer engaged in conversation with Adam, and that '*the male appeared calm and was speaking normally with the police officer*'. [63] Paramedic Allen briefly introduced himself to Adam and asked him how he was going however Adam gave no response.[64]

61. Paramedic Zoe Welsh had no interaction with Adam and provides no relevant observations of Adam within her evidence.

Adam's Presentation on the evening of 24 November 2016

62. I find that to Dr Laufer, Adam presented as suffering from an ongoing bipolar mental health condition characterised by mood swings between acute mania through to acute depression.

63. I find that to S/Cst Neave, Adam presented that evening as quietly spoken, calm, able to engage and provide clear and cogent answers throughout the conversation. I find that Adam's presentation, behaviour and demeanour throughout his entire interaction with S/Cst Neave exhibited no evidence that he appeared to have mental illness[65] nor that he was at risk of inflicting serious and imminent harm either to himself or another person.

[61] Statement of S/Cst Neave, Inquest Brief, p53.
[62] Ibid, p63.
[63] Statement of Paramedic Steve Allen, Inquest Brief, p122.
[64] Ibid, p124.
[65] Defined in s4 *Mental Health Act 2014* as a medical condition that is characterised by a significant disturbance of thought, mood, perception or memory.

What assessments were performed on Adam at this time, and what conclusions were drawn about those assessments?

What information did the Police members rely upon to determine that it was appropriate for Adam to leave the scene in a taxi on 24 November 2016?

64. Dr Laufer in a written statement gave evidence that upon the initial arrival of Police members, he informed them that '*Adam suffers from long standing bipolar depression of 10 years duration and in the last 24 hours has had an acute relapse. He has become psychotic, delusional and paranoid according to my own observations of his sudden change in behaviour and this is also the opinion of A/Professor Peter Ryan whom he consulted at around midday yesterday and recommended that he requires urgent hospitalisation in a psychiatric unit because of his paranoid delusional state*'.[66]

65. S/Cst Neave in a written statement indicated that throughout his conversation with Adam he assessed as presenting '*calmly and followed the conversation without issue. He exhibited no delusions, erratic behaviours or other obvious signs of mental health issues … … he was capable of expressing himself clearly*'.[67]

66. S/Cst Neave stated that he pushed Adam to see if he would slip up or could be provoked, he was challenging his version and his plans and further stated that he '*was fanning – being somewhat overbearing than I actually emotionally felt in an attempt to rattle him*'[68],[69] however Adam remained calm and quiet, he was able to advocate for himself clearly and without in anyway being rude he was polite and quietly spoken. [70]

67. Whilst S/Cst Neave was talking with Adam, S/Cst Ashton indicated in a written statement that he spoke with Dr Laufer to obtain collateral information. The precise content of that conversation is disputed by the parties involved.

[66] Statement of Dr Eljas Laufer, Inquest Brief, p25.
[67] Statement of S/Cst Neave, Inquest Brief, p53-54.
[68] Inquest Transcript, 167.23-168.7.
[69] Inquest Transcript, 93.4-13.
[70] Inquest Transcript, 167.3-5.

68. S/Cst Ashton's evidence was that he asked Dr Laufer whether Adam had made threats of self-harm or suicide that evening with Dr Laufer replying that he had not.[71] S/Cst Ashton asked Dr Laufer whether he had contacted the Crisis Assessment Team or taken Adam to hospital due to his concerns with Dr Laufer indicating that he had done neither of those.[72] In further questioning S/Cst Ashton also confirmed that Adam had not expressed a desire to be transported to hospital.[73] S/Cst Ashton questioned Dr Laufer as to whether an Involuntary Assessment Order had been issued in respect of Adam, with Dr Laufer confirming it had not.[74]

69. Dr Laufer disputed the contents of the conversation with S/Cst Ashton at Inquest, the only agreement in evidence being that Dr Laufer informed S/Cst Ashton that Adam had consulted Professor Ryan earlier that day or in the preceding days[75] and there was a subsequent discussion in respect of an assessment order.[76]

70. S/Cst Neave then spoke with Dr Laufer with S/Cst Ashton present. Dr Laufer repeated that Adam was psychotic, however S/Cst Neave indicated that Adam in his opinion was not presenting as psychotic.[77] S/Cst Neave also questioned Dr Laufer as to whether Adam had attended a doctor earlier that day and Dr Laufer indicated that he had spoken to a colleague whom Adam had visited and whom had formed the opinion that Adam was a danger to himself.[78] However when questioned further by S/Cst Neave it was established that the colleague had not issued any orders requiring involuntary psychological treatment in respect of Adam.[79] S/Cst Neave further confirmed with Dr Laufer that he had not contacted the Crisis Assessment Team during the day with his concerns.[80]

[71] Statement of S/Cst Ashton, Inquest Brief, p61.
[72] Ibid.
[73] Ibid, p62.
[74] Statement of S/Cst Ashton, Inquest Brief, p62; Statement of Dr Eljas Laufer, Inquest Brief, p26.
[75] Inquest Transcript, 212.16-19.
[76] Inquest Transcript, 63.24-65.7.
[77] Statement of S/Cst Neave, Inquest Brief, p54.
[78] Ibid, p55.
[79] Ibid, p55.
[80] Ibid, p55.

