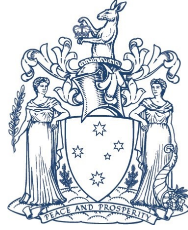

IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2016 0778

FINDING INTO DEATH WITH INQUEST

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

INQUEST INTO THE DEATH OF KIM LYNCH

Findings of:	State Coroner Judge John Cain
Delivered On:	7 September 2022
Delivered At:	65 Kavanagh Street Southbank, Victoria, 3006
Hearing Dates:	7 September 2022
Assisting the Coroner:	Samantha Brown, In-house Legal Service
Representation:	Karen Liu of K&L Gates on behalf of Monash Health Katherine Goldberg of Norton Rose Fulbright on behalf of the Chief Commissioner of Police
Catchwords	Family violence, psychiatric management, missing person investigation, homicide, Monash Health, Victoria Police

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SUMMARY

1. Kim Rebecca Lynch was 41 years old at the time of her death.

2. Ms Lynch had been in a relationship with LM[1] since about October 2015; both had mental health and substance use issues.

3. Following an incident of family violence on 17 January 2016, a safety notice was served on LM prohibiting him from contact with Ms Lynch. The following day, an intervention order was granted to protect Ms Lynch.

4. Ms Lynch died of neck compression at a time between 12 and 14 February 2016.

5. LM was charged with Ms Lynch's murder and on 22 May 2017 was found not guilty by reason of mental impairment.[2] LM was made subject to a Custodial Supervision Order for a nominal term of 25 years.[3]

CORONIAL INVESTIGATION

Jurisdiction

6. Ms Lynch's death constituted a *'reportable death'* pursuant to section 4 of the *Coroners Act 2008* (Vic) (**Coroners Act**), as her death occurred in Victoria and was unexpected, unnatural and violent.

Purpose of the Coronial Jurisdiction

7. The jurisdiction of the Coroners Court of Victoria (**Coroners Court**) is inquisitorial.[4] The purpose of a coronial investigation is to independently investigate a reportable death to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which the death occurred.

8. The cause of death refers to the medical cause of death, incorporating where possible, the mode or mechanism of death.

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[1] LM's name has been replaced by this pseudonym in compliance with an order of Hollingworth J prohibiting its publication: *Director of Public Prosecutions v LM* [2018] VSC 451.

[2] *Director of Public Prosecutions v LM* [2018] VSC 451.

[3] *Director of Public Prosecutions v LM* [2018] VSC 451.

[4] Section 89(4) *Coroners Act 2008.*

9. The circumstances in which the death occurred refers to the context or background and surrounding circumstances of the death. It is confined to those circumstances that are sufficiently proximate and causally relevant to the death.

10. 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 prevention role.

11. Coroners are empowered to:

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

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

    (c) make recommendations to any Minister or public statutory authority or entity on any matter connected with the death, including public health or safety or the administration of justice.

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

12. The power to comment, arises as a consequence of the obligation to make findings. It is not free ranging. It must be a comment "on any matter connected with the death". The powers to comment and make recommendations are inextricably connected with, rather than independent of, the power to enquire into a death or for the purpose of making findings. They are not separate or distinct sources of power enabling a coroner to enquire for the sole or dominant reason of making comment or recommendation.[5]

13. It is important to stress that coroners are not empowered to determine the civil or criminal liability arising from the investigation of a reportable death and are specifically prohibited from including a finding or comment or any statement that a

[5] *Harmsworth v The State Coroner* [1989] VR 989 at 996.

person is, or may be, guilty of an offence.[6] It is not the role of the coroner to lay or apportion blame, but to establish the facts.[7]

14. However, the principal registrar of the Coroners Court must notify the Director of Public Prosecutions if the coroner investigating a death believes an indictable offence may have been committed in connection with the death.[8]

15. All coronial findings must be made based on proof of relevant facts on the balance of probabilities.[9] In determining these matters, I am guided by the principles enunciated in *Briginshaw v Briginshaw*.[10] 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.

Inquest

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. Although I am not required to hold an inquest into Ms Lynch's death (even though it was the result of homicide),[11] I consider that a public hearing is likely to assist in maintaining public confidence in the administration of justice, health services or other public agencies. The Inquest was a Summary Inquest – one conducted without oral testimony – as there were no evidentiary conflicts or discrepancies that would justify calling witnesses.

Sources of Evidence

17. This Finding draws on the totality of the material the product of the coronial investigation into Ms Lynch's death. That is, the court records maintained during the coronial investigation, the Coronial Brief and further material sought and obtained by the Court, and written submissions made by the Interested Parties.

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[6] Section 69(1). However, a coroner may include a statement relating to a notification to the Director of Public Prosecutions if they believe an indictable offence may have been committed in connection with the death. See sections 69(2) and 49(1) of the Act.

[7] *Keown v Khan* (1999) 1 VR 69.

[8] Section 49(1).

[9] *Re State Coroner; ex parte Minister for Health* (2009) 261 ALR 152.

[10] (1938) 60 CLR 336.

[11] Section 52(3)(b) of the Act.

18. In writing this Finding, I do not purport to summarise all the evidence but refer to it only in such detail as appears warranted by its forensic significance and the interests of narrative clarity. The absence of reference to any particular aspect of the evidence does indicate that it has not been considered.

BACKGROUND

Personal History

19. Ms Lynch had three children who were not in her care at the time of her death. She had experienced periods of homelessness and had been subjected to violence in intimate relationships in the past.[12]

20. Ms Lynch also had a complex mental health history. She had multiple contacts with public mental health services since at least 2004. Monash Health medical records indicated a presentation for post-natal depression in November 2004, two weeks after giving birth.[13] The Client Management Interface (CMI)[14] database indicated multiple community contacts from 2005 until 2015 with Werribee, Alfred, Maroondah, Casey, Frankston, Dandenong, Mid West, North West and Monash area mental health services, as well as inpatient admissions from 20-24 April 2011 (Monash), 18-26 May 2011 (Maroondah) and 11-12 October 2011 (Dandenong).

21. Ms Lynch had been diagnosed with emotionally unstable personality disorder borderline type[15] and mental and behavioural disturbance due to harmful alcohol use.[16]

22. Ms Lynch's most recent episode of treatment by public mental health services was with Monash Health from 11-14 January 2015 following a discharge from the Alfred Hospital mental health ward. She had been admitted to Alfred Hospital after stabbing

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[12] Medical and WAYSS records relating to Kym Lynch.

[13] Monash Health SMR medical record, page 1395.

[14] Client Management Interface (CMI) is a statewide database that shares select client-level data between Victorian public area mental health services to support continuity of treatment and care.

[15] Emotionally unstable personality disorder is an ICD-10 diagnosis characterized by a definite tendency to act impulsively and without consideration of the consequences; unpredictable and capricious mood; liability to outbursts of emotion; incapacity to control the behavioural explosions; and a tendency to quarrelsome behaviour and to conflicts with others (especially when impulsive acts are thwarted or censored). Two types may be distinguished: the impulsive type, characterized predominantly by emotional instability and lack of impulse control, and the borderline type, characterized in addition by disturbances in self-image, aims, and internal preferences, by chronic feelings of emptiness, by intense and unstable interpersonal relationships, and by a tendency to self-destructive behaviour, including suicide gestures and attempts.

[16] Monash Health SMR medical record, page 470.

herself in the hand following an argument with a friend while intoxicated. She advised Alfred Hospital staff that she was raped two weeks earlier but did not want to speak with police or sexual assault services.

23. Ms Lynch was assessed by a mental health clinician in the Emergency Department (**ED**) on 17 January 2016 (described in more detail below) however no mental health follow-up was arranged; this was Ms Lynch's last known contact with mental health services.

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

24. On 17 January 2016, Ms Lynch reported to police that LM had chased her down the street and assaulted her by punching her repeatedly. A neighbour observed the incident.

25. When police attended, Ms Lynch presented with erratic speech and illogical thought patterns and reported consuming a bottle of LM's methadone that day. Police used their power under section 351 of the *Mental Health Act 2014* (Vic) to take Ms Lynch to Dandenong Hospital ED to be assessed by a mental health clinician.

26. Police issued a Family Violence Safety Notice (**FVSN**) and served it on LM at the scene. The FVSN's conditions prohibited LM from committing family violence against Ms Lynch, contacting or communicating with her, approaching her, or going within 200 meters of any place she lived.[17]

27. At Dandenong Hospital, Ms Lynch was assessed by a mental health clinician and found to not have any acute mental illness. She was given the psychiatric triage service (**PTS**) phone number, a referral for safe housing was made to WAYSS[18] by Victoria Police and referral to sexual assault services was planned.[19]

28. Ms Lynch remained in the ED overnight and was discharged with a taxi voucher to attend court the following morning for the police application for an intervention order.

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[17] Dandenong Magistrates' Court, Family Violence Safety Notice dated 17 January 2016.

[18] WAYSS is a family violence and housing support service in South East Melbourne.

[19] It was unclear whether this occurred or whether this was to be done by Monash Health or Victoria Police. Monash Health medical records stated "Police investigating [sexual assault], aimed to send straight to SECASA [South East Centre Against Sexual Assault]".

