IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2011 000291

FINDING INTO DEATH WITH INQUEST

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

Inquest into the Death of: HASSEN YASSIN

Delivered On:	20 August 2013
Delivered At:	Coroners Court of Victoria Level 11, 222 Exhibition Street Melbourne Victoria
Hearing Date:	9 and 10 May 2013
Findings of:	CORONER K. M. W. PARKINSON
Representation:	Mr Robert McClosky of Counsel for North Western Mental Health Service and Broadmeadows In Patient Unit; Mr Michael Regos of Counsel for Werribee Mercy Health Service; Dr Paul Halley of Counsel for Dr Keuneman.
Police Coronial Support Unit Assisting the Coroner	Leading Senior Constable Tania Cristiano

I, K. M. W. PARKINSON, Coroner having investigated the death of **HASSEN YASSIN**

AND having held an inquest in relation to this death on 9 and 10 MAY 2013

AT MELBOURNE

find that the identity of the deceased was **HASSEN YASSIN**

born on 21 August 1975

and that the death occurred on or about 23 January 2011

at 6/27 Ormond Road, West Footscray.

from:

1 (a) **HANGING**

in the following circumstances:

1. An inquest was held into the death of Mr Hassen Yassin on 10 May 2013. The following witnesses gave evidence in the proceedings: Consultant Psychiatrist, Dr Adegoke Okedara; Division 1 Registered Nurse, Ms Natalie Lentini of Werribee Mercy Hospital Mental Health Service ('Werribee Mercy MHS'); Division 2 Registered Nurse, Ms Carol Jones; Consultant Psychiatrist, Dr Richard Keuneman; Registered Division 1 and Consultant Psychiatrist, Dr Devapriya Rudolph; each of North West Mental Health Service Broadmeadows In Patient Unit ('BIPU'); and North West Area Mental Health Service Area Manager, Ms Joy Barrowman and Director of Operations, Mr Paul Kelly.

BACKGROUND AND CIRCUMSTANCES

2. Mr Hassen Yassin was a 35-year-old man who lived in residential premises at Footscray. Mr Yassin had rented the house to tenants and resided in the garage of the premises. Mr Yassin was father to one child who resides in Ethiopia and whom he visited when able. Mr Yassin came to Australia as a refugee from Ethiopia in 1998.

3. Mr Yassin reported a history of exposure to trauma including witnessing the death of close relatives in military action and having experienced torture and imprisonment.

4. He had a lengthy involvement with mental health services, with contact commencing in 1999. He had been diagnosed with schizophrenia, bi-polar affective disorder, post traumatic stress disorder and he had experienced a number of psychotic episodes.

5. Mr Yassin had experienced a number of hospital in-patient admissions as a result of his psychiatric illness. This usually involved short term stays and follow up treatment in the community after his condition had stabilised. His mental health care in recent times was usually provided by Werribee Mercy MHS, however he had been a patient of Casey Mental Health Services ('Casey') between 24 November 2010 and 10 December 2010. This was Mr Yassin's tenth mental health in-patient admission since 1999. He was discharged from Casey to continuing care with Werribee Mercy MHS.

6. His medication regime included Risperidone and Lithium. He was not always compliant with his medication regime. Doctors report that as with each admission, Mr Yassin's mental state improved within weeks of reinstituting his anti-psychotic medication, Risperidone.

Admissions leading up to absconding

7. On 17 December 2010, Mr Yassin was located behaving erratically and threatening a member of the public in a shopping centre. Police detained Mr Yassin pursuant to Section 10 of the *Mental Health Act 1986* and transported him to Werribee Mercy Hospital.

8. He was admitted to the in-patient mental health unit and was discharged on 1 January 2011 on an involuntary community treatment order ('CTO') being supervised by the Werribee Mercy MHS outpatient community treatment service. His compliance with and attendance upon that order was erratic.

9. On 7 January 2011, he was reviewed by Consultant Psychiatrist, Dr Adegoke Okedara of Werribee Mercy MHS. Dr Okedara concluded that his mental health was unstable and revoked the CTO. Mr Yassin was admitted as an involuntary patient to the Werribee Mercy Hospital on 7 January 2011 however there was no in-patient bed available and he remained in

the emergency department whilst inquiries were made as to the availability of an in-patient bed elsewhere.

10. On 8 January 2011, a bed was located at the North Western Mental Health Service Broadmeadows in-patient unit ('BIPU'), a hospital outside of Mr Yassin's residential area.