71. S/Cst Ashton gave evidence in a written statement that towards the end of the interaction '*I went and spoke to Adam, where a paramedic was also still talking to Adam. I observed that Adam was softly spoken and had his hoody pulled down partially over his face. I asked Adam if he had thoughts of suicide, or been thinking of harming himself, to which he replied no. He stated he just wanted space from his father and that he didn't want to go to hospital, as nothing was wrong with him. I confirmed what his intentions were, which was to get a taxi to the city for a hostel room … … At no point did Adam appear to be suffering from any obvious medical or psychological condition, nor did I have any immediate concerns for his welfare. Adam was very polite and cooperative'*.[81] It is noted however that no other witness gives evidence of observing S/Cst Ashton's interaction with Adam whilst Paramedic Allen was present however S/Cst Ashton rejected the assertion that such a conversation had never taken place.[82],[83]

72. It is not in dispute on all the available evidence that that evening, Adam interacted primarily with S/Cst Neave. The evidence remains in dispute as to whether S/Cst Ashton interacted with Adam as detailed within his evidence. Whether that conversation occurred between S/Cst Ashton and Adam however does not materially affect my Findings. I am satisfied that S/Cst Neave primarily interacted with and assessed Adam and made the requisite assessments pursuant to s351 *Mental Health Act* (noting that section refers specifically to 'a police officer' in the singular).

73. Adam and Dr Laufer remained separated throughout the entire interaction. Dr Laufer wanted to be involved in the conversation with Adam with S/Cst Neave stating '*he was not permitted to be part of a three way conversation which would have brought out his (Adam's) psychosis.*'[84] However S/Cst Neave indicated that '*I certainly wouldn't have encouraged Dr Laufer to directly confront Adam when Adam said he was trying to avoid his father*[85] *… … keeping parties away from each other when they're in a heightened state when emotions are running high is in our practice in our training the best way to prevent further conflict, if you try to speak to parties that are in conflict together you're just asking them to fight, which would not be appropriate for us*'.[86]

[81] Statement of S/Cst Ashton, Inquest Brief, p64.
[82] Inquest Transcript, 219.16-18.
[83] Inquest Transcript, 235.14-236.7.
[84] Inquest Transcript, 38.11-13.
[85] Inquest Transcript, 141.22-24.
[86] Inquest Transcript, 143.25-30.

Reasonableness of conduct of S/Cst Neave

74. In the absence of any form of assessment order pursuant to the *Mental Health Act 2014*, S/Cst Neave gave evidence that the only other legislated power to detain Adam was pursuant to s351 *Mental Health Act 2014*.[87] S/Cst Neave ultimately concluded that '*I did not believe Adam presented in such a way that he would meet the requirements of Section 351 of the Mental Health Act or any other legislation providing me with any power to detain him*'.[88]

75. S/Cst Neave gave evidence at Inquest that '*the first condition of the 351 arrest power is that the person presents with mental health issues. So, merely knowing that they have history of mental health issues is not sufficient to meet that standard and it's certainly not enough for the second and more severe condition, which is that the person needs to present as a clear and imminent danger to themselves or another. Again, describing historical behaviour is not going to be relevant to assessing them in that moment and it is quite a limited power in that we can only arrest where this fairly high standard is – um, is present*'.[89] In further evidence he indicated '*both nights that I spoke to Adam, his behaviour to me seemed strange, um but being strange is not grounds for anything, in terms of police intervention. He was almost too quiet and too polite but he was able to follow the conversation. He was aware of his surroundings … … He was able to rise to whatever standards that I put before him but I didn't like it. I would have rather arrested him if the power existed but no power existed*'.[90]

76. Under cross-examination by Counsel for Dr Laufer, S/Cst Neave's response to a line of questioning was insightful in respect of his obligations in respect of both the medical history conveyed to him by Dr Laufer, and the requirements that he conduct his own personal observations and assessments. When it was put to S/Cst Neave that '*so all of that information – psychotic, and you don't deny bipolar, with a long mental history and acting in a very illogical way – was still within your mind when you dealt with Adam on 24 November. Is that fair to say?*', the Senior Constable responded '*I might be being overly particular, but if you're saying was I aware that Dr Laufer had said these things, then yes, I was. If you're saying was I aware that Adam was psychotic, I would*

[87] Inquest Transcript, 94.3-27.
[88] Statement of S/Cst Neave, Inquest Brief, p54.
[89] Inquest Transcript, 96.19-30.
[90] Inquest Transcript, 98.13-24.

draw the distinction that he'd never presented to me as psychotic'.[91] Later during the exchange S/Cst Neave again indicated that '*but it's how they present on the occasion. The s351 is not um, a therapist's power, I am not delving into the persons issues. It is primarily for cases where we come in and the danger is so clear and so evident, and evident has the wording of the act says that there is no doubt whatsoever that it is necessary to detain this person for their own safety or the safety of others'.*[92]

77. It is clear on the available evidence that Adam was *not* prepared to attend hospital voluntarily for a mental health assessment[93], nor was there in existence a current Assessment Order issued pursuant to the *Mental Health Act 2014* that would have enabled Adam to have been involuntarily detained. The evidence is in dispute and cannot be reconciled in respect of the exact content of the conversations that occurred between Dr Laufer, S/Cst Neave and S/Cst Ashton that evening in respect of an assessment order.