29. On 18 January 2016, a Family Violence Intervention Order (**FVIO**) was granted at the Dandenong Magistrates' Court which included conditions prohibiting LM from contacting, communicating, or living with Ms Lynch.[20]

30. On 30 January 2016 Ms Lynch was visibly distressed at Palm Plaza in Dandenong. Peter Ronksley, an acquaintance of Ms Lynch and LM, approached to help and Ms Lynch reported being assaulted by her partner. LM then approached, asking Ms Lynch to leave with him but she refused, leaving with Mr Ronksley instead. Mr Ronksley offered to contact WAYSS or the Salvation Army for support, but Ms Lynch declined. Ms Lynch lived at a factory owned by Mr Ronksley for several days after this incident.[21]

31. Later on 30 January 2016, LM was admitted as an involuntary psychiatric patient to Dandenong Hospital after he contacted '000' and told attending paramedics that he had injected himself with poison the day before and was going to murder everyone around him if he could not get it removed.[22]

32. On 1 February 2016 police left a copy of the FVIO issued on 18 January 2016 at LM's home. This was a form of substituted service as they had been unable to serve him personally with a copy of the FVIO.[23]

33. On 5 February 2016, LM was granted three hours of leave from Dandenong Hospital, on the condition that he remain in the care of his grandmother, JN.[24] Upon leaving the hospital, LM directed JN to an address so that he could meet Ms Lynch. All three then went to LM's home. LM refused to return to the hospital and so his grandmother left without him and notified Dandenong Hospital.[25] Dandenong Hospital, in turn, notified

[20] Coronial brief, Appendix H, 310-311.

[21] Coronial brief, Statement of P Ronksley, 100.

[22] *DPP v LM* [2018] VSC 451, 1 [2]-[3]; Coronial brief, Statement of M De Silva; Statement of JN, 91-93; Appendix A, 184; Appendix B, 186.

[23] Coronial brief, Appendix H, 312.

[24] LM's grandmother has been deidentified to minimise the likelihood that LM will be identified from the association.

[25] Coronial Brief, Statement of JN, 92.

Victoria Police that LM was absent without leave and a missing person investigation was commenced.[26]

34. On 11 February 2016, Ricardo Gabbiani visited his friend LM's home. Ms Lynch was present, appeared visibly distressed and said that LM had 'bashed' her.[27] Ms Lynch left the property with Mr Gabbiani and stayed at his house that evening.[28]

35. The following day, on 12 February 2016, Mr Gabbiani returned Ms Lynch to LM's home. Ms Lynch told Mr Gabbiani she intended to collect some personal items, end her relationship with LM, and inform him that she was going to have him charged with breaching the FVIO.[29] This was the last time Ms Lynch was seen alive by anyone other than LM.

36. On 14 February 2016, LM contacted '000' and asked to be returned to Dandenong Hospital.[30]

37. On 20 February 2016, whilst at Dandenong Hospital, LM contacted his stepfather, IR,[31] by telephone and advised him that there was a body at his home. IR informed Victoria Police, and when police attended LM's home, they found Ms Lynch deceased in a closet.[32]

38. Later the same day, LM was arrested at the psychiatric unit of Dandenong Hospital and transported to Dandenong police station for interview but was found to be unfit for interview by a Forensic Medical Officer.

39. On 21 February 2016, LM was charged with Ms Lynch's murder and remanded in custody.

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[26] Coronial brief, Statement of M De Silva.

[27] Coronial Brief, Statement of R Gabbiani, 113.

[28] Coronial brief, Statement of R Gabbiani, 113.

[29] Coronial brief, Statement of R Gabbiani, 114.

[30] *DPP v LM* [2018] VSC 451, 2 [6].

[31] LM's stepfather has been deidentified to minimise the likelihood that LM can be identified from the association.

[32] *DPP v LM* [2018] VSC 451, 2 [8]; Coronial brief, Statement of IR, 73-74.

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

40. Fingerprint analysis and comparison was undertaken to identify Kim Rebecca Lynch born 26 February 1974.[33]

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

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

42. On 21 February 2016, Forensic Pathologist Dr Sarah Parsons from the Victorian Institute of Forensic Medicine (VIFM) conducted an autopsy of Ms Lynch's body. Dr Parsons attended the scene of Ms Lynch's death, reviewed post-mortem computed tomography (**CT**) scans of the whole body, the Police Report of Death for the Coroner (Form 83)[34] and a Section 27 Form[35] before providing a written report dated 15 April 2016.[36]

43. Among Dr Parsons' anatomical findings were bruising in multiple levels of the strap muscles of the neck associated with a ligature *in situ*, some petechial haemorrhages, and evidence of blunt force trauma to the face, upper and lower limbs.[37] There was also evidence of natural disease (myocardial fibrosis, splenomegaly and cirrhosis).[38] Decomposition complicated interpretation of some post-mortem findings.[39]

44. Dr Parsons commented that the marks on the neck were in keeping with ligature strangulation however manual strangulation could not be excluded.[40]

45. Toxicological analysis of post-mortem samples identified the presence of alcohol, morphine, methadone,[41] methylamphetamine, oxazepam and delta-9-tetrahydrocannabinol.[42]

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[33] Determination by Coroner of Identity of Deceased dated 23 February 2016.

[34] 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.

[35] A 'Section 27 Form' is a form requesting that an autopsy be performed.

[36] Report of Dr Sarah Parsons dated 15 April 2016.

[37] Report of Dr Sarah Parsons dated 15 April 2016.

[38] Report of Dr Sarah Parsons dated 15 April 2016.

[39] Report of Dr Sarah Parsons dated 15 April 2016.

[40] Report of Dr Sarah Parsons dated 15 April 2016.

46. Dr Parsons provided an opinion that the medical cause of death was:

    1(a) neck compression.[43]

47. I accept Dr Parsons' opinion.

FOCUS OF INVESTIGATION

48. The focus of my investigation of Ms Lynch's death was threefold:

    (a) The adequacy of the service response to the incident of family violence reported on 17 January 2016;

    (b) The adequacy of LM's mental health management, and in particular:

        i. Communication of critical information about LM between his community and inpatient treating teams;

        ii. The decision to grant LM supervised leave on 5 February 2016; and

        iii. The response to LM being absent without leave; and

    (c) The adequacy of the investigation to locate LM after he was reported missing.

49. I will discuss each of these issues in turn.

Adequacy of service response to family violence incident on 17 January 2016

50. Several service providers had contact with Ms Lynch and LM following the incident of family violence reported by Ms Lynch to police on 17 January 2016.[44]

51. Monash Health's service contact with LM and Victoria Police's missing person investigation will be addressed in separate sections below.

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[41] Information from the Department of Health and Human Services indicated that no permit to treat Ms Lynch with methadone had been issued.

[42] Report of Dr Sarah Parsons dated 15 April 2016.

[43] Report of Dr Sarah Parsons dated 15 April 2016.

[44] The coronial investigation also considered the service response of (a) the Alfred Hospital following Ms Lynch's presentation to the ED on 19 October 2015 with suicidal ideation when she reported being physically and sexually assaulted by an unnamed partner; (b) Austin Health following Ms Lynch's presentation with suicidality on 12 January 2016, though the records do not reflect any disclosure of family violence; and (c) Ms Lynch's contact with WAYSS for housing assistance on 22 October 2015, apparently before her relationship with LM.

Monash Health

52. Ms Lynch was taken to Dandenong Hospital by police exercising powers under the *Mental Health Act* 2014. During the mental health assessment conducted in the ED, Ms Lynch confirmed telling police that she was suicidal but stated that she was no longer suicidal. She disclosed consuming alcohol and methadone that day and methamphetamine the previous day; she presented as 'obviously substance affected'.

53. The mental health clinician documented an impression that Ms Lynch was experiencing distress related to the recent assault but no acute mental illness. She was given the psychiatric triage service (**PTS**) phone number and referral to sexual assault services was planned.[45]

54. Ms Lynch stayed in ED overnight and was discharged the following morning with a taxi voucher.

Victoria Police

55. The actions of Victoria Police following Ms Lynch's report of the family violence incident on 17 January 2016 appear congruent with the *Code of Practice for the Investigation of Family Violence* applicable at the time. Police appropriately assessed the family violence risk by completing a Form L17, commenced a criminal investigation and gathered evidence including photographs and a witness statement. A FVSN was issued to protect Ms Lynch and referrals were made for Ms Lynch and LM.[46]

56. Police also addressed concerns for Ms Lynch's welfare by arranging for her to be conveyed to hospital for mental health assessment, contacting WAYSS to ensure she had crisis accommodation support, and arranging for members of the local Sexual Offences and Child Abuse Investigations Team to speak with her following her disclosure of a recent sexual assault (by someone other than LM).

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[45] It was unclear whether this occurred or whether this was to be done by Monash Health or Victoria Police. Monash Health medical records stated "Police investigating [sexual assault], aimed to send straight to SECASA [South East Centre Against Sexual Assault]".

[46] Coronial Brief. Statement of T Griffiths, 171-173; Appendix H, 313-314; Victoria Police, LEAP records relating to Kim Lynch, 31-39.

