IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2015 6477

FINDING INTO DEATH WITH INQUEST

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

Inquest into the Death of: PAUL SIMON TAOUK

Findings of:	**AUDREY JAMIESON, CORONER**
Delivered on:	28 June 2019
Delivered at:	Coroners Court of Victoria 65 Kavanagh Street, Southbank 3006
Hearing Date:	21 June 2018
Counsel assisting the Coroner:	Sarah Gebert, Coroners Court of Victoria
Appearances	Naomi Hodgson of Counsel; instructed by Lander & Rogers on behalf of St Vincent's Hospital Paul Lawrie of Counsel; instructed by the Victorian Government Solicitors Office on behalf of the Chief Commissioner of Police

Contents

BACKGROUND AND CIRCUMSTANCES 3

THE PURPOSE OF THE CORONIAL INVESTIGATION 5

Identity of the Deceased 6

Medical cause of death 6

Evidence as to Circumstances 7

Recent Health history 7

Events of 23 December 2015 9

FOCUS OF MY INVESTIGATION 11

Response to Absconding 12

3.4.1 Requesting police to apprehend 15

ESTA management of call 18

Victoria Police welfare check 19

Victoria Police Policies and Procedures 19

Paul's Family 22

FINDINGS 22

RECOMMENDATIONS 23

I, AUDREY JAMIESON, Coroner having investigated the death of **PAUL SIMON TAOUK**

AND having held an inquest in relation to this death on 21 June 2018

at MELBOURNE

find that the identity of the deceased was **PAUL SIMON TAOUK**

born on 24 December 1975

and the death occurred on 23 or 24 December 2015

at HLT Oulton Park, Preston

from:

1 (a) Carbon Monoxide Poisoning[1]

in the following circumstances:

BACKGROUND AND CIRCUMSTANCES

1. Paul Simon Taouk[2], born 24 December 1975, was 40 years of age at the time of his death. He resided with his aunt, Mona Taouk, in Clifton Hill and had done so for about two years. Paul was the eldest son of Sabah and Chehade Taouk, with a younger brother Raymond. Mona Taouk is the sister of Sabah. Paul was of Lebanese heritage but had been born in Australia. He was single and had no children.

2. Mona Taouk said that Paul displayed some behavioural problems from a young age and '*would become stressed and have emotional reactions to the smallest things.*' She said, *I remember him telling me that he would hear things at extreme volumes and he couldn't escape it. Things like hearing the birds out the window at home, me tapping my nails on my coffee cup or the table, or someone chewing loudly or slurping their food would sometimes send him into severe anxiety. Paul would lock himself in his room to try and escape these*

[1] Carbon monoxide is a poisonous, odourless, colourless gas produced from the incomplete combustion of organic fuels. It is present in cigarette smoke and in automobile exhausts.

[2] With the consent of Mona Taouk, Paul Taouk was referred to as "Paul" during the Inquest. For consistency, save where I have determined formality requires the use of his full name, I have endeavoured to refer to him only as "Paul" throughout the Finding.

noises.'[3] Paul's condition meant he was unable to complete school or maintain employment. He was in receipt of a disability support pension.

3. Mona Taouk said that Paul did not enjoy being amongst large groups of people.

4. Paul, through his own research, believed he had suffered from a condition known as Misophonia ('hatred of sound') since he was 15 years old. He was described as being very knowledgeable about medical matters related to the management of his own symptoms but also sought assistance from naturopaths and psychics in an effort to understand and treat his symptoms. It was his view that doctors would not listen and were quick to prescribe drugs.

5. In about 2012, Mona Taouk noticed a change in Paul's behaviour. His mood improved, and he said that it was as a result of injecting some form of *cleansing substance.* She later discovered that he was taking Ice.

6. Associate Professor (**A/Prof**) Peter Bosanac, Director Clinical Services, St Vincent's Mental Health, reported that Paul had a 4-5 year history of schizophrenia as well as a history of previous methamphetamine, benzodiazepine and opiate use disorders, and continuing use of over-the-counter panadeine. He also had Hepatitis C. He further reported that Paul had a history of poor engagement with mental health services and adherence to treatment, resulting in significant deterioration in his mental state and culminating in episodes of acute risk to self and others in the past.[4]

7. Paul was reviewed by his case manager and a consultant psychiatrist at the Clarendon Community Mental Health Service (**CCMHS**) on the afternoon of 23 December 2015 regarding his compliance with the compulsory treatment criteria. Paul's presentation was such that his clinicians determined that his Compulsory Treatment Order should be revoked immediately and that he be made an inpatient. Paul was upset with the decision and he left the premises not waiting to be taken for further treatment.