78. What is not in dispute however is that *no* Assessment Order existed at the time of the interaction, and whilst Dr Laufer's disputed evidence is that he said to S/Cst Ashton '*I will write you an assessment order on the spot or I'll get Ryan and he will write one*', Dr Laufer subsequently conceded that himself authoring an assessment order necessarily involved Adam being transported to hospital.[94] Likewise contacting Professor Ryan to facilitate him issuing an Assessment Order would necessarily have involved delay and Adam being detained. To facilitate either option would have involved Adam being taken into police custody for at least a short period of time for which S/Cst Neave had no available power to exercise.

[91] Inquest Transcript, 117.22-30.
[92] Inquest Transcript, 121.21-30.
[93] Inquest Transcript, 79.22-24.
[94] Inquest Transcript, 79.1-12.

79. In those circumstances the only legislated power available to S/Cst Neave was pursuant to s351 *Mental Health Act 2014* that provides that:

> *(1) A police officer, or a protective services officer on duty at a designated place, may apprehend a person if the police officer or the protective services officer is satisfied that-*
>
> *a. the person appears to have mental illness; and*
>
> *b. because of the person's apparent mental illness, the person needs to be apprehended to prevent serious and imminent harm to the person or to another person*
>
> *(2) A police officer or a protective services officer is not required for the purposes of subsection (1) to exercise any clinical judgement as to whether the person has mental illness.*

80. Counsel Assisting in submissions referred me to the High Court Authority of *Stuart v Kirkland-Veenstra*[95] and in particular the judgement of Chief Justice French. Whilst this authority considered the predecessor to the current s351, that being s10(1) *Mental Health Act 1986 (Vic)*, both sections are couched in very similar although not identical terms. Section 10(1) provided a power of apprehension to a member of the police force in respect of a person who appeared to be mentally ill if the member of the police force had reasonable grounds for believing the person had recently or was likely to attempt suicide or cause serious bodily harm to themselves or another person. I am of the opinion that in respect of the current analysis, nothing material arises from the slight differences in which s10(1) has been constructed, and Counsel for any of the Interested Parties did not seek to persuade me otherwise.

81. The Chief Justice stated the following:

> *The power which the section confers on police officers is subject to two necessary conditions. The first requires that a person "appears to be mentally ill" … … in the context in which the term is used in s10, before a person can be apprehended it is clear that he or she must appear* ***to the apprehending officer*** *to be mentally ill. That is to say, the officer must form the opinion that the person is mentally ill. This*

[95] *Stuart v Kirkland-Veenstra* (2009) 237 CLR 215.

requires a subjective opinion by the officer … … The requisite opinion is an opinion formed, having regard to the behaviour and appearance of the person, that the person has a mental condition characterised by a significant disturbance of thought, mood, perception or memory. This does not require "clinical judgement" by the officers. A layman's opinion conforming with the broad definition of "mentally ill" is s8(1A) would suffice … … Given its proper construction and the emergency situations with which s10 is concerned, there is no scope for argument, in deciding whether the power to apprehend was enlivened, that, contrary to the opinion formed by the officer, there were indicia of mental illness which should have been apparent to him or her. The power is not enlivened by objective circumstances but by the opinion of the officer'[96]

82. I am satisfied that S/Cst Neave relevantly informed himself in respect of the information provided by Dr Laufer, that is Dr Laufer conveyed his belief that Adam suffered from bipolar depression and had become psychotic, delusional and paranoid (either in those exact terms or in similar terms that conveyed the same meaning). The evidence supports the conclusion that S/Cst Neave was aware of Dr Laufer's assessment of Adam's mental health and risks. It was submitted by Counsel for Dr Laufer that S/Cst Neave '*basically wasn't interested in Dr Laufer's opinion*'[97] and '*had no regard to the opinion and the information from Dr Laufer that, of course, bipolar disease, being a mood-change type of disease, was one where a history was particularly relevant, as it would be in any, in my submission, long-term mental health patient*'. I reject such a submission and am satisfied, on all the evidence before me, that the information provided by Dr Laufer was materially considered by S/Cst Neave, albeit it was *not*, and *could not*, be determinative in the application of the s351 apprehension power.

83. I am satisfied that S/Cst Neave appropriately assessed Adam who presented as exhibiting no delusions, erratic behaviours or other obvious signs of mental health issues. Further I am satisfied that S/Cst Neave clearly understood both the correct interpretation of the section and the power provided to him pursuant to s351, and having regard to the subjective test required, satisfied himself that he did *not* have the requisite available evidence or level of satisfaction that would have allowed him to exercise that power. I have had the benefit of witnessing S/Cst Neave give evidence at Inquest and found him to be an honest, forthright and credible witness.

[96] *Stuart v Kirkland-Veenstra* (2009) 237 CLR 215 at 239-240.
[97] Inquest Transcript, 308.27-30.