57. Police did not obtain statements from either Ms Lynch or LM at the time of the incident; however, I consider that it was appropriate in the circumstances to prioritise Ms Lynch's mental health assessment particularly as a FVSN was in place in the interim.

58. It is unclear what steps Victoria Police took to interview LM or serve the FVIO on him after 18 January 2016. LM was hospitalised on 30 January 2016 and the FVIO served, by way of substituted service at his residence, two days later on 1 February 2016.

59. Although LM's hospitalisation for mental health assessment on 30 January 2016 involved contact with Victoria Police, given his presentation at the time it was arguably not appropriate to serve documents or seek to interview him at that time. The available medical records do not suggest that Victoria Police contacted Dandenong Hospital to ascertain whether it was appropriate to serve the FVIO after his admission.[47] That said, there is no indication that the Informant knew LM had been hospitalised given that she submitted a 'whereabouts' on 9 February 2016, suggesting she had been unable to locate him.[48]

<u>WAYSS</u>

60. Ms Lynch had contact with WAYSS on 18 January 2016, at which time a comprehensive family violence risk assessment and safety planning were undertaken.[49] However, it is noted that the only action on the safety plan was 'call 000' which appears inadequate given the risk assessment guidelines applicable at the time. Those guidelines[50] indicate that a safety plan should include, at a minimum, contact numbers for family violence organisations, emergency contact numbers, the location of a safe place to go (and store valuables and important documents) in an emergency, and specifically address any barriers to the person affected by family violence implementing the safety plan. Since 2016 there has been significant reform in the

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[47] Monash Health, records relating to LM, 1889, 2474-2550.

[48] A LEAP Person Whereabouts is a notification placed on LEAP and available to police across Australia to 'flag' persons wanted by police and alert members who may encounter the person to the recommended action to be taken: VPM - Guidelines – Tagging of records to locate suspects or offenders. I note that the 'Whereabouts' was submitted by the investigating members on 9 February 2016, having satisfied her supervisor that she'd 'conducted all reasonable enquiries' to locate him without success: Whereabouts file (Informant Griffiths).

[49] WAYSS, records relating to Kim Lynch, 20-21.

[50] Department of Human Services, *Family Violence Assessment and Risk Management Framework and Practice Guides 1-3*, (2012) 2nd Ed, 51.

family violence sector which means that the risk of misalignment of risk assessment and management unlikely.

61. During her contact with WAYSS, Ms Lynch indicated that she wanted to return to LM's home, that she felt safe doing so and that LM had not previously been violent towards her. She declined an offer from WAYSS to assist with crisis accommodation and was encouraged to contact the service again if needed.[51]

62. Like many family violence and community support agencies, WAYSS can only provide services to people who voluntarily engage with the service.

Hallam Family Practice

63. Ms Lynch presented to Hallam Family Practice on 21 January 2016 reporting that she had been assaulted by 'an ex-boyfriend' several days earlier, which appears to be a reference to the family violence incident on 17 January 2016. Records from this presentation indicate that Ms Lynch reported being no longer in a relationship with the person who had assaulted her and that she intended to move interstate. The records do not disclose whether the general practitioner provided Ms Lynch with referrals to family violence support services, nor does the record indicate any awareness of Ms Lynch's contact with Victoria Police or referral to WAYSS. This is potentially a missed opportunity for intervention. However, as I have previously noted, significant reform in the family violence sector has occurred since 2016 and referral to family violence support services is likely to be given greater priority by treating general practitioners now.

Adequacy of LM's mental health management

64. LM had an extensive history of mental illness including a diagnosis of paranoid schizophrenia, substance abuse, aggression and violence, and had an acquired brain injury.[52]

65. LM had had a lengthy involvement with Monash Health mental health services. File alerts were present for a high risk of absconding, a high risk of aggression and a high

[51] WAYSS, records relating to Kim Lynch, 31-32.

[52] Coronial Brief, Statement of Dr P de Silva.

risk of substance use.[53] Prior to his January 2016 admission, LM was case managed by Casey Community Mental Health Team (**CMHT**) on a compulsory community treatment order (**CTO**) under the *Mental Health Act 2014*. Due to his risk of harm to others, LM was encouraged to attend CMHT for appointments, and if home visits were required this was only to occur with two staff present. LM had been prescribed the long-acting antipsychotic injection aripiprazole 400mg every four weeks since December 2015.[54]

66. On 15 January 2016, LM's antipsychotic injection was due, but he failed to attend the scheduled appointment. He told his case manager he missed the appointment because he had broken up with his girlfriend and did not feel well.

67. On 20 January 2016, CMHT visited LM at home where his antipsychotic injection was administered. LM presented as dishevelled, guarded, irritable and restless, but did not appear substance affected. He was not responding to auditory hallucinations and did not voice delusional ideation. Chronic risks of misadventure and harm to others in the context of his ongoing substance abuse were noted. His presentation was consistent with his baseline mental state and no acute symptoms or risks were noted. Chronic risks were noted regarding home visits and a plan was made for LM to continue attending CMHT and to review each request for a home visit based on his current mental state and the need for him to receive his injection. There was no evidence that CMHT staff were aware that LM had allegedly assaulted Ms Lynch on 17 January 2016, or that a FVIO had been granted to protect her.

68. On 30 January 2016, LM called triple zero claiming that he injected himself with poison the day before and stating that if he could not get it out, he would murder everyone around him. He was arrested by police under section 351 of the *Mental Health Act 2014* and taken to Dandenong Hospital for mental health assessment.

69. On assessment LM presented as thought disordered, angry, dishevelled, and malodorous. He was delusional and responding to auditory hallucinations. His risks were noted to have increased, including a medium risk of self-harm, and high risks of substance use, non-compliance with treatment, harm to others and sexual assault (due to a history of sexual assault on the ward). LM's CTO was varied to an inpatient

[53] File alerts indicate chronic risks and/or history of risks but are not reflective of current and changing risks.

[54] Prior to this he had been prescribed long-acting antipsychotic injection risperidone.

treatment order (ITO) and he was admitted to the high dependency unit (HDU)[55] of the psychiatric unit.

70. A code grey was called, and LM was placed in seclusion for two hours during his first night on the unit.[56] During the initial days of his admission, he reported several disparate delusional and paranoid beliefs, refused prescribed oral medications but demanded drugs of addiction, hit a window, and called triple zero twice from his mobile phone to request a transfer to another hospital because he was 'being poisoned'. Various medications were introduced and increased to address his psychotic symptoms.

71. On the afternoon of 1 February 2016, LM was transferred to the low dependency unit (**LDU**), and thereafter began asking for periods of leave so that he could smoke cigarettes (though this was initially declined).

72. On 3 February 2016, LM was frustrated by being unable to smoke. Treating consultant psychiatrist Dr Vinit Mathur approved staff-escorted leave on hospital grounds for up to 15 minutes, and leave with staff so that an x-ray could be performed. LM was initially frustrated when told that he could not smoke either on hospital grounds or while escorted by staff but settled when the Nurse Unit Manager explained the hospital policies. LM's grandmother visited that evening and asked nursing staff to arrange for her to speak with LM's doctor.

73. On 4 February 2016, a meeting between LM and the Centrelink outreach worker ended prematurely because LM became irritable and verbally abusive.

74. On the same day, psychiatric registrar Dr Laura Pejnovic contacted JN who raised concerns about her grandson's finances, housing situation, poor self-care, and lack of social supports. She also advised that LM had asked her to take him on leave.

75. LM contacted his CMHT case manager Rafaela Rivera on 4 February 2016 and asked that she take him home to ensure that the door was locked. Clinician Rivera phoned Dr Pejnovic for additional information but ultimately advised her that this was 'beyond scope of [her] role and a risk while in [LM was] this state'. Clinician Rivera did, however, agree to attend alone as she would be in the area on other home visits.

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[55] Referred to in medical records as Flexicare.

[56] Contemporaneous notes indicate that this was due to aggressive behaviour, however the discharge summary stated that this was due to an attempt to abscond.

Clinician Rivera's note of this phone call in the CMHT medical record included that she was concerned about LM's risks if she were to take him on leave, however no similar notation was documented in the inpatient medical record by Dr Pejnovic.

76. Dr Pejnovic documented that LM wanted leave to check if his house was secure and see his girlfriend but due to his agitation in the Centrelink meeting earlier in the day, he was not approved for leave that day but could have leave the following day.

77. LM left the inpatient unit escorted by security staff to attend for an x-ray as was approved by Dr Mathur the previous day. No issues were noted as having occurred during the leave. LM's overall risk assessment from the beginning of his admission until 4 February 2016 was rated as high.

78. When Clinician Rivera attended LM's home on 4 February 2016, Ms Lynch was present. Ms Lynch told Clinician Rivera that she had found methamphetamines inside and showed her the house which was in disarray and had broken glass on the living room floor. Ms Lynch informed Clinician Rivera that LM had recently assaulted her and that there was an FVIO in place. All this information was documented in the CMHT record as was Clinician Rivera's phone conversation with a nurse at the inpatient unit. The phone call is not recorded in LM's inpatient records.[57]

79. LM's inpatient notes reflect a visit by his 'partner' on 4 February 2016, and that the visit occurred with 'nil concerns'.[58]

80. On 5 February 2016, Dr Pejnovic advised consultant psychiatrist Dr Piyumali De Silva that the previous day Dr Mathur had approved LM for leave with his grandmother on 5 February 2016 but had not completed the relevant documentation. As Dr Mathur was unexpectedly away that day,[59] Dr Pejnovic asked Dr De Silva to complete the paperwork to approve leave. Dr De Silva agreed.