11. Prior to admission on 8 January 2011, BIPU Consultant Psychiatrist Dr Richard Keuneman discussed with Dr Okedara the patient's most recent risk assessment and reviewed the most recent documented assessments. It was noted that there was an absence of any acute suicidal risk concern in any of the risk assessments.

12. Despite being an involuntary patient, he was assessed by clinicians at BIPU as appropriate for management in the low dependency unit, as he was not regarded as being at immediate risk of absconding or of self-harm or harm to others. Clinicians consulted with Werribee Mercy MHS clinicians in relation to their management of Mr Yassin and the appropriateness of low dependency unit management. Dr Okedara advised that the main risks prompting the involuntary re-admission were active psychotic symptoms (grandiose themes, persecutory ideas) and disorganised behaviour, with questionable oral medication compliance and only variable engagement with the Crisis Assessment and Treatment Team (CATT) over the week since discharge from the Werribee Mercy Inpatient Unit.

13. Dr Keuneman noted that in the progress notes he received from Werribee there were no documented concerns of specific suicidal risk in any of the assessments and there was no recent documented suicidal or self harm behaviour in the clinical history he had reviewed[1]. Mr Yassin was however noted in the course of an admission in 2008 to have threatened self harm by hanging. The only other documented reference to self harm related to current admission involving a toy pistol and Mr Yassin advising that 'he would not hurt anyone else only himself'.

14. Mr Yassin was admitted to the BIPU Low Dependency Unit on 8 January 2011, where he remained until 10 January 2011. He was placed on half hourly observations and his medication regime was reinstituted.

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[1] Exhibit 2 – Statement Dr Richard Keuneman 2 February 2012.

15. At approximately 11.00 a.m. on 10 January 2011, Mr Yassin attended for a review and assessment by Dr Keuneman. At this consultation, which continued for approximately 20 - 25 minutes, Dr Keuneman reported that there was evidence of grandiose delusions, although he denied self-harm or aggressive thoughts and whilst he had limited insight, he was accepting of hospitalisation and treatment.

16. Dr Keuneman's diagnosis was of mixed manic psychotic relapse secondary to presumed non-compliance and psychosocial stressors and possible substance (Khat) abuse. The acute risks identified were of vulnerability, disorganisation and he was regarded as at low risk of self-harm, low risk of absconding and of low risk to others.

17. Dr Keuneman's treatment plan was to stabilise medication and for observation to continue. Dr Keuneman's evidence was that it was necessary and appropriate for Mr Yassin to remain an involuntary in-patient as he was vulnerable to further relapse in his mental state in the community. He stated:

> "So things getting much worse very quickly if he were not on treatment in a supervised environment such as the ward, and I guess in addition to that I did feel that there was a significant containing aspect to those risks in a hospital environment, even with some periods of leave off the ward with nursing staff."[2]

18. After the consultation with Dr Kueneman concluded at approximately 11.30 a.m., there was no record of any further sighting of Mr Yassin at the Broadmeadows MHS facility. The last charted visual observation was at 11.00 a.m. and nursing staff report that this observation may have been made at any time between 11.30 a.m. and 12.00 p.m. It is unclear whether Mr Yassin returned to the ward. The ward chart identifying visual observation of patients last recorded Mr Yassin as being sighted at 11.00 a.m. He was not observed on the ward at any subsequent time.

19. Enrolled Nurse Ms Carol Jones commenced her shift at approximately 1.00 p.m., commencing after handover. At approximately 2.20 p.m., Ms Jones noted that Mr Yassin was not on the

[2] Transcript dated 9 May 2013 at page 38.27.

ward and that he was not sighted at 12.00 p.m. and that the last time he had been recorded on the visual observations board in the ward was at 11.00 a.m.

20. Nurse Jones undertook a search of the facility and when she was unable to locate Mr Yassin, she reported the absence to the nurse in charge who instructed that police be notified that he had absconded. Nurse Jones stated that she telephoned Broadmeadows Police Station at approximately 4.00 p.m. to verbally advise that Mr Yassin was missing.

21. The usual procedure was to advise police by telephone and to document and fax the details of the patient to the local police station. Upon receipt of the faxed patient detail, local patrols are notified and police will attend at the missing person's residential address. On this occasion the incorrect telephone number was entered into the machine and consequently the facsimile did not transmit to the Broadmeadows police station and the police did not receive the details of Mr Yassin to enable follow up.