84. Victoria Police were *not* in a position to lawfully detain Adam who had expressed a very clear intention *not* to return home. Adam informed S/Cst Neave that he did not want to live with his parents and wanted to stay in the city overnight and then make other arrangements. Dr Laufer wanted Adam immediately transported to hospital for an assessment pursuant to the *Mental Health Act*. S/Cst Neave described the situation as '*once we'd concluded that we didn't have any authority to intervene, it became a simple case of two adults who each have full independent rights who had a disagreement of some nature and one of them wants to follow the other and the one that's being followed doesn't want to be followed … … he wants to get into a taxi and leave he can*'. Whilst Dr Laufer was recalled and disputed that a disagreement existed between himself and Adam that evening, the evidence clearly establishes Adam expressed to S/Cst Neave a very clear intention and desire *not* to return home.

85. On all of the available evidence, the conduct of S/Cst Neave in assessing Adam, concluding that no relevant power existed pursuant to s351, and allowing him to leave in a taxi, against the express concerns voiced by Dr Laufer was reasonable and in accordance with the legislation.

What information was communicated between the Police members and Ambulance Paramedics about Adam's presentation on 24 November 2016?

What information did Ambulance Paramedics rely upon to determine to leave the scene on 24 November 2016?

86. S/Cst Neave gave evidence in a written statement that '*Ambulance members arrived at the scene and in company with Adam I explained the situation to the best of my knowledge. I then asked Adam to speak to the Ambulance staff and told him that I wouldn't be listening if there was anything he wasn't comfortable discussing in front of Police. Adam agreed and while he began speaking to Ambulance members, I first spoke to Constable Ashton regarding his conversation with Eljas, and I then spoke to Eljas in company with Constable Ashton*'.[98] Later S/Cst Neave indicated that '*I again spoke to Adam and the Ambulance members. The Ambulance members stated that Adam seemed fine*'.[99] S/Cst Neave was unable to recall the time period during which Paramedic Allen was alone speaking with Adam[100] although suggested it was a matter of minutes.[101]

87. During evidence at Inquest S/Cst Neave clarified that in explaining the situation to the Paramedics, '*I think it was more along the lines of Adam wanted to leave and that his father was saying that he had some manner of psychotic break and that I was asking them to speak to Adam outside my hearing, to make their own independent assessment, whether that's a formal assessment or just an informal one and that if there was – if they felt that there were um, major concerns that they let me know*'.[102] S/Cst Neave was ultimately unsure whether he requested Paramedics to formally assess Adam.[103]

88. S/Cst Ashton had no discussion with Ambulance Paramedics upon their arrival, with S/Cst Neave providing the briefing in Adam's presence however gave evidence that '*the paramedics then spoke to Adam in private, as myself and S/Cst Neave spoke to each other*'.[104] Likewise S/Cst Ashton later had no communication with Ambulance Paramedics, giving evidence that '*S/Cst Neave then went over to the Paramedics and Adam, then came back over to myself and Dr Laufer and informed us that Adam checked out fine and the Paramedics didn't have any concerns*'.[105] S/Cst Ashton was

[98] Statement of S/Cst Neave, Inquest Brief, p54.
[99] Ibid, p55.
[100] Inquest Transcript, 87.27-29.
[101] Inquest Transcript, 88.1-3.
[102] Inquest Transcript, 155.14-21.
[103] Inquest Transcript, 157.22-24.
[104] Statement of S/Cst Ashton, Inquest Brief, p63.
[105] Ibid, p64.

however adamant in his oral evidence that a Paramedic had a private conversation with Adam[106] for several minutes.[107] In evidence S/Cst Ashton clarified that his usage of the term Paramedics could refer to either the singular or plural and that he only recalled one Paramedic talking with S/Cst Neave and Adam whilst the other Paramedic stood with himself and Dr Laufer.[108],[109]

89. Paramedic Steve Allen gave evidence in a written statement that upon arrival '*I spoke to a nearby police officer who indicated the police had the case in hand … … neither Zoe nor I spoke to the male person. We did not examine him. Shortly after our arrival, the police officer told us an ambulance was not required for this case and we left the scene at approximately 04:12 hours. We did not complete a patient care record (PCR) of the attendance, as we had not spoken to or carried out an assessment of the male person*'.[110]

90. In a supplementary statement Paramedic Allen confirmed his evidence that '*after we located the patient and disembarked from the ambulance, we were told by the police at the scene that we were not required*'[111] however clarified his later evidence in respect of interacting with Adam that '*I briefly introduced myself to the patient and I asked him how he was going, but he gave no response … … at paragraph 6 of my original statement, I said that Ms Welsh and I did not speak with the patient as I had no proper conversation with him'.*

91. Paramedic Zoe Welsh was aware from the event type 'EME THR psychiatric patient' that they had been requested to attend a mental health patient, '*someone suffering some degree of mental health, a mental health event*'.[112] Paramedic Welsh does not recall having any conversations with Adam, Dr Laufer, S/Cst Neave or S/Cst Ashton that evening.[113] She does however recall observing Paramedic Allen speak to Adam[114] and for a period of time she opined if she had to choose '*between seconds and minutes I would choose minutes … … it wasn't a couple of seconds*'.[115]

---

[106] Inquest Transcript, 188.21-23.
[107] Inquest Transcript, 187.26-27.
[108] Inquest Transcript, 185.18-186.17.
[109] Inquest Transcript, 234.9-235.3.
[110] Statement of Paramedic Steve Allen, Inquest Brief, p122.
[111] Statement of Paramedic Steve Allen, Inquest Brief, p124.
[112] Inquest Transcript, 260.17-22.
[113] Statement of Paramedic Zoe Welsh, Inquest Brief, p127.
[114] Inquest Transcript, 260.4-6.
[115] Inquest Transcript, 260.9-16.