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[57] Coronial Brief, Statement of Dr P De Silva dated 15 April 2019.

[58] LM's medical records.

[59] Dr Mathur stated that he did not approve LM to have escorted leave with his grandmother on 5 February 2016. Dr Mathur did not document in the medical record regarding leave. Dr Pejnovic documented in the medical record on 4 February 2016 that LM could have escorted leave with his grandmother the following day however did not document that this had been discussed with Dr Mathur. Dr Pejnovic's statement indicated that she made this note after a discussion with Dr Mathur, who reportedly agreed that LM have escorted leave with his grandmother the following day. Dr De Silva noted in her statement that she had a good working relationship with Dr Pejnovic, had supervised her for six months in 2015, and considered her to be a

81. At 11am, Dr De Silva completed a leave form, granting LM escorted leave with his grandmother for a period of three hours. The conditions of leave included that LM remain with JN at all times, not use drugs or alcohol and return within three hours.

82. Two risk assessments were completed by the same nurse before LM left the unit, at 9am and 11.10am. Both rated LM's overall risk as medium, with substance use being rated as medium at 9am and low-medium at 11.10am and absconding, cognitive impairment, non-compliance, harm from others, harm to others and other risks all being rated as low-medium on both risk assessments.[60]

83. JN collected LM from the inpatient unit between 11.30am and midday. Immediately on leaving the hospital, LM told his grandmother that he wanted to see Ms Lynch and phoned her. Ms Lynch and Mr Ronksley directed LM to the factory at which she was staying, and Ms Lynch then accompanied LM and JN to LM's home.

84. On arrival, LM refused to return to hospital and told JN that he wanted to spend time with Ms Lynch alone and would make his own way back to hospital. JN left and immediately contacted the inpatient unit to advise that LM was no longer with her and refused to return to hospital.

85. Inpatient unit staff reported LM to police as a compulsory patient who was absent without leave (**AWOL**).

Communication of critical information

86. Drs Pejnovic, Mathur and De Silva all stated that during LM's admission, they were unaware of his history of violence towards Ms Lynch and that an intervention order was in place. Clinician Rivera became aware of this when she visited LM's home on 4 February 2016 and spoke with Ms Lynch. This information, along with Ms Lynch's account of finding bags of methylamphetamine consistent with heavy use and observations of a house in disarray, was documented by the clinician in the CMHT medical record. However, these notes were not available to inpatient staff. Clinician Rivera also documented her contact with the inpatient unit the same day to advise that the door to LM's home was locked and ask a social worker to discuss possible

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competent and conscientious registrar who was cautious in her judgements and strict about seeking and following the instructions of her supervising psychiatrist.

[60] All other risks were rated as low.

accommodation issues on discharge with LM. There is no evidence that Clinician Rivera handed over information about LM's recent violence towards Ms Lynch, the intervention order, or drugs at the house.

87. A verbal handover of critical information in addition to entries in the medical record would ensure that critical information is known and considered in clinical decision making such as when granting LM leave off hospital grounds as well as when allowing visitors – such as Ms Lynch – on the ward.[61] Had this information been known to inpatient staff, it would be expected that the conditions of LM's leave include that he have no contact with Ms Lynch and that his grandmother be advised of this condition. It is unclear whether JN was aware of the FVIO before taking LM on leave however if not, being informed of this by inpatient unit staff could have resulted in her declining LM's request to collect Ms Lynch after they left the hospital.

<u>The decision to grant LM supervised leave</u>

88. Dr De Silva stated that her involvement in LM's admission was limited to 'signing [his] leave documentation on 5 February 2016 on behalf of his treating psychiatrist'.[62] She did not personally assess LM nor did she refer in statements provided to the coronial investigation to reviewing his medical record before completing the leave form.[63] Dr De Silva relied on information provided by Dr Pejnovic.[64]

89. Section 64(2)(b) of the *Mental Health Act 2014* provides:

> The authorised psychiatrist may grant a leave of absence for any period and subject to any conditions that he or she is satisfied are necessary or vary the conditions or duration of the leave of absence- (a) having regard to the purpose of the leave; and (b) if satisfied on the evidence available that the health and safety of the person or the safety of any other person will not be seriously endangered as a result.

[61] The available information indicated that Ms Lynch visited LM at Dandenong Hospital during this admission.

[62] Statement of Dr P De Silva dated 15 April 2019.

[63] Statements of Dr P De Silva dated 15 April 2019 and 5 February 2021.

[64] Statement of Dr P De Silva dated 15 April 2019.

90. Therefore, as the authorised psychiatrist granting leave,[65] Dr De Silva's involvement extended to satisfying herself that the health and safety of LM and others would not be seriously endangered by her decision to grant leave.

91. Chief Psychiatrist Dr Neil Coventry observed that 'under normal circumstances' a leave of absence should be granted by the patient's treating psychiatrist as s/he is the clinician best placed to balance the risks of leave to the patient and others with the patient's right to be treated in the least restrictive way possible.[66]

92. Where the treating psychiatrist is unavailable, rather than decline to grant leave (which may be contrary to the least restrictive treatment principle) another authorised psychiatrist might reasonably grant leave, even if s/he has not personally reviewed the patient during an episode of care.[67]

93. In Dr Coventry's view, a psychiatrist granting leave to the patient of a consultant colleague, would be expected to seek advice from experienced members of the clinical team regarding the patient's mental state, degree of recovery, previous episodes of leave, the patient's views and preferences, the purpose of leave and its associated benefits and risks and (where relevant) the views of carers.[68]

94. Dr Coventry observed that where the patient is recovering well and previous episodes of leave proved helpful, the decision to grant leave will be relatively straightforward. However, in other situations, the psychiatrist would be expected to examine the patient, consult the clinical record and where possible contact the treating consultant, carers and other relevant parties.[69]

95. The Chief Psychiatrist noted that although guidance may be provided by the treating psychiatrist, the psychiatrist granting leave must always exercise personal judgement

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[65] Section 151(1)(a) of the *Mental Health Act* 2014 allows an authorised psychiatrist to delegate any power, duty or function (other than that of delegation) to another psychiatrist.

[66] Statement of the Chief Psychiatrist dated 7 December 2020.

[67] Statement of the Chief Psychiatrist dated 7 December 2020.

[68] Statement of the Chief Psychiatrist dated 7 December 2020.

[69] Statement of the Chief Psychiatrist dated 7 December 2020.

regarding leave requests based on 'sufficient information' to make an 'informed decision'.[70]

96. Professor David Clarke, Program Director, Mental Health at Monash Health endorsed the comments of the Chief Psychiatrist.[71]

97. According to Dr De Silva, Dr Pejnovic told her that Dr Mathur had given approval for LM to go on leave with his grandmother on 5 February 2016 and that he was willing to accept the risks of absconding and substance abuse. Dr De Silva did not review the medical record or review LM because she understood that the clinical decision to approve leave had already been made by Dr Mathur.[72]

98. Dr Mathur confirmed that he did not discuss LM's leave with Dr De Silva but recalled discussing family member escorted leave with Dr Pejnovic, though not the details of the discussion nor that any specific date for such leave had been agreed.[73] Dr Mathur did not document that LM could have leave with his grandmother on 5 February 2016 in the medical record.

99. There is a note, made by Dr Pejnovic on 4 February 2016 after phone calls with JN and Clinician Rivera, that LM was 'not for leave today, leave tomorrow'.[74] While there was no indication in the note that this course was discussed with Dr Mathur,[75] in her statement, Dr Pejnovic indicated there was a discussion with Dr Mathur.[76]

100. Given Dr Pejnovic was LM's treating psychiatric registrar and she asked Dr De Silva to approve LM's leave, it is not unreasonable for Dr De Silva to assume that Dr Pejnovic would have communicated any relevant mental state and risk information. It was

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[70] Statement of the Chief Psychiatrist dated 7 December 2020.

[71] Statement of Prof D Clarke dated 23 December 2021.

[72] Statement of Dr P De Silva dated 15 April 2019.

[73] Despite not having agreed to a specific date for leave, Dr Mathur stated that based on his review of the medical record entries for 5 February 2016, he believed that LM was suitable for escorted leave with his grandmother.

[74] Dandenong Hospital digital medical record part 4, page 521 of 1006.

[75] Though there was evidence that Dr Pejnovic had discussed with Dr Mathur LM's leave for the purposes of an x-ray on 4 February 2016.