22. After the facsimile was sent, there was no procedure followed to ensure that the details had been received by police and Nurse Jones was called away to assist with an urgent matter involving another patient. The documents which were attempted to be faxed to the police station were not placed on the patient file and their whereabouts are unknown. They did not form a part of the documentation subsequently sent to the Werribee Mercy MHS when Mr Yassin's care was transferred back to that service.

23. There was no procedure or protocol requiring subsequent follow up with police in order to establish what steps police were taking in relation to locating the missing patient and as police did not receive any faxed documentation there was no formal notification to them of a missing person. As a result no attempts were made to locate Mr Yassin by police soon after he absconded.

24. A call was made by Nurse Jones to a telephone number for Mr Yassin's sister, Ms Semira Yassin. However when that number did not answer, it does not appear that any message was left (although Nurse Jones thought she may have left a message) and the hospital did not otherwise follow up the missing patient with family members on that, or subsequent days. Family reported that they were unaware that Mr Yassin was missing up to the time of his death.

25. It is unclear how Mr Yassin left the facility however there was no barrier to his leaving from the open ward and through the front door of the facility. The facility does not have an available security video which may have recorded his exit.

26. Mr Abrea Ayalew, a friend of Mr Yassin, advised police that he had observed Mr Yassin on 15 January 2011, walking along the Geelong Road at Point Cook. That is the last sighting of Mr Yassin.

27. On 23 January 2011, police were called to Mr Yassin's premises by a person visiting the house, who observed Mr Yassin through the garage window. Police attended and Mr Yassin was located hanging from the garage roof rafters. It was apparent that Mr Yassin was deceased and that he had been deceased for some time. Police report that there was no sign of forced entry or evidence to suggest anyone else had been involved in his death.

FORENSIC PATHOLOGIST EXAMINATION AND EVIDENCE

28. An examination was undertaken by Dr Michael Burke, Senior Forensic Pathologist at the Victorian Institute of Forensic Medicine. Dr Burke reported that the cause of death was Hanging and that whilst the CT scan showed marked changes of decomposition, there was no suggestion of any injury to the skull and no fractures identified. Dr Burke commented that whilst the external examination was difficult due to decomposition, there was no suggestion of facial fracture and no evidence of any other overt injuries. Dr Burke reported that a reasonable cause of death was: 1(a) Hanging.

ISSUES

29. The issues that arise in this case are:

    a. The ability of an involuntary patient to walk out of an in-patient psychiatric ward without being noticed;

    b. That Mr Yassin's absence was not noticed for some significant period of time, that is some 3 hours passed before steps were taken to attempt to locate him;

c. That there was an inadequate notification process to police and no follow up with police by any responsible mental health authority as to the results of their (police) inquiries regarding Mr Yassin's whereabouts; and

d. That there was no ongoing follow up by any of the mental health services, to attempt to locate Mr Yassin after his disappearance and apparent confusion as to who was responsible for his ongoing follow up or care.

30. The result was that over a significant period of time, when he was likely to be at risk, Mr Yassin was without any supervision and treatment.

WHICH MENTAL HEALTH SERVICE WAS RESPONSIBLE FOR MR YASSIN'S CONTINUED FOLLOW UP, CARE AND SUPERVISION AFTER HE ABSCONDED

31. On 10 January 2011, after Mr Yassin had absconded, Broadmeadows transferred his psychiatric care under the *Mental Health Act 1986*, arising from his involuntary status, back to Werribee Mercy Health. This occurred by documentation completed by Dr Keuneman on 10 January 2011, however he was not formally discharged off the ward numbers until 12 January 2011 when his care was documented by Dr Keuneman as completed and he was administratively (that is on the papers) transferred back to the Werribee Mercy Hospital.

32. Whilst Dr Keuneman's evidence was that after 10 January 2011, there was continued follow up by the Broadmeadows Mental Health Service as to the patient's whereabouts, this does not in fact appear to be the case.

33. On 11 January 2011, Mercy Health's after hours co-ordinator, Nurse Natalie Lentini, received the first and only telephone call from the BIPU advising that Mr Yassin was missing. Ms Lentini entered this information on the state-wide RAPID database, which enabled some of the information to be seen by mental health service clinicians state-wide. She also entered Mr Yassin on the Werribee Mercy Health Absconders/Missing person database so that staff within the Mercy Health service would be aware that he had absconded and she entered Mr Yassin on the Werribee Mercy Health System as a triage alert, so that in the event clinicians working in triage were contacted by or in relation to him, they would be alert to the fact that he was a person who was missing, possibly in crisis or relapsing and in need of help.