92. It was Dr Laufer's opinion that Paramedic Welsh attended, stood with him and S/Cst Ashton for a period of approximately two minutes without speaking, and then returned to the ambulance[116] with the entirety of Ambulance Victoria's attendance being 5-6 minutes.[117] Whilst Paramedic Welsh was unable to recall any conversation with Dr Laufer, she does not dispute Dr Laufer's evidence that he told her that '*Adam had a ten year history of bipolar disorder. He has become acutely psychotic and paranoid and will likely kill himself if he isn't transported to hospital*'.[118]

93. Dr Laufer never spoke with Paramedic Allen[119] however gave oral evidence of '*quite a brief conversation'* between Paramedic Allen and S/Cst Neave upon the arrival of Ambulance Victoria, and then '*Allen walked across to Adam, spoke to Adam. I didn't see a response from Adam and he was pretty much looking the other way*'.[120] Further in oral evidence Dr Laufer indicated '*Mr Allen walked in front of Senior Constable Neave, tried to engage Adam in conversation. I don't believe he got a response and walked back after a very short period because he had gotten no* response'.[121] Dr Laufer however indicated that he was unable to hear any of the conversation that had occurred.[122]

94. I note the entry in the ERTCOMM Event Register at 4:12:18 that read 'BN: CANCELLED BY 56 ON ARR 0412'.[123]

95. During evidence at Inquest both S/Cst Neave and S/Cst Ashton disputed telling the Ambulance Paramedics that they weren't required on scene or alternatively that police had the situation in hand.[124],[125],[126]

96. Paramedic Welsh gave evidence that had a full and thorough assessment been conducted by Paramedic Allen upon Adam that it would have consumed at least a 10-15 minute timeframe.[127]

---

[116] Inquest Transcript, 31.21-32.10; 35.18-23.
[117] Inquest Transcript, 62.12-23.
[118] Inquest Transcript, 269.7-28.
[119] Inquest Transcript, 37.9-12.
[120] Inquest Transcript, 34.9-21.
[121] Inquest Transcript, 35.7-12.
[122] Inquest Transcript, 34.29-35.4.
[123] ERTCOMM Event Register, Inquest Brief, p130.
[124] Inquest Transcript, 86.2-7.
[125] Inquest Transcript, 156.1-5.
[126] Inquest Transcript, 181.29-31.
[127] Inquest Transcript, 280.21-23.

97. It is difficult to reconcile the conflict in the evidence given by the Police Officers and Ambulance Paramedics both in their written statements and in oral evidence at Inquest. It is not possible to reconcile these differing accounts of whether Ambulance Victoria had or had not been cancelled by Victoria Police. I am unable to reach a conclusion on this issue, the evidence suggests that there may have been confusion or a misunderstanding.

98. The evidence is settled that Ambulance Victoria were on-scene for an approximate 9 minute period (4:03:30am-4:12:21am or 4:03:25am-4:12:18am)[128] although there is some uncertainty, as conceded in the evidence of Paramedic Welsh, as to whether these respective times were manual inputs by Paramedics or slightly time delayed by dispatchers.[129] Irrespective of whether Ambulance Victoria were or were not cancelled by Victoria Police, the evidence is clear that Paramedic Allen did *not* conduct an assessment of Adam. Paramedic Welsh's evidence that a thorough assessment would have taken anywhere from 10 to 15 minutes makes it incontrovertible that such an assessment was never conducted.[130] The absence of any formal Patient Care Record also strongly supports this conclusion.

99. Further I accept that Paramedic Allen did speak with Adam for a short period of time (at most a matter of minutes but likely to have been shorter) however there was either no or minimal engagement from Adam following which Paramedic Allen ceased to attempt to engage. I accept the evidence of Ambulance Victoria that in circumstances where no assessment was undertaken of Adam, that none of the Clinical Practice Guidelines contained within the Inquest Brief were engaged.[131]

100. I note S/Cst Neave's evidence in respect of the purpose for which he sought to have a Paramedic speak with Adam '*was that I wasn't asking them to have the official role because as already discussed, they don't have an equivalent 351 power. But I just wanted as many – as many shots at goal as possible, so to speak. If it wasn't – it was just me that couldn't get this out of him, perhaps someone else could get it out of him … … it was another opportunity for him to either choose to reveal or accidentally reveal something that would require action*'.[132]

[128] ERTCOMM Event Register, Inquest Brief, p128-130.
[129] Inquest Transcript, 256.7-13.
[130] Inquest Transcript, 280.16-23.
[131] Statement of Michael Stephenson, Inquest Brief, p149.
[132] Inquest Transcript, 169.19-28.

101. The *Mental Health Act 2014* provides *no* apprehension power to Ambulance Paramedics in the circumstances of Adam's presentation that evening. The only available apprehension power pursuant to s351 is specifically provided to a police officer. It is clear on the available evidence that S/Cst Neave was aware of this limitation and further, that by seeking to have Adam engage with the Paramedics, he was in no way attempting to transfer the power provided to him pursuant to s351 to the Paramedics. Rather S/Cst Neave recognised that in certain circumstances, people are reluctant to disclose matters of a personal and sensitive nature to Police Officers and was therefore availing himself of another potential avenue of sourcing information in respect of Adam's mental health. The fact that Adam declined to engage with Paramedic Allen in any meaningful way should in no way be adversely interpreted against any of the parties involved.