[76] The same medical record entry by Dr Pejnovic indicated a discussion between Dr Pejnovic and Dr Mathur about escorted leave to have an x-ray on 4 February 2016, but no discussion about family escorted leave on 5 February 2016. Dr Mathur confirmed that on 3 February 2016 he approved leave for LM to have an x-ray, which was taken on 4 February 2016.

unclear from the available records whether Dr De Silva knew Dr Pejnovic had reviewed LM on the morning of 5 February 2016, but in any event, it was reasonable for Dr De Silva to assume that any relevant information from a review would have been communicated. Dr De Silva stated, 'as far as I can recall my discussion with Dr Pejnovic on 5 February 2016 did not yield any concerns about a risk to … [LM]'s girlfriend'.[77]

101. Dr De Silva did not recall discussing with Dr Pejnovic when LM had last been reviewed by a consultant psychiatrist but had assumed that Dr Mathur had reviewed LM in the context of forming the leave plan the previous day.[78] The medical record shows that LM was reviewed by consultant psychiatrist Dr Le Bas on the day of admission (30 January 2016) and by Dr Mathur on 1 February 2016.[79] Dr Pejnovic reviewed LM on 2, 3, 4 and 5 February 2016 and Dr Mathur was not documented as present at those reviews.[80]

102. Dr De Silva stated that she satisfied herself that the health and safety of LM and others would not be seriously endangered as a result of granting leave on the basis of:

    (a) Dr Pejnovic's advice that Dr Mathur had approved LM to have leave with his grandmother on 5 February 2016;

    (b) Her belief (via information from Dr Pejnovic) that Dr Mathur had assessed the appropriateness of leave the previous day, including an assessment of risk, and risks of substance abuse and absconding were accepted by Dr Mathur in making the clinical decision;

    (c) The absence of any indication of deterioration in LM's mental state or escalation in risk in the period between when she believed Dr Mathur to have agreed LM could have leave and when she (Dr De Silva) approved leave; and

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[77] Statement of Dr P De Silva dated 5 February 2021.

[78] Statement of Dr P De Silva dated 5 February 2021.

[79] With a registrar, possibly with Dr Pejnovic present.

[80] Dr Pejnovic stated that on 4 February 2016 she 'discussed the patient's presentation with Dr Mathur and the prospect of the patient having leave with his grandmother,' indicating that Dr Mathur was not present when Dr Pejnovic reviewed LM that day. Dr Mathur did not work on 5 February 2016 and therefore was not present at that review.

(d) Her confidence that Dr Pejnovic was familiar with LM and her account of the plan for leave as approved by Dr Mathur was reliable.

103. It is fair to say that some of the information on which Dr De Silva relied when granting LM leave on 5 February 2016 was misleading and/or unreliable; contrary to the impression provided by Dr Pejnovic, Dr Mathur had not approved leave on 5 February 2016 nor had he reviewed LM the previous day.

104. It would therefore be prudent for the psychiatrist approving leave on behalf of a consultant colleague to review the medical record and review the patient when first-hand information is not available, to improve the safety of clinical decision making.

105. It is also fair to say that information critical to the decision to grant leave to LM was unavailable as information known to the CMHT was not accessible nor handed over to the inpatient unit: neither Dr De Silva nor Dr Pejnovic knew of LM's recent violence towards Ms Lynch, the existence of a FVIO, that his house was in disarray or that methamphetamine was found there. Furthermore, Dr De Silva was unaware that Clinician Rivera had declined Dr Pejnovic's request[81] to escort LM on leave the previous day, in part because she was concerned about the risk he posed to her, and his risk of absconding.[82]

106. That said, I am obliged to assess the reasonableness of Dr De Silva's decision to grant LM leave with his grandmother on 5 February 2016 without the benefit of hindsight. Accordingly, I conclude that there was a reasonable basis for Dr De Silva to be satisfied on the evidence available to her that the health and safety of the person or the safety of any other person would not be seriously endangered as a result of granting leave to LM pursuant to Section 64(2)(b) of the *Mental Health Act* 2014.

107. Moreover, it is not possible to determine whether Dr De Silva would have made a different decision about leave had she reviewed LM herself, especially in circumstances where Dr Pejnovic had reviewed LM on the morning of 5 February 2016. I note that Dr

[81] Dr Pejnovic did not document this aspect of her conversation with Clinician Rivera in the inpatient medical record and it appeared that she also did not hand this information over to Dr De Silva.

[82] Statement of Rafaela Rivera.

Mathur opined that on his review of the medical record, he believed the decision to approve leave was appropriate.[83]

108. Finally, I note that while it is accepted practice for a consultant psychiatrist to complete leave documentation without reviewing the patient, Dr De Silva advises that she has changed her own practice such that she has direct verbal or written confirmation from a consultant colleague that the leave plan is approved before signing a leave form.[84] This change in Dr De Silva's practice is to be commended and will likely reduce the possibility of miscommunication in clinical decision making.

The response to LM being AWOL

109. The Monash Health Mental Health Missing Persons (Absconded and Absent Without Leave) Procedure[85] (**AWOL Procedure**) in place at the time LM was absent without leave specified the actions to be taken by staff responding to a patient who had absconded or was AWOL. Notification of the Nurse in Charge, consultant psychiatrist, Psychiatric Triage Service (**PTS**) and police were required to occur within 15 minutes.

110. When JN reported that LM was AWOL, an MHA124 Apprehension of a Patient Absent Without Leave form was completed,[86] Dandenong Hospital faxed information to Dandenong police[87] to commence a missing person investigation and a verbal handover occurred by phone.[88]

111. Contrary to the AWOL Procedure, the PTS was not notified and, though it was not required at the time, it would not have been unreasonable for inpatient staff to inform CMHT that LM was AWOL given the involvement of that service and attendance by a CMHT clinician at LM's home the previous day.

112. The AWOL Procedure required staff to 'make all reasonable efforts to contact patient/nominated person/relatives to inform them and engage their assistance to locate the patient/consumer'. This contact should occur within the first 30 minutes after the

[83] Statement of Dr V Mathur dated 8 February 2021.

[84] Statement of Dr P De Silva dated 15 April 2019.

[85] Dated 30 January 2015.

[86] Dandenong Hospital digital medical record part 1, page 129 of 759.

[87] Dandenong Hospital digital medical record part 3, page 886 of 996; Dandenong Hospital digital medical record part 4, page 524 of 1006.

[88] Dandenong Hospital digital medical record part 4, page 525 of 1006.

patient is due back.[89] There's no evidence of contact with LM's nominated contacts (after JN reported him AWOL) and as will be seen below, details of 'people contacted', relationships and contact numbers were omitted from the Absconder Notification Form faxed to police.

113. The *Department of Health and Human Services – Victoria Police Protocol for Mental Health: A Guide for Clinicians and Police* (**DHHS Protocol**) also states that mental health staff should make attempts to have patients who are AWOL located by family members. This protocol states that when a compulsory patient is AWOL:

> Police assistance can only be requested after reasonable steps have been taken to notify the nominated person, guardian, carer (if satisfied that the person's absence will directly affect the carer and the carer's relationship) or parent (if the patient is under the age of 16 years) to try to locate the person.

114. There was no indication that IR (listed as LM's next of kin) and JN (his emergency contact person) were unable to assist in locating him. Indeed, JN spoke to LM by phone the day after he went AWOL, when LM said he was at his mother's house. There was no evidence that JN informed mental health staff or police of LM's whereabouts at that time, nor did it appear that she made attempts to return LM to hospital.

115. In accordance with the DHHS Protocol and the AWOL Procedure, it would have been reasonable to ask LM's grandmother and stepfather to attempt to locate him and return him to the inpatient unit. It is unclear whether LM would have agreed to return, however this was a missed opportunity to potentially locate and return him to hospital before causing harm to Ms Lynch.

116. Similarly, the failure to inform the PTS (or CMHT) that LM was AWOL was a missed opportunity for assertive follow up, even though it is unknown whether this would have averted the fatal outcome.

117. The AWOL Procedure also required staff to continue to try to contact the patient at the beginning of the morning shift and, if by day seven the patient is still not found, a

[89] LM was due back at 3.00pm but reported to the ward as AWOL at 1.00pm as he breached his leave conditions by not remaining with his grandmother at all times. The AWOL Procedure outlines an expectation that when a patient fails to return from leave, the contact nurse will 'attempt to contact the patient/nominated person/relatives on two occasions in the first 30 minutes after the time the patient is due back.'

statistical discharge would occur on CMI and IMP.[90] The medical record did not indicate any attempts to contact LM while he was AWOL and it appeared that he was discharged 28 hours after he was reported AWOL.[91]

118. Statistical discharge earlier than anticipated by the AWOL Procedure would not have prevented LM's readmission to the inpatient unit. However, it is unknown whether attempts to contact LM would have been successful and whether they may have resulted in the identification of information that would have resulted in more assertive action by police to locate him, LM agreeing to return to the ward or his whereabouts becoming known and his family or police being able to return him to the inpatient unit before any harm came to Ms Lynch.

In-Depth Review

119. Monash Health conducted an in-depth review of LM's AWOL from the Dandenong Hospital psychiatric inpatient unit in 2016.

120. The key findings of the review were:

(a) Communication between the CMHT and inpatient unit 'could have been better', in particular:

i. The CMHT should have been notified of LM's admission to the inpatient unit at Dandenong Hospital;

ii. There was a 'disconnect' in communication and access to documentation by clinicians in different parts of the mental health service because of different recording systems and reliance on paper records at the time such that records were not available to clinicians at other sites in real time;

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[90] A statistical discharge indicates that the patient is no longer considered an inpatient for the purposes of bed statistics and their bed is no longer kept available for their return. However, this does not mean that the patient will not be readmitted when located, especially when the patient is subject to an inpatient treatment order.