34. Ms Lentini tried unsuccessfully to contact Mr Yassin by telephone on his home number and having noted that he was described as being an 'open' case on the community treatment program, but without a case manager, she notified the program manager by email of the actions she had taken, in anticipation that the community treatment team would then follow up Mr Yassin.

35. However it appears that as Mr Yassin had not yet attended an appointment scheduled for 7 February 2011, that he was not regarded as being a client of the Community Treatment program at the time Ms Lentini advised of his absconding. Consequently no action was taken by the Community Treatment Programme Manager in relation to Ms Lentini's email and no further follow up occurred from any service area in Werribee Mercy MHS as a result.

36. Mr Dean Stevenson, Director of Clinical Services Werribee Mercy MHS advised the court that Mr Yassin had been allocated an initial assessment however he had not yet attended this appointment and therefore he was not regarded as receiving services for the Community Treatment Program. Consequently it appears that there was no follow up or referral back to Ms Lentini from that service[3].

37. The administrative or paper referral from the BIPU to the Werribee Mercy MHS occurred on 12 January 2011, by a transfer of paperwork and it appears that there was no direct discussion between clinicians from the respective services as to the transfer, or as to the fact that Mr Yassin had absconded.

38. After this transfer, the BIPU did not have any ongoing role in following up on the patient's whereabouts. Mr Peter Kelly of the BIPU gave evidence that it was not the responsibility of that facility or its CTT or CATT service, to follow up the patient, as he had been discharged back to the mental health service in his residential zone, from where follow up would occur.

39. Ms Lentini's evidence was that as Mr Yassin was no longer an in-patient at the Werribee Mercy MHS, the fact that his care had been administratively transferred back to the inpatient team by the BIPU, did not operate to activate any action on the part of the Werribee Mercy in-

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[3] Inquest Brief page 18 – Letter dated 15 February 2012.

patient service[4]. Her evidence as to the procedures which applied for absconding patients from the Werribee Mercy MHS inpatient service, which involved weekly review and follow up, did not apply in this case as he was not *'missing from our inpatient unit'*. Ms Lentini's evidence identifies the complexity associated with identifying who or what service is responsible for an 'out of area' absconding patient. She stated:

> "So is this policy applicable to Mr Yassin? In his circumstances no. He was not missing from our inpatient unit so he was not subject to following this inpatient procedure because he had absconded from the Broadmeadows Unit. So at this point he had nothing to do with our inpatient. He was now an absconded patient in the community. What about that fact that at some point it appears that Broadmeadows have transferred everything to Werribee while he was in the absconded patient class. Does that change that? –No, it doesn't make him a patient in our inpatient unit subject to this policy. It still makes him an ITO, that's AWOL in the community. So he wasn't an in-patient at the Werribee Mercy so he wasn't subject to those procedures."[5]

40. Ms Lentini's evidence was that she herself was unaware that the BIPU psychiatrist had transferred Mr Yassin's care from Broadmeadows to Werribee as this transfer did not occur until 12 January 2011. Although she had followed up Mr Yassin on 11 January 2011 out of concern for his welfare, she had regarded the Community Treatment Team as being the appropriate service for further follow up.

41. The consequence of this complexity and confusion of processes and procedures, was that there was no one following up Mr Yassin or his whereabouts for a significant period of time after he absconded.

FACTORS CAUSING AND CONTRIBUTING TO DEATH

4 Transcript dated 9 May 2013 at page 108.12.

5 Werribee Mercy MHS Inpatient Unit Absconding Patient procedure page 108 to 111 Inquest Brief.

42. I am satisfied having regard to Mr Yassin's prior psychiatric history, his mental health status as at the time he left the in-patient psychiatric facility, and the circumstances in which Mr Yassin was located, that Mr Yassin took his own life and that there were no suspicious circumstances.

43. I am satisfied that Mr Yassin's actions were intentional in the sense that he activated the plan, however his mental health status suggests that his psychiatric illness was a significant factor in the action he took to end his own life.

44. The opportunity for intervention at an early stage in his absconding was lost as a result of the failure to communicate information to police and family members. Earlier intervention by police or family members may have resulted in a different outcome for Mr Yassin as it is apparent that he acted to take his own life, not immediately, but a number of days after he absconded from the facility and that it was likely in circumstances where he was no longer in receipt of appropriate medication. I am satisfied that his death likely occurred on or after 15 January 2011.