102. In all of the circumstances I am of the opinion that the conduct of Ambulance Victoria Paramedics was reasonable and appropriate that evening.

Referral to the Director of Public Prosecutions

103. It was submitted by Counsel for Dr Laufer that Victoria Police owed a duty of care to Adam, and that by their conduct they had breached that duty of care, and that it was a gross breach in circumstances such that it was tantamount to manslaughter such that I should consider referring this matter to the Director of Public Prosecutions. In support of this submission the alleged breaches were summarised as follows:

    (a) S/Cst Neave failed to properly inform himself as to the danger that existed to Adam by his failure to have regard to Dr Laufer's opinion as both a father and a medical practitioner.[133]

    (b) S/Cst Neave failed to properly inform himself by his failure to reasonably take the opportunity to obtain input and information from Ambulance Victoria Paramedics.[134]

    (c) S/Cst Neave and S/Cst Ashton under S/Cst Neave's direction who both restrained Dr Laufer to facilitate Adam's departure.[135]

[133] Inquest Transcript, 320.15-20.
[134] Inquest Transcript, 320.21-321.12.
[135] Inquest Transcript, 321.13-21.

104. Referrals to the Director of Public Prosecutions by an investigating Coroner under s49(1) *Coroners Act 2008* that relevantly provides

> '*The Principal Registrar must notify the Director of Public Prosecutions if the coroner investigating the death or fire believes an indictable offence may have been committed in connection with the death or fire*'.

105. Within the submissions by Counsel for Dr Laufer repeated reference was made, in various terms, to the fact that Adam actually suicided some 16 hours later as '*ultimately vindicating his concerns for his son's safety*'.[136] I am acutely aware of the risk of either hindsight bias and/or outcome bias affecting an assessment of the events of that evening.

106. Whilst not explicitly stated by Counsel for Dr Laufer, I have inferred that the reference to manslaughter is a reference to manslaughter by criminal negligence. The offence of manslaughter by criminal negligence would require proof that S/Cst Neave owed Adam a duty of care, that he breached that duty by criminal negligence, that the act which breached the duty of care was committed consciously and voluntarily, and that S/Cst Neave's breach of the duty caused the victim's death.

107. Counsel's submissions are problematic in numerous aspects. There is settled High Court authority on the question of whether S/Cst Neave owed Adam a legal duty of care.[137] Hypothetically were a legal duty of care to have existed, S/Cst Neave's conduct would have had to have fallen so far below the standard of care a reasonable person would have exercised, and to have involved such a high risk of death or really serious injury, that that conduct merited criminal punishment.[138] Further evidence would be required that S/Cst Neave's breach of the duty (if there was one) caused Adam's death, the issue of causation being significantly problematic given the approximate sixteen hours that elapsed following Adam's departure.

108. On the facts as I have found them, I do not believe that an indictable offence may have been committed, manslaughter or otherwise, by either S/Cst Neave or S/Cst Ashton.

109. Accordingly, I decline to refer this matter to the Director of Public Prosecutions.

---

[136] Inquest Transcript, 321.22-28.
[137] *Stuart v Kirkland-Veenstra* 237 CLR 215 at 252-256 per Gummow, Hayne and Heydon JJ.
[138] (*R v Lavender* (2005) 222 CLR 67; *Wilson v R* (1992) 174 CLR 313; *Andrews v DPP* [1937] AC 576; *R v Bateman* (1925) 19 Cr App R 8; *R v A C Hatrick Chemicals* (1995) 152 A Crim R 384; *R v Richards & Gregory* [1998] 2 VR 1).

SUMMARY OF FINDINGS REGARDING CIRCUMSTANCES OF 24 NOVEMBER 2016

110. Having applied the requisite standard to the evidence, I find that:

(a) to Dr Laufer, Adam presented as suffering from an ongoing bipolar mental health condition characterised by mood swings between acute mania through to acute depression;

(b) to S/Cst Neave, Adam presented that evening as quietly spoken, calm, able to engage and provide clear and cogent answers throughout the conversation;

(c) Dr Laufer conveyed in strong terms to S/Cst Neave, S/Cst Ashton and Paramedic Welsh his opinion in respect of Adam's mental health and his immediate and serious concerns in respect of Adam's welfare;

(d) There was no Assessment/Treatment Order in force pursuant to the *Mental Health Act 2014* that would have empowered Victoria Police to apprehend Adam;

(e) Adam's presentation, behaviour and demeanour throughout his entire interaction with S/Cst Neave exhibited no evidence that he appeared to have mental illness[139] nor that he was at risk of inflicting serious and imminent harm either to himself or another person;

(f) S/Cst Neave's decision that there was no proper basis for apprehending Adam pursuant to s351 *Mental Health Act 2014* based on his assessment of Adam was reasonable and in accordance with the legislation;

(g) Ambulance Victoria Paramedics did not conduct an assessment of Adam and there appeared to be confusion and misunderstanding between Victoria Police and Ambulance Victoria. Paramedic Allen did introduce himself to Adam following a conversation with S/Cst Neave however there was no meaningful engagement in reply from Adam and he thereafter took no further steps to assess Adam;

[139] Defined in s4 *Mental Health Act 2014* as a medical condition that is characterised by a significant disturbance of thought, mood, perception or memory.