[91] When inpatient staff were informed that LM was AWOL, police were notified and multiple follow up calls were made to police to obtain updates but no attempts to contact LM were documented. Two medical record entries were made on 6 February 2016 both indicating that LM had not made contact with the unit and the second stating 'bed declared available at 1700 and [LM] removed from stats as admitted patient'. No further entries were made in the medical record until LM was re-admitted. Dandenong Hospital digital medical record part 4, page 525 of 1006.

iii. There was no inpatient record of the CMHT clinician's phone call to the inpatient unit on 4 February 2016 and her record of the home visit was not accessible to the inpatient treatment team;

iv. The CMHT should have been advised when LM did not return from leave as this could have enabled enquiries as to his whereabouts;

v. The Psychiatric Triage Service should have been advised when LM did not return from leave and could have facilitated enquiries as to his whereabouts.[92]

(b) There was a lack of clarity in relevant policies about the meaning and distinction between 'accompanied' and 'escorted' leave and that family members needed to have a clear understanding of expectations when accompanying patients on leave.[93]

(c) The decision to grant LM leave on 5 February 2016 was not inappropriate.[94]

121. Several changes to policy and procedure have been made since the review was completed in 2016, and subsequently:

(a) *Changes to medical record-keeping*: Monash Health mental health inpatient units now use an Electronic Medical Record such that a patient's medical record is maintained online/electronically and available contemporaneously. Records made by the outpatient/community team are now made directly into the Scanned Medical Record system and are also available contemporaneously. The effect of these changes to how medical records are maintained is that a patient's inpatient and outpatient/community records are contemporaneously accessible to all clinicians.[95]

(b) In 2016, both the *Mental Health missing persons (abscond and absent without leave)* and *Mental Health Leave from Inpatient Units* procedures were

[92] Statement of Prof D Clarke dated 4 November 2020.

[93] Statement of Prof D Clarke dated 4 November 2020.

[94] Statement of Prof D Clarke dated 4 November 2020.

[95] Statements of Prof D Clarke dated 4 November 2020 and 23 December 2021.

amended to ensure the difference between 'accompanied' and 'escorted' leave was clear.[96]

(c) The *Mental Health missing persons (abscond and absent without leave)* procedure was reviewed and updated (more than once since 2016) to ensure it provided clear guidance about the reporting and actions required when a patient absconds or is absent without leave. A simplified flow diagram was incorporated, from 2020, into the revised procedure as a separate 'implementation tool'.[97]

(d) The *Mental Health Leave from Inpatient Units* procedure (last reviewed in July 2021) was updated to ensure leave planning is multidisciplinary and consultative and a decision to grant leave is not 'spur-of-the-moment' but contextualised by the patient's long-term treatment plan. Accordingly, the procedure now involves a discussion presided over by a consultant psychiatrist in the weekly ward round and/or patient reviews about a patient's eligibility for leave and, if leave is granted, the treating consultant psychiatrist formulates a clear plan.[98]

(e) The *Mental Health Case Management* procedure (last reviewed in July 2021) was updated to require, where possible, a case manager to remain involved in the care of a patient admitted to the inpatient unit, through contact between clinicians of the in- and outpatient services to facilitate continuity of care and between case managers and admitted patients.[99]

122. Monash Health conducts audits of compliance with its *Mental Health missing persons (abscond and absent without leave)* procedure. An audit conducted in late 2021 found improved compliance with search, notification/escalation and documentation requirements of the procedure, reasonable compliance with actions to be taken upon a patient's return to the inpatient unit and no gaps in staff training.[100]

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[96] Statement of Prof D Clarke dated 4 November 2020.

[97] Statements of Prof D Clarke dated 4 November 2020 and 23 December 2021.

[98] Statement of Prof D Clarke dated 23 December 2021.

[99] Statement of Prof D Clarke dated 23 December 2021.

[100] Statement of Prof D Clarke dated 23 December 2021.

123. I am satisfied that the review conducted has identified areas for improvement and that these have been implemented. In addition, the compliance audit provides an ongoing opportunity for review and ongoing improvement and Monash Health is to be commended for the actions taken to date.

Adequacy of the missing person investigation

124. In 2016, Dandenong police station used hard copy forms and files to record missing person reports and investigations.[101] A 'missing person report' comprised primarily of Forms L18A (Part 1 and 2), Form L10 and Form L1 which contain, respectively, details of the missing and reporting persons and a risk assessment, a physical description of the missing person, and a 'case progress narrative'.[102] The reporting member (the police member who received notification that a person is missing) was responsible for completing these documents and faxing them and phoning through their contents to the Central Data Entry Bureau (**CDEB**) so that the data could be recorded on the Law Enforcement Assistance Program (**LEAP**),[103] a database accessible by all Victoria Police members.

125. The hard copy missing person file was kept at the police station on a clip board and the details of each active missing person file recorded on a white board in the Section Sergeant's office.[104]

126. In 2016 and now, the reporting member retains responsibility for the missing person investigation (unless it is reassigned) notwithstanding that other police members performing watchhouse duties are often tasked to make enquiries about active missing person investigations subject to 'station dynamics and workloads'.[105]

127. In 2016 and now, missing person investigations are conducted in accordance with the Victoria Police Manual (**VPM**) procedures and guidelines for missing person

[101] Statement of A/S/Sgt S Dawson.

[102] Missing Person File relating to LM.

[103] Statement of A/S/Sgt S Dawson.

[104] Statement of A/S/Sgt S Dawson.

[105] Statement of A/S/Sgt S Dawson.

investigations in force at the time (**MPVPM**).[106] The MPVPM designates the responsibilities of the reporting member, that member's 'supervisor' and those of the 'work unit manager'. It also establishes a regime to 'check' all 'active' missing person reports at particular intervals,[107] including a Crime Investigation Unit '[CIU] update of risk assessment and categorisation after 7 days.'[108]

<u>LM's missing person report</u>

128. In 2016, in addition to phoning in a missing person report, mental health service staff completed and faxed to police completed L18A (part 1) and L10 forms when reporting a patient missing with other relevant materials. In LM's case, the fax included an 'Absconder Notification Form' (which did not identify any nominated contacts nor with whom LM had been on leave) and 'MHA124 Apprehension of Patient Absence without Leave' form, which identified LM's 'home'[109] as an address where he may be found.

129. At about 3.45pm on 5 February 2016, a police member[110] on reception duties at Dandenong police station received a call from a nurse at Dandenong Hospital psychiatric inpatient unit reporting LM missing. The call taker's contemporaneous notes document 'paperwork faxed over 14:40.'[111] A copy of those notes appear with an annotation, presumably made by the reporting member, that the fax was 'not received'.[112] The fax *was* received[113] because it appears in Victoria Police's missing person file though its contents do not appear to have informed the investigation substantially, if at all.

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[106] Victoria Police Manual – Procedures and Guidelines Missing Persons Investigations (as updated 17 August 2015) (MPVPM); given the circumstances in which LM was reported missing, the following VPMs are also relevant: 'Escapees and Absconders' and 'Apprehension of persons under the Mental Health Act'.

[107] Relevantly, on days 3 and 7 post-report.

[108] MPVPM.

[109] MHA124 Form completed by Monash Health in relation to LM.

[110] The reporting member (not the member who took the first call reporting LM missing) misidentified the colleague who handed over the missing person report; the contemporaneous notes of the call taker were provided to the coronial investigation.

[111] Notes of Constable TP. Monash Health fax cover sheet that appears in the Missing Person file contains an annotation that inpatient unit staff had been 'unable to get through since 1315 hrs to discuss faxed @1440'.

[112] Notes purportedly of Constable BT, apparently annotated by the reporting member.

[113] When the fax was received is not clear – the Monash Health fax cover sheet that appears in the Missing Person file was transmitted on 5 February 2016 at 21:33 (though it's not clear whether the date/time stamp was accurate).

130. Unable to complete the forms comprising the missing person report during his shift, the call taker handed over the task (and a copy of his notes) to a colleague on the incoming shift: this member, First Constable (**FC**) McLean, became the reporting member.

131. The L18A (Part 1 and 2), L10 and L1 forms completed by FC McLean contained the following information:

    (a) LM is an involuntary psychiatric patient at Dandenong Hospital;

    (b) He left hospital 'with his mother on day release at 1300 hours on 5/2/16, and [has] not returned';

    (c) His destination is unknown and his mother's address is unknown, 'so can't attend';

    (d) Nine indicators of risk were identified[114] including: self-harm or suicide [3]; reported missing by a person other than someone with whom he usually lives [6]; suffering from physical illness, disability, or mental health problems [10]; and drug or alcohol dependent [19];

    (e) LEAP records relating to LM showed 'warning flags' for 'severe psych conditions', 'carrying a knife', and violence towards police.