45. Mr Yassin was an involuntary patient. Although assessed by Broadmeadows as of low risk of absconding, he had previously absconded from Werribee Mercy MHS in-patient service, he had a history of medication non-compliance and a history of not attending at the outpatient mental health service, even when subject to a compulsory treatment order.

46. The evidence is that clinicians regard themselves as constrained by the provisions of the *Mental Health Act 1986* as to the level of restriction they may impose, including their capacity to lock doors to low dependency units. However *'involuntary'* status must have some meaning in terms of the capacity be able to detain (i.e. prevent from leaving) particularly in a patient identified as at continuing risk to himself from his own behaviours in the community. I am satisfied that the failure to provide for measures to ensure that Mr Yassin was not able to abscond from the facility, indirectly contributed to his death.

47. In this case, despite there being a state-wide mental health regime, the lack of co-ordination and communication between services and facilities resulted in Mr Yassin having absconded and remaining undetected for some days after leaving the facility.

48. This lack of communication and co-ordination also meant that there were no further attempts by mental health workers to establish his welfare status. The evidence of Ms Lentini is that had there been clarity of responsibility in either in-patient service or outpatient service, then there would have been regular discussion of the steps taken to locate the patient.[6]. The evidence of Mr Rudolph was that had Mr Yassin not been an out of area patient, but an in area patient of the BIPU, then responsibility for follow up would have been transferred to other branches of the North West Area Mental Health Service and that follow up intervention would have occurred.[7]

49. As there was a significant period between the absconding and 15 January 2011, the date on which Mr Yassin was last sighted, I am satisfied that had there been intervention in that early period by mental health services and by police in locating Mr Yassin, that his suicide would likely have been prevented. In that context I am satisfied that the lack of co-ordination and response by the two mental health service providers contributed to the death.

COMMENTS

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

50. Family members were not contacted and spoken to by the hospital after Mr Yassin absconded. It was an inadequate attempt at contact to make only one telephone call and then not to retry until contact is made. The procedures provided for in the Continuum of Care policy at the BIPU relating to absconding patients were not adopted.

51. There was a lack of co-ordination and responsiveness of the care provided to Mr Yassin. The provision of mental health services, within the construct of residential eligibility, meant that no one took responsibility for the ongoing liaison and follow up when he went missing.

52. The fact that episodic care is the treatment model meant that because Mr Yassin was not 'in receipt of an episode of care' from the outreach mental health team at Werribee, he was not regarded as their patient and therefore not followed up by that service.

[6] Transcript dated 9 May 2013 at pages 106 to 110.

[7] Transcript dated 9 May, 2013 - Dr Devapria Rudolph at page 118. 11 and page 121.

53. The mental health system is described as operating on a state-wide model. However on this occasion it appears that the services were delineated by residential boundary and that once a nominal paper transfer back to Mr Yassin's local service or zone occurred, there was no obligation for any follow up of the patient by the out of area service (Broadmeadows) even though he had absconded from that facility.

54. The BIPU did not consider that it had any ongoing responsibility for the patient follow up after the transfer had occurred administratively, although it acknowledged that the initial communication procedures with police were inadequate.

55. Initially the BIPU advised the court that it had adopted a process whereby a follow up call was made by staff after the faxing of documentation to police. It now appears in view of an alteration to the police processes relating to LEAP forms, that this is no longer the case.

56. Consequently, the changed BIPU process as set out in counsel's submissions does not appear to address the issue of ongoing follow up by the hospital of an absconding patient. These circumstances are not an ordinary notification of a missing person. It is notification of the absconding of a mental health patient from lawful custody as an involuntary patient.

57. It is not a sufficient response by the mental health service to rely upon the provision of verbal advice over the telephone to a police officer, assume that the relevant information has been conveyed and recorded accurately and then to take no further steps to follow up.

58. In view of the lack of any follow up in this case and the potential for a patient to 'fall through the cracks' under the existing system, it would seem desirable that the mental health services utilise their own formal documentation and convey this information to police, setting out the authority by which the person is to be apprehended, the details of their condition and the background information which may be of assistance to police. This documentation should then be placed on the patient's file for future reference by clinicians who may come into contact with the patient.