(h) Paramedic Welsh did not speak to Adam throughout the entire period and remained standing near Dr Laufer;

(i) In the circumstances the conduct of Ambulance Victoria was reasonable;

(j) The weight of the evidence does not support a conclusion that an indictable offence may have been committed in connection with Adam's death, and accordingly I decline to make a referral to the Director of Public Prosecutions.

COMMENTS

111. I make the following comments connected with Adam's passing pursuant to s67(3) *Coroners Act 2009*.

112. It is hard to imagine a more frustrating and upsetting situation than the position Dr Laufer found himself in the early hours of the 24 November 2016. Having witnessed his son significantly decline over the past decade, to the immediate circumstances of the past 24-48 hours where he saw what he believed was an imminent and significant risk to his son's mental health. He believed that Adam was so desperately unwell necessitating immediate treatment, and in those circumstances, his pleas to Police are entirely understandable.

113. However, the range of options for Police members dealing with a person who is not prepared to be assessed voluntarily, and for which an assessment order does not exist, is limited to the power conferred by s351. The s351 power is, understandably, prescriptive and only confers a power of apprehension to Police in limited circumstances. As previously stated I am satisfied that S/Cst Neave clearly understood both the correct interpretation of the section and the power provided to him pursuant to s351, and having regard to the subjective test required, satisfied himself that he did *not* have the requisite available evidence or level of satisfaction that would have allowed him to exercise that power. It is also understandable that in the circumstances, Dr Laufer was very upset and frustrated and disagreed with that assessment.

114. Within their evidence both S/Cst Neave and S/Cst Ashton detail the frequency of mental health assessments that they encounter as a General Duties Uniform Officer. Both give evidence that Family Violence and Mental Health occupy the vast bulk of regular frontline general duties. Both Police members by their evidence were also experienced

in dealing with mental health assessments and transfers, having both served as the uniformed member on a PACER Team (where a mental health clinician performs a shift in company with a police officer, not as a first responder to a mental health crisis, but to assist Police Officers who have rendered the scene safe and are subsequently conducting a mental health assessment upon a person). Of note at the time of Adam's passing, PACER Teams were only rostered to 11.00pm and only accepted jobs up to 10.00pm.[140]

115. It is abundantly clear that a much greater range of options are required to assist family members, Victoria Police and Ambulance Victoria manage these very challenging situations. In the absence of an assessment order (which may be almost impossible to facilitate in the very early hours of the morning), either a voluntary assessment or a prescriptive s351 power provides Victoria Police with a very limited and constrained range of options.

116. I note Section 7 *Coroners Act 2008* and the requirement that I avoid unnecessary duplication of inquiries and investigations. To that end the Royal Commission into Victoria's Mental Health System (RCVMHS) delivered its final report on 3 February 2021 and it was tabled in Parliament by the Victorian Government on 2 March 2021. I am of the opinion that there are a number of recommendations highly relevant to the circumstances of this case.

117. In respect of responding to mental health crises, the Royal Commission recommended pursuant to Recommendation 8(1):

> *ensure each Adult and Older Adult Area Mental Health and Wellbeing Service delivers a centrally coordinated 24-hours-a-day telephone/telehealth crisis response service accessible to both service providers and to members of the community of all ages that provides:*
>
> *a. crisis assessment and immediate support;*
>
> *b. mobilisation of a crisis outreach team or emergency service response where necessary; and*
>
> *c. referral for follow-up by mental health and wellbeing services and/or other appropriate services.*

[140] Inquest Transcript, 101.12-19.

118. In respect of developing 'safe spaces' and crisis respite facilities, the Royal Commission recommended pursuant to Recommendation 9(1):

> *invest in diverse and innovative 'safe spaces' and crisis respite facilities for the resolution of mental health and suicidal cases which are consumer led and, where appropriate, delivered in partnership with non-government organisations.*

119. In respect of supporting responses from emergency services to mental health crises, the Royal Commission recommended pursuant to Recommendation 10:

> 1. *ensure that, wherever possible, emergency services' responses to people experiencing time-critical mental health crises are led by health professionals rather than police.*
>
> 2. *Support Ambulance Victoria, Victoria Police and the Emergency Services Telecommunications Authority to work together to revise current protocols and practices such that, wherever possible and safe:*
>
>   a. *Triple Zero (000) calls concerning mental health crises are diverted to Ambulance Victoria rather than Victoria Police; and*
>
>   b. *Responses to mental health crises requiring the attendance of both ambulance and police are led by paramedics (with support from mental health clinicians where required).*
>
> 3. *Ensure that mental health clinical assistance is available to ambulance and police via:*
>
>   a. *24-hours-a-day telehealth consultation systems for officers responding to mental health crises;*
>
>   b. *In-person co-responders in high-volume areas and time periods; and*
>
>   c. *Diversion secondary triage and referral services for Triple Zero callers who do not require a police or ambulance dispatch.*

120. During the Inquest these recommendations arising from the Royal Commission were put to both S/Cst Neave[141] and S/Cst Ashton[142] with both Officers agreeing that had they been available that evening, the options outlined within those recommendations potentially could have been of valuable assistance in managing the circumstances. Dr Laufer[143] also commented specifically in respect of recommendation 10 a concern that in circumstances where a patient is uncooperative and unwilling to participate in a voluntary assessment, that the apprehension power still resides with Victoria Police pursuant to s351, as opposed to a clinician with a greater level of mental health expertise.