8. A call was made to Triple Zero at approximately 2.50pm and police were requested to attend Paul's home in Clifton Hill, apprehend Paul and take him to the Emergency Department of St Vincent's Hospital.

---

[3] Coronial brief, statement of Mona Taouk; dated 16 May 2016, p.13

[4] Coronial brief, Statement of Peter Bosanac dated 6 May 2016, 19.

9. The job was despatched by the Emergency Services Telecommunications Authority **(ESTA)** operator to police as a *welfare check* and the police said that they attended the nominated address at 3.20pm but they *did not find him at that location*. They also patrolled the area to locate him. Police cleared the job as 'No person home.'

10. A missing person's report was made the following morning, 24 December 2015, by staff of CCMHS.

11. At 10.10am, that morning Paul was located deceased in his vehicle in the carpark of HLT Oulton Park in Preston.

THE PURPOSE OF THE CORONIAL INVESTIGATION

12. Mr Taouk's death constituted a *reportable death* pursuant to section 4 of the *Coroners Act 2008* **(the Act)**, as his death occurred in Victoria and was unexpected.[5]

13. The jurisdiction of the Coroners Court of Victoria is inquisitorial.[6] The primary purpose of the coronial investigation of a reportable death[7] is to ascertain, if possible, the identity of the deceased person, the cause of death (interpreted as the medical cause of death) and the circumstances in which the death occurred.[8]

14. An investigation is conducted pursuant to the Act. The practice is to refer to the medical cause of death incorporating, where appropriate, the mode or mechanism of death, and to limit investigation to circumstances sufficiently proximate and causally relevant to the death.

15. Coroners are also empowered to report to the Attorney-General on a death they have investigated; the power to comment on any matter connected with the death, including matters relating to public health and safety or the administration of justice; and the power to make recommendations to any Minister, public statutory or entity on any matter *connected with the*

---

[5] Section 4 *Coroners Act 2008.*

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

[7] Section 4 of the Act requires certain deaths to be reported to the coroner for investigation.

[8] Section 67 of the Act.

death, including recommendations relating to public health and safety or the administration of justice.[9] This is generally referred to as the prevention role of the coroner.

16. All coronial findings must be made based on proof of relevant facts on the balance of probabilities. 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, unless the evidence provides a comfortable level of satisfaction that they caused or contributed to the death.

17. At the time of Paul's death, he was a *person placed in care or* custody as he was a patient under the *Mental Health Act 2014* (Victoria) (*Mental Health Act*), and whilst not physically detained when he died, he was subject to being apprehended as a person without leave under section 352. A mandatory inquest is therefore required.[11]

Identity of the Deceased

18. A statement of identification was completed by his Aunt Mona Taouk and he was identified as Paul Simon Taouk, born 24 December 1975.

19. On 28 December 2015, a Form 8 *Determination by of Identity of Deceased* was completed by Coroner Carlin by the cogency and consistency of available information: Statement of Identification by Mona Taouk; Victoria Police Report of Death (Police Form 83); Admission Photograph of Deceased Person.

20. Identification was not an issue and required no further investigation.

Medical cause of death

21. On 29 December 2015, Professor David Ranson, Forensic Pathologist at the Victorian Institute of Forensic Medicine performed an external examination on the body of Paul Taouk and reviewed the Form 83 Victoria Police Report of Death and the post mortem computed tomography (CT) scan. He observed no signs of unequivocal ante mortem recent injury.

---

[9] Sections 72(1), 72(2) and 67(3) of the Act regarding reports, recommendations and comments respectively.

[10] (1938) 60 CLR 336.

[11] Sections 3(i) and 52(2)(b) of the Act

22. Toxicological analysis of post mortem blood detected the presence of carboxyhaemoglobin level at 76%[12] and a therapeutic level of hydroxyrisperidone[13].

23. Professor Ranson provided an opinion that the medical cause of death was 1(a) Carbon Monoxide Poisoning.

24. I accept his opinion on this matter.

Evidence as to Circumstances

25. Senior Constable Renee Brogan, the nominated coroner's investigator[14] conducted an investigation of the circumstances surrounding Paul's death, at my direction. This included the preparation of a coronial brief which contained, *inter alia,* witness statements, family statements, photographs and other documentation.