59. The LEAP documentation utilised by Victoria Police is internal police documentation and should not be relied upon by the hospital, as a substitute for its own formal documentation of notification. The effect of counsel's submissions is that the revised BIPU process relies upon

Victoria Police to call back the hospital, as the only means of follow up on the report. This process is deficient in that it places responsibility for all follow up on police and retains none to the mental health service from where the patient absconded. It suffers from the same potential for error as that which applied to Mr Yassin.

60. Werribee Mercy MHS acknowledged that the level of follow up in which it engaged was less than desirable and that the system adopted at that time failed to provide for an adequate and certain follow up of patients who had absconded. That service has reviewed its process and adopted a new system which requires notification to the treating community team, acknowledgment by the team of that notification, their review and the recording of actions to be taken; the incident will not be considered complete until there is such a record. If there is no follow up, contact will be made by telephone with the case or team manager to request follow up. The incident will not be closed by that service on the RAPID database until the treating team has recorded any action taken.

<u>Involuntary patient in a Low Dependency Unit</u>

61. It was apparent that the staff were conscious of the requirements of the *Mental Health Act 1986* and the imperative in s4(2)(a) of that Act that care and treatment be provided in the least possible restrictive environment and least possible intrusive manner and that restriction upon liberty of patients with a mental disorder be kept to the minimum necessary in the circumstances. In this context it is relevant to note that the opportunity to leave the in-patient psychiatric facility, despite being an involuntary patient, arose as the low dependency unit was an unlocked ward with no security code or other mechanism required to exit the facility.

62. The fact that Mr Yassin could walk out of the facility, despite it being against his interests as identified by the psychiatric clinicians[8], suggests that there is a flaw in the security offered to involuntary patients.

63. BIPU has made some alterations to access arrangement into and out of the unit with capacity for doors to be locked and unlocked from an override switch located at the ward reception area, one which is generally staffed and allows for direct visual observation. This change

[8] Transcript dated 9 May 2013 Dr Keuneman at page 38.20 to 39.10.

allows for a level of greater supervision and security against involuntary patients leaving the facility provided the door is locked whilst such patients are on the low dependency unit.[9]

RECOMMENDATIONS

1. That the North Western Mental Health Service review the security arrangements relating to exiting the Broadmeadows In patient facility, in the context of admission of involuntary patients to the low dependency unit at that facility.

2. That the North Western Mental Health Service review its procedures relating to notifications to police of absconding patients and documentation on patient file and follow up of same with police by the Mental Health Service staff.

3. In view of the review and new procedures adopted by the Werribee Mercy Hospital MHS in relation to the follow up of absconding patients and improvements in the effectiveness of the liaison between in patient services and the Community Treatment Team, I make no recommendation as to this matter.

4. The Secretary of the Department of Health and/or the Chief Psychiatrist should ensure that a state-wide co-ordinated procedure for notification of and locating absconding mental health patients is adopted in order to ensure that a co-ordinated approach is adopted and follow up occurs. This procedure may appropriately be advised by way of the existing procedures published by the Department of Health in relation to accessing services[10].

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[9] Transcript dated 10 May 2013 Mr Peter Kelly at page 155.16.

[10] Department of Health Mental Health, Drugs and Regions *Out of Area Patients* reviewed 2010, http://www.health.vic.gov.au/mentalhealth/pmc/outofarea.htm.

Office of the Chief Psychiatrist *Clinical Practice Guideline Access to Beds* reviewed 2010 http://www.health.vic.gov.au/mentalhealth/cpg/beds.htm.

Department of Health Mental Health, Drugs and Regions *Accessing Services Across Regions and Areas* reviewed 2010, http://www.health.vic.gov.au/mentalhealth/pmc/access_across_regions.htm.

5. In the absence of a state-wide procedure the responsibility for follow up of an absconding patient ought to rest primarily with the facility from which the unauthorised absence occurred. There should be no administrative transfer of care to another facility until the patient has been located. This approach would appear to be supported by existing Departmental directives referred to in the footnote to Recommendation 4 herein.

6. During the course of the Inquest it became apparent that there were limitations upon access by responsible clinicians to the RAPID database in a context of an absconding involuntary patient. Access arrangements to absconding patient details ought to be reviewed in order that all information on that database is available to any mental health clinician state-wide with responsibility for follow up of an absconding patient.

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

The Family of Mr Yassin;
The Secretary, Department of Health (Victoria);
The Chief Psychiatrist (Victoria);
The Interested Parties; and
The Investigating Police Officer.

Signature:

CORONER K. M. W. PARKINSON
Date: 20 August 2013