121. The Victorian Government Department of Health June 2021 Mental Health and Wellbeing Act: Update and Engagement Paper notes 'to *meet the Royal Commission's vision of a more balanced mental health and wellbeing system, the redesigned system will move from a crisis-driven model to a system built around community-based services. Not all changes will be driven through legislation. Other system reforms also aim to enhance voluntary methods of treatment, care and support to meet people's needs and preferences'*[144].

122. The RCVMHS's redesign promotes accessible, appropriate and responsive public community services which enable early engagement[145] thereby reducing the need for crisis-responses.

123. On the day prior to his death Adam had consulted with three private practitioners who knew him well and an Emergency Department, and no interventions were made other than contacting Adam's family on one occasion. The RCVMHS focused on public mental health services, therefore the role of private practitioners in engaging people early with services appropriate to their level of distress will continue to rely on the efforts of individual practitioners.

124. Area Mental Health Services currently offer 24-hour contact lines with support which were available at the time of Adam's death. The RCVMHS Recommendation 8 promises crisis assessment and immediate support, mobilisation of crisis outreach teams or an emergency response if needed. Such immediate support may enable and

[141] Inquest Transcript, 98.29-102.19.
[142] Inquest Transcript, 199.31-204.5.
[143] Inquest Transcript, 292.30-
[144] Mental Health and Wellbeing Act: update and engagement paper June 2021
[145] Mental Health Reform Victoria strategic plan 2020 to 2022.

increase earlier engagement by families, friends, private practitioners and the community.

125. The RCVMHS Recommendation 9 provides 'safe spaces' which if they had been available in 2016 may have offered Adam a safe place to seek help, or for Victoria Police and Ambulance Victoria to encourage Adam to go to, instead of going home or leaving to find his own accommodation. It is acknowledged that Adam's voluntary attendance at such a space cannot be assumed.

126. RCVMHS Recommendation 10 aims to improve the response to community-based crises through Ambulance Victoria providing the first response. The circumstances of how and when paramedics will provide a clinical first response to a mental health crisis have not been established.

127. The new Mental Health and Wellbeing Act objectives include *providing people living with mental illness or psychological distress with assessment and treatment in the least restrictive way possible with the least possible restrictions on human rights and human dignity*[146]. It remains unclear how the current Victoria Police powers to arrest pursuant to s351 will be managed under the new Mental Health and Wellbeing Act. The new Mental Health and Wellbeing Act is unlikely to support a more restrictive approach than the current prescriptive s351.

128. Dr Laufer, Victoria Police and Ambulance Victoria did not have a range of options available to them. The RCVMHS recommendations when implemented should provide a greater range of options for patients, families and first responders who are involved in a community-based crisis response. It is clear however that the implementation of recommendations will only be effective where they are properly resourced and available around the clock on a 24/7 basis given mental health crises are not limited to the convenience of business hours.

129. The new Mental Health and Wellbeing Act seeks to put the views, preferences and values of people living with mental illness or psychological distress, families, carers and supporters at the forefront of policies, programs and services but how this will translate into the s351 equivalent is unknown.

[146] Mental Health and Wellbeing Act: update and engagement paper June 2021

RECOMMENDATIONS

130. I make the following recommendation connected with the death to Mental Health Reform Victoria:

    (a) That recommendations 8, 9 and 10 arising from the Royal Commission into Victoria's Mental Health System be prioritised and implemented in their entirety as recommended by the Royal Commission.

131. I make the following recommendation connected with the death to the Department of Health:

    (a) That the current power provided pursuant to s351 *Mental Health Act*, however it is to be drafted into the new *Mental Health and Wellbeing Act*, and or the supporting documentation, provides clear and practical guidance on the role of the family, if any, in informing the use of police powers in circumstances requiring a community based crisis response.

FINDINGS AND CONCLUSION:

132. Having held an inquest into the death of Adam Laufer, I make the following findings, pursuant to section 67(1) of the Act:

    (a) the identity of the deceased was Adam Laufer born on 14 October 1984; and

    (b) the death occurred on 24 November 2016 at LaTrobe Street Overpass, Docklands;

    (c) from 1(a) multiple injuries sustained in a fall from a height; and

    (d) that the death occurred in the circumstances set out above.

133. I convey my sincerest sympathy to Adam's Family.

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

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

    (a) Dr Eljas Laufer, Senior Next of Kin and Adam's Father.

    (b) Chief Commissioner of Police, Mr Shane Patton APM.

    (c) CEO Ambulance Victoria, Mr Tony Walker ASM.

    (d) CEO Mental Health Reform Victoria, Ms Pam Anders.

    (e) Secretary of the Department of Health, Professor Euan Wallace AM.

    (f) Senior Constable Lambros Ouzounis, Coroner's Investigator.

Signature:

JUDGE JOHN CAIN

STATE CORONER

Date: 26 July 2021

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.