Recent Health history

26. In the year or more prior to Paul's death there were serious incidents which appeared to coincide with drug use. These included, a siege which the police attended on 22 November 2013 resulting in an approximate 3-week hospital stay, a psychotic episode involving a threat of suicide with a chainsaw on 2 February 2014, also resulting in a 3-week admission and an overdose in August 2015, where he was placed in an induced coma for 4 days and was kept in ICU.

---

[12] When carbon monoxide is inhaled, it displaces oxygen from haemoglobin, reducing the ability of blood to retain oxygen. The degree of displacement is typically quantified as percent saturation; that is the percent of haemoglobin that is bound to carbon monoxide. Normal concentrations of carbon monoxide in non-smokers living in an urban environment are generally less than 2%. In smokers, concentrations may reach 6%. Levels of carboxyhaemoglobin that exceed 50% saturation are considered as life threatening. Analysis of a series of fatalities due to accidental or intentional inhalation of automobile exhaust gases has revealed carboxyhaemoglobin concentrations ranging from 48 to 93% with an average of 72%. (Source: Victorian Institute of Forensic Medicine).

[13] 9-hydroxyrisperidone (paliperidone) is the metabolite of risperidone. Risperidone is an atypical antipsychotic, prescribed for schizophrenia and some behavioural disorders, including delusions and aggression.

[14] A coroner's investigator is a police officer nominated by the Chief Commissioner of Police or any other person nominated by the coroner to assist the coroner with his/her investigation into a reportable death. The coroner's investigator takes instructions direction from a coroner and carries out the role subject to the direction of a corner.

27. Paul's family thought he was going to die as a result of the last incident. He returned to Mona Taouk's home to live. She said that she kept all his medications and monitored everything he would take.

28. Paul had been discharged from the St Vincent's Acute Inpatient Service (following transfer from the Austin Hospital) on a Community Treatment Order (CTO) administered by St Vincent's Psychiatry with regular follow-up case management at the CCMHS. A/Prof Bosanac oversaw his treatment.

29. Anna Peake, a registered nurse and Paul's case manager since March 2015 said that she had fortnightly contact with Paul to assess his mental state and to administer depot medication as required under his CTO. Paul refused any further contact and reported to her that he was capable of monitoring his own mental health with the support of his family and general practitioner. He also said that he did not have a mental illness and did not need treatment.[15]

30. Paul's medical records from the Clifton Hill Medical Group indicated that he mainly saw Dr Emma Rattray from February 2015. In mid-August, Dr Rattray had spoken to Ms Peake and was advised that he was doctor shopping again. They agreed that Clifton Hill Medical Clinic would not provide further scripts of benzodiazepines or opiates in the foreseeable future. Dr Rattray notified the Department of Health and Human Services of his drug dependency and benzodiazepine misuse.

31. Mona Taouk said that Paul ceased taking his Suboxone toward the end of November 2015 and reported that he was no longer having cravings and was not *a drug addict*.

32. On 25 November, Dr Rattray recorded that she saw Paul and that he said he had stopped suboxone and had since abused codeine.

33. A/Prof Bosanac last reviewed Paul on 16 December 2015. Paul said that he had ceased taking his prescribed medication and requested cessation of his antipsychotic medication, saying that he had been 'ok'.

34. His treatment at that time consisted of regular assessment and administration of four weekly paliperidone injections. The last injection was administered on 12 November 2015 with the

---

[15] Coronial brief, Statement of Anna Peake dated 5 September 2016, 60

next due on 10 December 2015. Paul reported that he did not believe that he required compulsory treatment, the paliperidone injections, or any involvement of the CCMHS including case management.

35. At that time, it was the view of A/Prof Bosanac that the risks of cessation of Paul's anti-psychotic medication outweighed the potential benefits.

Events of 23 December 2015

36. Paul attended the CCMHS on 23 December 2015 by himself. Mona Taouk would ordinarily attend with him, but on this day, she was absent and had no reason to suspect the events that would follow.

37. Paul was seen by Ms Peake and Dr Dominika Baetens and as noted it was for a second opinion regarding Paul's request to cease his long-acting antipsychotic medication, which was at that time 2 weeks overdue. It was thought that, a second opinion from an alternative psychiatrist, would offer increased therapeutic engagement with Paul.[16]

38. The review was conducted at approximately 1.30pm. Paul was assessed as probably depressed, unsafe and at increased risk of self-harm requiring an inpatient admission. Paul was upset with the decision and subsequently left the clinic not waiting to be transported to the Emergency Department.