132. FC McLean phoned through the missing person report to CBED and notified his supervising sergeant and the divisional supervisor of the missing person.[115]

133. As noted above, Part 2 of the Form L18A is a risk assessment tool. It contains 22 risk factors the presence of which will 'guide'[116] categorisation of the risk associated with the missing person/circumstances of disappearance and the type of investigative

[114] The nine risks identified are: self-harm or suicide; reported missing by a person other than someone with whom he usually lived; suffering from physical illness, disability, or mental health problems; unable to interact safely with others or in an unknown environment; currently a client of DHS or other care facility or special accommodation; known to have previously gone missing and was exposed to harm; drug or alcohol dependent; subject to other unlisted factors which police consider should influence risk assessment; did not complete last known intended action/keep intended appointment: Form 18A (part 2) in relation to LM.

[115] Statement of FC L McLean.

[116] The Form L18A incorporates four 'dot points' of advice/instruction between the 'Risk Factor Guide' and the 'risk Assessment Categories & Description' sections. The first states that 'the above risk indicator is a guide only & the below Risk Assessment weighting will depend on the circumstances of each case'. The second indicated the risk indicator is a tool to assist 'making professional judgment of risk levels', and the third, confirms that 'supervisors have responsibility for oversighting risk assessment'.

response required. Risk assessment weighting is described as contingent upon the 'circumstances of each case'.[117] The form's instructions also state – in bold typeface – that:

> '[i]f ANY of the above Risk Factors 1 to 8[118] are present, then the Risk Assessment MUST be HIGH'; and
>
> If any one or more of the risk factors 7 to 10 are crossed,[119] or specialist search capacity/advice required S&R coordination centre MUST be notified (emphasis in original).[120]

134. Form L18A must be endorsed by a supervisor with the appropriate level of risk – low, medium or high. Risk ratings help determine the initial course of a missing person investigation, with investigations categorised as 'low'[121] or 'medium'[122] risk remaining at the local level and progressed by members performing desk duties with supervision and oversight provided by senior members, and notification of specialist areas such as the Criminal Investigation Unit (**CIU**) of those categorised as 'high'[123] risk, with referral from local members dependent on circumstances.

135. The risk indicators identified by FC McLean included risks 3, 6 and 10, each of which on their face, indicate a risk categorisation of 'high'.[124] I note that risk indicator 4 (the subject of a recent history of serious family conflict/abuse) was not identified. While this is not a risk Monash Health staff would have communicated when reporting LM missing, it is arguably one that should have been identified by Victoria Police given the LEAP entry relating to the family violence incident on 17 January 2016. That said,

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[117] See generally Form L18A.

[118] These eight risk factors are that the missing person is: (1) the presence of circumstances that give rise to an aspect of suspicious or concern (specify in narrative); (2) suspected to be subject of a significant crime in progress (e.g. abduction); (3) likely to cause self-harm or attempt suicide; (4) the subject of a recent history of serious family conflict/abuse; (5) known to have left behind personal belongings/items required for a period of absence; (6) reported missing by a person other an someone they normally reside with; (7) last seen near a body of water; and (8) vulnerable due to age, infirmity or any other similar factor.

[119] Risk factors (9) and (10) are that the missing person is: (9) likely to be exposed to inclement weather conditions that would seriously increase risk to health and (10) suffering from a physical illness, disability or mental health problems.

[120] See generally the Form L18A used at the time LM was reported missing.

[121] Low risk assessment category is defined as 'no apparent threat or danger to either the missing person or the public'.

[122] Medium risk assessment category is defined as 'missing person or the public possibly facing some danger'.

[123] High risk assessment category is defined as 'risk posed is immediate and there are substantial grounds for believing that the missing person or the public is in danger'.

[124] Form L18A completed in relation to LM.

though risk indicator 4 is another risk automatically requiring a high risk categorisation, as three other such risks were identified it's omission is unlikely to have adversely affected management of the missing person investigation.

136. Indeed, the 'supervisor risk assessment' confirmed the 'high' risk categorisation.[125] Once the level of risk is determined to be high, according to Form L18A, immediate notification of CIU is mandatory.[126] There is no evidence that the CIU were notified.

Actions taken by Victoria Police to locate LM

137. On 5 February 2016, the FC McLean attempted to contact the nurse who reported LM missing but she was unavailable.[127] He phoned the inpatient unit, speaking to a duty nurse who told him that she believed LM had left the unit early that morning in his mother's care and that no records were kept about into whose care a patient was released.[128] She was unable to describe the clothing LM was wearing when he went on leave as she was not on duty.[129]

138. FC McLean performed a 'name search' on LEAP to identify LM's mother.[130] Information held by Victoria Police of a woman believed to be LM's mother dated to 2009 and all recorded phone numbers were disconnected or not answered when called. Nonetheless, the reporting member requested police attend her last known address to establish if LM was present; no response to this request was received.[131]

139. Before going off shift, FC McLean requested a 'keep a look out for' (KALOF) broadcast be issued in relation to LM[132] and handed the missing person file to the section sergeant on duty.[133]

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[125] Form L18A completed in relation to LM.

[126] Form L18A completed in relation to LM.

[127] Statement of FC L McLean.

[128] Statement of FC L McLean.

[129] Statement of FC L McLean.

[130] Statement of FC L McLean.

[131] Statement of FC L McLean.

[132] A KALOF is a type of record tag issued to one police are to others: VPM - Guidelines – Tagging of records to locate suspects or offenders.

[133] Statement of FC L McLean.

140. On 7 and 12 February 2016, the FC McLean contacted Dandenong Hospital to ascertain whether LM had returned; he had not.[134] As required by the MPVPM, FC McLean updated the LEAP case progress narrative to reflect these enquiries.

141. There is no evidence that any police unit was dispatched to LM's home in an effort to locate him between 5 and 14 February 2016.[135]

142. There is no clear evidence of any 'check' of the missing person investigation on days three and seven nor of any CIU 'update of risk assessment and categorisation after 7 days' as required by the MPVPM. The only other notation on the LEAP case progress narrative is a note made on day four by the section sergeant that the case is 'still on [the] board'.[136]

LM is classified as a 'located' missing person

143. At about 2.15pm on 13 February 2016, LM's neighbour contacted police after LM jumped the fence into his yard. When the neighbour confronted him, LM said he was schizophrenic and hearing voices.[137] LM returned an hour later wearing different trousers and was seen walking along the top of the rear fence of his own property before jumping into the yard of the house directly behind that of the neighbour in whose yard he had been earlier. The neighbour called the police again.[138]

144. Although a 'suspect loiter' job was created for Victoria Police at about 2.20pm, no patrol unit was able to attend until after 8pm.[139] Police spoke to the neighbour noting the 'description matched [LM]' and attended LM's home but he was not there.[140] The final comment connected with the job was that a named police member would 'follow up on next shift'.[141] What prompted the planned follow-up is unclear from the available records.

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[134] LEAP Text Editor – Incident ID 160044293.

[135] Statement of A/S/Sgt S Dawson and 'Event Search Summary'.

[136] LEAP Text Editor – Incident ID 160044293.

[137] Event Chronology– Event #: P1602089567.

[138] Event Chronology – Event #: P1602089567.

[139] Event Chronology – Event #: P1602089567.

[140] Event Chronology – Event #: P1602089567.

[141] Event Chronology – Event #: P1602089567.

145. About four hours later, at 12.14am on 14 February 2016, LM contacted triple zero from a phone box at the Dandenong train station and asked to be returned to the Dandenong Hospital psychiatric unit.

146. At 12.32am, police attended Dandenong train station where paramedics were already on site.[142] The electronic patrol duty record indicates that LM identified himself to police and a LEAP 'name check' was undertaken which revealed he was an involuntary psychiatric patient who had been reported missing from Dandenong Hospital, and that there was an outstanding 'whereabouts'[143] alerting members that LM was wanted for questioning in relation to the allegation he assaulted Ms Lynch on 17 January 2016.[144]

147. A short time later, LM was transported by ambulance to Dandenong Hospital[145] and a Located Missing Person (Form L18C) was completed.[146]

Assessing the adequacy of missing person investigations

148. I sought clarification from Victoria Police about several aspects of missing person investigations – information reconciliation, risk assessment and resource allocation, 'checks' at prescribed intervals – including whether the missing person investigation conducted in relation to LM met Victoria Police expectations considering the MPVPM.

149. Detective Acting Inspector (**D/A/Insp**) Tony Combridge, Officer in Charge Missing Person Squad, provided a statement on behalf of Victoria Police.

150. D/A/Insp Combridge observed that although the process for entering missing person reports on LEAP has been 'streamlined' since 2016, with members able to self-authorise entering them directly onto Victoria Police's system,[147] there is 'no prescribed process or structure that reconciles the information provided by people reporting a missing person [with how that information] appears on LEAP'.[148] Rather, it

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142 ePDR 13-14 February 2016 for call sign TST615.

143 LM was considered 'not fit for interview' at that time.

144 ePDR 13-14 February 2016 for call sign TST615.

145 ePDR 13-14 February 2016 for call sign TST615.

146 Missing Person File relating to LM.

147 Missing Person reports are one of only two reports that can be entered without a supervisor's authorisation.

148 Statement of D/A/Insp T Combridge.

is anticipated that as inquiries progress, information will be added and any inconsistencies clarified where possible.