39. According to the medical records, Ms Peake recorded that Paul's CTO was varied to an inpatient treatment order at 3.15pm.

40. Ms Peake made a call to Triple Zero at approximately 2.50pm and requested that police attend Paul's home in Clifton Hill, and that he be apprehended and taken to the Emergency Department of St Vincent's Hospital. It was clear that Ms Peake communicated the following:

    a) that Paul's order had been changed to an ITO and he had left the clinic;

    b) his diagnosis was of paranoid schizophrenia;

    c) a description of Paul and what he was wearing;

---

[16] Coronial brief, Statement of A/Prof Peter Bosanac dated 6 May 2016, 20

d) that he had left in his car;

e) that he was intending upon going home and details of his home address in Clifton Hill;

f) the type of car he was driving (and although attempts were made by Ms Peake to give a number plate, the call taker declined to hear it);

g) Ms Peake's name and her mobile phone number, and

h) an offer to fax through paperwork.

41. Ms Peake called Mona Taouk around 3.00pm advising her of the situation, including that police had been requested to take Paul to hospital.

42. According to Mona Taouk she said that the staff contacted her following Paul absconding and she thought that home was going to be the best place for Paul over the coming days with his birthday on 24 December and then Christmas. She said that she was advised that police would be searching for him and was surprised the following morning when police from Collingwood came to her house and said that they had only just been advised to search for him that morning.

43. According to the medical records at 3.15pm, Ms Peake recorded that Paul's community treatment order was varied to an inpatient treatment order. She also alerted the Emergency Department to expect him.

44. It is apparent that Paul went to his parent's home in Thornbury at some time following leaving the CCMHS.

45. At around 3.18pm, Paul hired a generator from Kennards in Heidelberg Heights and another generator at approximately 5.07pm, at Masters, Northland Shopping Centre, Northland.

46. On 24 December 2015 at approximately 7.30am, Ms Peake contacted Mona Taouk to check if Paul had been located and then said she made a 'missing person's report' to the Collingwood Police Station. Ms Peake also alerted Psychiatric Triage Service.

47. At approximately 7.30am, tradesman Sione Faaili noticed a person in a vehicle in a car park and thought that he was asleep. The car was positioned in the corner of the car park in the HLT Oulton Park, Preston and there were no other cars present.

48. After 10.10am, Mr Faaili returned to the car park and contacted police when he saw the same person in the same position. Emergency Services attended and located Mr Taouk deceased. A generator he had hired was on the back seat.

49. Police attended the scene shortly after, and in addition to the Coroner's Investigator, members of the Darebin Criminal Investigation Unit attended.

50. I note that it is approximately a two-minute drive from Masters, Northland (the place of Paul's last purchase) to the car park.

FOCUS OF MY INVESTIGATION

51. On 14 June 2017 and 22 March 2018 respectively, I convened directions hearings in relation to this matter. I also sought a number of further statements and submissions to clarify the circumstances of Paul's death. The following three issues emerged:

    a) Whether the response from clinicians (St Vincent's Hospital) to Paul leaving the CCMHS complied with relevant policies, procedures and legislative requirements;

    b) The handling of the triple 000 call from St Vincent's Hospital on 23 December by ESTA, and

    c) The manner in which the police undertook the *welfare check* requested by ESTA on 23 December.

52. I sought the assistance of the Coroner's Prevention Unit [17] who reviewed Paul's medical records. The role of this unit is to assist coroners investigating deaths, particularly deaths that occur in a healthcare setting or where there has been prior medical attendance. The CPU is staffed by medical professionals including, mental health care practitioners, who are independent of the institutions under consideration. Their review was not critical of the decision to revoke his community treatment order in accordance with the requirements of the

[17] The role of the CPU is to assist coroners investigating deaths, particularly deaths that occur in a healthcare setting or where there has been prior medical attendance. The CPU is staffed by medical professionals including, mental health care practitioners, who are independent of the institutions under consideration.

Mental Health Act, however concern was raised regarding whether the response to Paul leaving the CCMHS was in accordance with applicable policy and practice.

53. With respect to the need to revoke his community treatment order I note the following:

a. Ms Peake said, '*During further discussion, Mr Taouk became increasingly distressed and agitated when he was advised that both Dr Baetens and I had significant concern for this mental health and immediate safety, and that we felt he needed to be admitted to the Acute Inpatient Services (AIS) at SVMH.*'[18]

b. Dr Baetens said, '*I formed the opinion that the inconsistency of Mr Taouk's responses made it difficult to gauge the risk he posed to himself or others and that his lack of insight into his condition and poor engagement limited community-based assessment and treatment options. I anticipated that his refusal to accept medication would exacerbate his risks.*'[19]

c. A/P Bosanac – '*It was Dr Baetens' view that Mr Taouk's withdrawal from treatment likely indicated that he was experiencing increasing depressive symptoms and was at an increased risk of self-harm, having regard to his clinical history.*'[20]

Response to Absconding

Whether the response from clinicians (St Vincent's Hospital) to Paul leaving the CCMHS complied with relevant policies, procedures and legislative requirements.

54. My investigation regarding this question was somewhat circuitous and it is worthwhile outlining how it progressed.

55. By her first statement dated 6 September 2016, Ms Peake indicated that she had made a missing person's report to police on 23 December 2015 and filed a second missing person's report on the morning of 24 December 2015. A further statement dated 7 March 2017 confirmed that she only made one call directly to police on the morning of 24 December 2015.

---

[18] Coronial brief, Statement of Anna Peake dated 5 September 2016, 59-64

[19] Coronial brief Statement of Dr Dominika Baetens dated 8 September p.65-68

[20] Coronial brief Statement of A/Prof Peter Bosanac dated 6 May 2016, 56-58

56. Following a request from the Court, A/Prof Bosanac provided a letter dated 26 October 2016 which enclosed a document entitled the *St Vincent's Health Absent or Absconded Patient Policy July 2014*, said to be the relevant policy to missing person and/or absconding for compulsory and voluntary patients that applied at the time of Paul's death. I was referred in that correspondence to section 4.6 in relation to guidelines that apply to communications with Victoria Police. This section referred to a requirement to contact local police followed by the completion of missing persons forms.

57. The policy enclosed appeared to be consistent with Ms Peake's first statement where she indicated that she made a missing person's report.

58. On the basis of the documents provided by A/Prof Bosanac, it appeared that the following would have been required to be undertaken after Paul absconded and I invited submissions with respect to these requirements:

    a) A phone call to the section Sergeant to inform the police of a missing person (in the event that no Sergeant is available, a conversation with the police member on duty).

    b) Appropriate forms should be completed and faxed to the police (VP Form L10 Person Physical Description and VP Form L18A Missing Person & Risk Assessment).

59. A submission in response dated 2 May 2017 was filed on behalf of St Vincent's Hospital but by letter dated 20 July 2017, solicitors for St Vincent's Hospital indicated that the *St Vincent's Health Absent or Absconded Patient Policy July 2014* did not apply to the CCMHS at the time and that the earlier submission was withdrawn.

60. Additional statements were also provided by A/Prof Bosanac dated 12 July 2017 and Ms Peake dated 13 July 2017. Ms Peake clarified in her statement that she did not make a missing person's report on 23 December 2015.

61. In his statement, A/P Bosanac referred to a document titled - *Department of Health and Victoria Police – Protocol for Mental Health 2010* as the relevant policy at the time. The actions taken following Paul absconding which comprised a request for a welfare check via a Triple Zero call, were consistent this policy.

62. I remained concerned, however, that the statements of the clinicians appeared to suggest that they were not requesting a *welfare check* but for Paul to be taken to ED, and it was not clear

whether this could occur without written authorisation unless Paul accompanied the police willingly.

63. A/P Bosanac indicated that St Vincent's Health were undertaking an amendment to the *St Vincent's Health Absent or Absconded Patient Policy July 2014*, to reflect that it applied to inpatient sites only (which was apparently unclear), and an additional policy to apply to community mental health sites would be developed.

64. As a consequence of the response from St Vincent's Hospital, clarification was sought from the Office of Chief Psychiatrist (OCP) who replied by letter dated 22 December 2017 and advised:

a) That Paul's Community Treatment Order was varied to an Inpatient Order on 23 December 2015;

b) A community mental health service is technically part of a designated mental health service as defined by the *Mental Health Act*. In practice, the term is restricted to facilities used to receive inpatients;

c) An Inpatient Treatment Order enables a person to be taken to, and detained in, a designated mental health service. A person awaiting transfer to an inpatient unit who leaves a community mental health service without the approval of the authorised psychiatrist is therefore deemed to be absent without leave;

d) It is expected that clinicians will take all reasonable steps to ensure the safety of a person awaiting transfer to an inpatient unit. In the event that the person absconds, section 352 of the *Mental Health Act* empowers the authorised psychiatrist to arrange for the person to be apprehended and taken to an inpatient unit, and

e) A psychiatrist is not required to arrange for the apprehension of the person, which will clearly depend on the circumstances of the matter.