151. D/A/Insp Combridge asserted that 'the fact that inquiries made and/or other information does not appear in LEAP does not necessarily mean that inquiries were not made, or actions taken'. He noted that such information may be recorded in other places but that best practice – and the MPVPM – required it be recorded centrally in LEAP, particularly as missing person investigations (and supervision) often passed through many hands.[149]

152. D/A/Insp Combridge conceded that 'it would have been preferable for LEAP to have contained a more detailed record of all the inquiries made to locate' LM.[150]

153. D/A/Insp Combridge confirmed that the missing person risk assessment informs police bout the risks posed to the missing person and to others which, in turn, informs the level of response required for the missing person report. He highlighted that the resources of police stations are finite and on any given day, several other priorities or emergencies may be competing for those resources.[151]

154. He conceded that the 'victim or perpetrator of domestic violence' risk should have been identified but noted that the risk was assessed as 'high' nonetheless and information about the family violence incident was available to all investigating members via LEAP.[152]

155. While acknowledging that the L18A form required notification of the local CIU of missing person reports categorised as high risk, the MPVPM does not require investigative primacy to be allocated to the CIU, in LM's case, D/A/Insp did not consider that the investigation warranted immediate referral to CIU.[153] He noted there were no known threats against Ms Lynch's life and, without minimising the assault

[149] Statement of D/A/Insp T Combridge.

[150] Statement of D/A/Insp T Combridge.

[151] Statement of D/A/Insp T Combridge.

[152] Statement of D/A/Insp T Combridge.

[153] Statement of D/A/Insp T Combridge.

suffered by Ms Lynch on 17 January 2016, noted it resulted in 'scratches, minor bruising and grazes' and was the only reported incident.[154]

156. D/A/Insp further contextualised his view by noting that Victoria Police receives about 18,000 missing person reports each year most of which are resolved without CIU involvement.[155] Indeed, 95% of missing person cases are resolved within 72 hours, and half of those not resolved within three days are resolved within seven days. Missing person cases not resolved within 30 days (about 30-40 cases per year) are regarded as 'long term' missing persons and are often allocated to detectives at that point.[156]

157. Given this context, D/A/Insp Combridge observed that resourcing for missing person files will necessarily depend on the specific circumstances of each. He contrasted the likely different resource allocation attracted by an elderly person with dementia missing from home for an hour and an adult with a long history of non-life-threatening self-harm who went missing from an unknown time and location; both would be categorised as 'high risk', though the former case would likely attract an active search of the area and the latter a focus on investigation rather than search.[157]

158. It was noted that local section sergeants are responsible for local resourcing decisions and should make recommendations to sergeants managing patrols and work to ensure work allocations balance the various competing demands. Irrespective of the demands on resourcing generally, however, D/A/Insp would expect a missing person file would 'always be allocated for investigation (which would include active inquiries, for example attending the missing person last known address, speaking to his/her neighbours etc)'.[158]

159. D/A/Insp Combridge confirmed that timing of 'checks' of missing person investigations reflected were times by which such matters are ordinarily resolved. Checks are not supposed to be 'perfunctory' but are intended to ensure the matter is

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[154] Statement of D/A/Insp T Combridge.

[155] Statement of D/A/Insp T Combridge.

[156] Statement of D/A/Insp T Combridge.

[157] Statement of D/A/Insp T Combridge.

[158] Statement of D/A/Insp T Combridge.

being progressed, reviewed for adequacy and any further work or lines of inquiry required clearly indicated.[159]

160. Save for the concessions concerning best practice noted above, D/A/Insp Combridge refused to comment on whether or not the investigation undertaken to locate LM met Victoria Police standards.[160] He noted that Victoria Police set practice expectations and requirements without being overly prescriptive to ensure members have flexibility to tackle investigative challenges. Moreover, without knowing more about the 'call on resources of the relevant personnel and station at the relevant times, the nature of the inquiries conducted, and supervision undertaken' he could not comment 'directly' on the efficacy or otherwise of inquiries and supervision.[161]

FINDINGS

161. Having investigated the death of Kim Rebecca Lynch, and having held an inquest in relation to her death on 7 September 2022 at Melbourne, I make the following findings, pursuant to section 67(1) of the Coroners Act:

    (a) that the identity of the deceased was Kim Rebecca Lynch, born on 26 February 1974;

    (b) that Ms Lynch died at a residential address in Hallam between 12 February and 14 February 2016 from neck compression;

    (c) in the circumstances described above.

ACKNOWLEDGEMENTS

162. I convey my sincere condolences to Ms Lynch's family for their loss and acknowledge the distress caused by this protracted coronial investigation.

[159] Statement of D/A/Insp T Combridge.

[160] Statement of D/A/Insp T Combridge.

[161] Statement of D/A/Insp T Combridge.

COMMENTS

Pursuant to section 67(3) of the *Coroners Act* 2008, I make the following comments connected with the death:

1. Six years have passed since Ms Lynch's death. In that time, the Royal Commission into Family Violence (**RCFV**) and later, the Royal Commission into Victoria's Mental Health System (**RCMHS**), have enhanced the community's understanding of family violence and mental health issues. Both Royal Commissions made numerous recommendations to improve safety and service delivery to Victorians impacted by mental health and family violence. Significant changes have already occurred in the family violence sector and implementation of the RCMHS' recommendations is anticipated to provide similar enhancement of the mental health system in this state.

Family Violence

2. Widespread systemic changes have been implemented since publication of the 227 recommendations made by the RCFV in March 2016. Among these are the establishment of information sharing schemes between services, such as the Family Violence Information Sharing Scheme, which reinforces and informs assessments made using new frameworks for risk assessment and management. The applicable Family Violence Risk Assessment and Risk Management Framework in place at the time of Ms Lynch's death was the Common Risk Assessment Framework (**CRAF**). The RCFV recommended that the CRAF be reviewed, and that the new framework be legislated within the *Family Violence Protection Act* 2008 (Vic), so that prescribed organisations would be required to align their policies, procedures, practices and tools with it. In response to these recommendations, the Family Violence Multi-Agency Risk Assessment and Management Framework (**MARAM**) was developed to support practitioners in assessing, monitoring, and managing family violence risk. The MARAM provides much more comprehensive guidance regarding family violence risk assessment and safety planning, and the implementation of these reforms has led to significant changes across the entire service sector.

Monash Health

3. While I commend the technological improvements made by Monash Health to enhance the accessibility of medical records across clinical teams, accessibility alone will not ensure critical information is in the hands of decision makers when it is needed. Rather, in addition to the recognition and recording of critical information by clinicians, verbal handover of this information is essential to ensure that other members of the patient's treating team are aware of it as soon as practicable. Verbal handovers are an embedded practice particularly in shared clinical settings; establishing a system to ensure timely verbal handover of critical information between clinicians *not* operating from a shared setting has great potential to improve clinical decisions and patient safety.

4. Non-verbal handover of important or potentially critical information need not be 'high tech'. A register of patient leave escorts and their contact details (maintained in a central location at the inpatient unit) could provide a swift and silent handover to clinicians with no first-hand knowledge of an AWOL patient and, in turn, facilitate relay of accurate information to the missing person investigation and potentially identify a point of origin for a search or lines of inquiry. Monash Health may want to consider this as a further enhancement to their current process.

Victoria Police – Missing person investigations

5. Recognition and recording of critical information are as essential to the work of police members as they are to clinicians. When information is recorded in a central, accessible location within an organization, training and supervision must ensure that what is relevant (or critical) is recognised. While reliance on information clarification through inquiry rather than a more formal process to assess the accuracy of information informing a missing person investigation may be sufficient, the method does pre-suppose further inquiries are undertaken. When supervision of a missing person investigation involves periodic review to ascertain adequacy and progress on the basis of a written record, the record must be central and accessible and made as soon as practicable. The impediments to attaining the best practice to which individuals and organisations aspire are obvious in dynamic environments replete with competing priorities, but this does not absolve Victoria Police (or any other organisation) of the need to measure any distance between theory and practice.

6. The investigation into Ms Lynch's death highlights the importance of robust systems to ensure the timely communication of accurate information critical to decision makers and their decisions. This is the case whether the decision makers are managing a family violence incident, determining the suitability of a compulsory psychiatric patient for leave, or allocating resources to locate a missing person. Robust systems are necessary whether the communication occurs within, across or between organisations or different parts of them, and to ensure different entities working in the same or complementary service areas do so effectively. Many recommendations for change have come from the RCFV and the RCMH. Some reforms have been implemented, others are underway. It is hoped that the implementation of recommendations from both Royal Commissions will enhance the safety and delivery of services to Victorians impacted by mental health and or family violence. It is hoped that once implemented these reforms will reduce the risk of loss of life occurring in similar circumstance in the future.

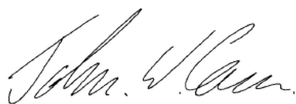
ORDERS

Pursuant to section 73(1) of the *Coroners Act* 2008, I order that this finding be published on the internet.

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

Ms Lynch's family
Monash Health
Victoria Police

Signature:



Judge John Cain
State Coroner
Date: 7 September 2022