65. In lieu of calling a witness from the OCP to give evidence at the Inquest, I posed a series of further questions to assist with my investigation. I noted by correspondence dated 18 June 2018, the Deputy Chief Psychiatrist said that:

a) The *Apprehension of Patient Absent Without Leave Form* (MHA 124), is one means by which the authorised psychiatrist or treating clinician may ensure that the person authorised to apprehend the person who is absent without leave, is provided with sufficient details to locate the person but the MHA 124 is not mandatory. The information may be conveyed in some other way, such as over the phone or in an email, if that is more expeditious in the circumstances.

b) A clinician may take all reasonable steps to ensure the safety of the person subject to an inpatient treatment order while they are at the premises of the community health clinic waiting to be transferred to an inpatient unit, however once the person absconds, the extent to which treating clinicians might be in a position to take action will depend on the circumstances and the risks involved.

c) The *Department of Health and Victoria Police – Protocol for Mental Health 2010* was current at the time of the incident, but only to the extent that it provided guidance that reflected good general practice. All legislative references in the protocol were out of date.

d) The Triple Zero call made by Ms Peak is consistent with *Department of Health and Victoria Police – Protocol for Mental Health* 2016 Protocol (3.4.1) and the information provided on an MHA 124 form. The OCP considers such action is reasonable.

66. In addition, I was advised that the Chief Psychiatrist would expect mental health services to have procedures concerning what to do if a patient absconds and may use the MHA 124 Form if it is the most expeditious means of conveying information to an 'authorised person' asked to locate and detain the person.

67. I noted that 3.4.1 of the 2016 Protocol (extracted below) required direct notification to police and specific forms to be provided (which was not done in this case) and further queried the OCP regarding this matter.

3.4.1 Requesting police to apprehend

A mental health clinician should directly notify local police by telephone and then fax a completed form MHA 124 Apprehension of Patient Absent Without Leave, to police. When police receive the MHA 124 they will arrange for the patient's details to be entered into LEAP.

68. I received the following advice by correspondence dated 20 June 2018,

The mental health practitioner at the Clarendon Clinic called 000 to contact the police. While this is not exactly the action described in 3.4.1 of the Protocol, it is action contemplated by the Protocol and reasonable in the circumstances. Paragraphs 3.1.1 and 3.2 of the Protocol states that for urgent police assistance the clinician should call 000. Mr Taouk absconded from the clinic in his car, his location was unknown, and the matter was urgent. The actions of the clinician in phoning 000 are consistent with attempting to obtain police assistance to apprehend Mr Taouk and take him to a designated mental health service as soon as practicable, as is required by section 58(4) of the Act.

Paragraph 3.4.1 of the Protocol states that a completed MHA 124 form should be faxed to the police so that the person's details may be entered into LEAP. The MHA 124 form is not a prescribed form. It is a means of conveying information that is relevant to the apprehension of the person. There are a number of ways the police could be satisfied that they are authorised to apprehend the person. For instance, they may be satisfied based on discussions with a mental health practitioner, by sighting evidence of the person's order or by receipt of a MHA 124 form. The police are assisted in apprehending a person by the information supplied on the MHA 124 form. When the mental health practitioner at the clinic called 000 they conveyed information consistent with the information provided on a MHA 124 form.

We consider that in the circumstances of Mr Taouk's absconding, where his location was not known, he was able to move quickly as he was driving his car, and it was important to apprehend him as quickly as possible to prevent serious or imminent harm to Mr Taouk or others, the action [taken by St Vincent's Health] *was consistent with paragraph 3.4.1 of the Protocol and reasonable in the circumstances.*

69. Based on this advice, I accept that the MHA 124 is not compulsory and Counsel for the CCP advised me that whilst it was preferable for police to have the form, *there could be a range of circumstances where members have to proceed without the form in their hands.*[21] That is, it is not a requirement for the exercise of power for the police officer to have possession of the document.

---

[21] T p.25, L p. 5-7

70. A/Prof Bosanac gave evidence at the inquest and said that it was his experience that MHA 124 forms were used in an inpatient setting when a person was absent without leave from hospital. Other forms, such as the MHA 111 (Variation of Temporary Treatment Order or Treatment Order), allowed them to enact relevant sections of the *Mental Health Act*.

71. I was taken to the St Vincent's Hospital '*Clinical risk 1 assessment and management guidelines*' dated September 2017, made subsequent to Paul's death, and was advised that it applied to bed based services as well as the community services.[22] I was drawn in particular to the follow up actions required where a person poses an imminent risk to themselves or others. These included a requirement to: document all contacts and discussions; document rationales and plans; fax relevant documents to police; keep trying to contact the *consumer*; relay any new information to police.

72. At Inquest, the potential *disconnect* between the requirements of 3.1.1/3.2 (Urgent Request for Police Attendance which required a Triple Zero call) and 3.4.1 (Request for Police to Apprehend) of the *Department of Health and Victoria Police – Protocol for Mental Health 2010* was highlighted by Counsel for St Vincent's Hospital, to which A/Prof Bosanac said he would welcome any opportunity to improve the consistency and effectiveness of communication between mental health services and police who he regarded as key partners.

73. A/Prof Bosanac did however agree that in this case the clinicians were dealing with an urgent request as well as a request for police to attend, that is, both elements were required to be addressed.

74. Counsel for the CCP suggested that if the protocol could make it clearer that the clinician facing the same circumstances, should first resort to Triple Zero and then follow up with the local police station and the faxing of the MHA124 form.

75. Peter Ferguson APM, Inspector in Charge of Police Communications provided a statement dated 3 October 2017 and noted the limitations of a response to a Triple Zero call. He referred to approaching the local police contact with the capacity to open an investigation which can

[22] Exhibit 4

be sustained across multiple shifts rather than being confined to the once off welfare check response (*longitudinal supervision of the job*).[23]

76. I agree with the suggestion that this clarity would be helpful.

ESTA management of call

The handling of the triple 000 call from St Vincent's Hospital on 23 December by ESTA

77. With respect to the management of the Triple Zero call made by Ms Peake, I sought ESTA's advice as to whether the conduct of the call complied with relevant ESTA policies and procedures. I was provided with a statement from Timothy Madigan, Manager of Operations for World Trade Centre and Police/SES which indicated that the event type used (*Welfare Check*) recorded by the despatcher was not correct.

78. He said that once an event type is recorded, the choice generates a set questions and:

a) The information provided by Ms Peake should have prompted the event type as *Psychiatric Patient*, which would involve a multi-agency event and a notification to both Vic Pol and AV.

b) However, had the Call-Taker selected this event, the questions that followed would have led to confirmation that Paul was a male person not at a location. The consequence of this would have been that there was no requirement for AV to attend and the Call-Taker would have been required to select – *Person Escaped Custody*.

c) Furthermore, as Paul was an involuntary patient the event type in itself would have been *Person Escaped Custody*, an event to which only Victoria Police responds.

79. Mr Madigan concluded that, based on the information relayed by Ms Peake, whether it was classified as a *welfare check* or *person escaped custody*, the priority would have been **'2'** and the police dispatch would have been conducted in the same manner.

80. In addition, Mr Madigan noted that Ms Peake offered the details of Paul's registration number to the call-taker, but the call-taker did not return to that discussion to take those details.

---

[23] T p.26, p. 23

81. Mr Madigan concluded that, *The Call-taker has been provided feedback and advice on the correct usage of ... [the event types] .... reinforced Customer Service expectations and professionalism. Customer Service refresher training is arranged for the Call-taker and will be delivered within two weeks.*[24]

82. I accepted the advice provided by Mr Madigan and the concession made on behalf of ESTA.

Victoria Police welfare check

The manner in which the police undertook the welfare check requested by ESTA on 23 December.

83. During the first Directions Hearing, Mona Taouk said that the police had not knocked on her door on 23 December 2015 at any time during that day. A statement was obtained from Mona Taouk dated 2 September 2017 which reiterated this information.

84. Consequently, I sought supplementary statements from the police members involved in conducting the welfare check. These statements confirmed Mona Taouk's advice.

85. In summary, the officers said that they understood that Paul was driving a vehicle and could not locate any vehicles in the vicinity linked to his address and that they patrolled the area over some time but could not locate him.

86. I note that no description of the car or registration was recorded on the Event Chronology (although the 000 transcript which the police would not have had notes a 'Toyota Station wagon').

87. I formed the view that a thorough welfare check was not carried out by Victoria Police and it should have included an attempt to raise any occupants of the address to ascertain whether Paul was at that location. I also sought information regarding whether police are required to call back a caller following a triple 000 request with the outcome of a welfare check and whether this would be different if the call was categorised as Person Escaped Custody.

Victoria Police Policies and Procedures

88. Inspector Ferguson noted, amongst other things, the following:

---

[24] Coronial Brief Statement of Timothy Sean Madigan; page 103.

a) The computer aided dispatch (**CAD**) records all requests for assistance by event code. The event code 573, which is a *welfare check*, was allocated to the Triple Zero in relation to Paul. This event code is used when police are requested to check on the welfare of an individual for any reason and to ascertain the health and safety of a person.

b) A *welfare check* is not related to any criminal behaviour or activity. Victoria Police policy does not elaborate on what is a *welfare check* or prescribe how a police officer should conduct a *welfare check* because every check depends on the circumstances of each individual case and the information provided to the police via the Triple Zero call.

c) That irrespective of the CAD event recorded in respect of the Triple Zero call, the event was correctly handled based on the information supplied by Ms Peake.

d) As a matter of course, no responses are provided to any Triple Zero caller by ESTA staff to advise the outcome of an event or to give them a progress report.

e) Once an event is accepted into CAD, and it is dispatched to the relevant emergency service/s, it then becomes the responsibility of the particular emergency service to resolve the event which can include police officers contacting a Triple Zero caller.

f) If a Triple Zero caller made a specific request for a response, this fact would be recorded into CAD when dispatched to Victoria Police and would become the responsibility of police to return the call if appropriate.

g) While a police officer can contact a Triple Zero caller to provide them with an outcome, there is no requirement or policy that this be done.

89. He said,

In my experience, the police officers would be guided by the circumstances of each emergency situation as to whether they considered it necessary to make contact with a '000' caller.

In Mr Taouk's case, at the time the relevant entries were made into CAD on 23 December 2015 and was dispatched to, and accepted by Victoria Police, it became the responsibility of Victoria Police to speak to the '000' caller if necessary. I consider it reasonable that the police officers who responded to the call (NSW 302) did not contact the '000' caller after entering an entry into the Mobile Data Terminal because it would not be expected that the police members would

contact the '000' caller unless there was a specific request to do so, or the circumstances are such, that the matter/incident could not be resolved without the '000' caller's further involvement.

From my review of CAD, there was no specific record made that the '000' caller wished for police to return her call. Further, whilst I understand that police did not call the '000' caller on 23 December 2015, from a review of Ms Peake's statements dated 6 September 2016 and 7 March 2017, I am aware that she was contacted by a police officer from Collingwood Police Station to discuss Mr Taouk on 24 December 2015 shortly after she contacted '000' that day. I further understand police later contacted her on 24 December 2015 to advise her of Mr Taouk's death.

90. By letter dated 26 September 2017, the CCP disagreed with the notion that a thorough welfare check was not carried out by Victoria Police and submitted that it was *adequate and reasonable* in all the circumstances.

91. A further submission dated 12 June 2018, on behalf of the CCP was received by the Court, which said:

It is submitted that the members' decision not to knock on the front door of the premises was not the result of a lack of conscientiousness but rather, an error of judgement. So much is evident from their efforts to locate a vehicle connected to Mr Taouk when they first attended at 3.20pm and again at 5.30pm.

Nonetheless, the circumstances of this case called for inquiries to be made at the premises and the members regret that they did not do so. They and Victoria Police also wish to express sincere regret for the additional burden of concern and upset suffered by Mr Taouk's family through trying to understand why police did not knock on their front door.

92. I accept these submissions and the concession made on behalf of the CCP.

93. I also acknowledge the CCP's apology to Mr Taouk's family for not taking the step of knocking on the door and *any concerns or additional sorrow that may have occasioned.*

Paul's Family

94. I was grateful for the assistance of Mona Taouk with my investigation. I understand that Paul's mother has been devasted by the loss of her son and did not feel she could participate in the process. I accepted that Mona Taouk was a spokesperson for her family. At the conclusion of the Inquest, she told me that Paul was a gentle, kind, loving human being with a heart of gold who was always willing to help others. Amoungst other things, Mona Taouk said that he was gifted and highly intelligent; and is missed by his family every day.

FINDINGS

Having investigated the death of Paul Taouk and held an Inquest in relation to his death on 21 June 2018 at Melbourne, I make the following findings, pursuant to section 67(1) of the *Coroners Act 2008*:

a) the identity of the deceased was Paul Simon Taouk born on 24 December 1975;

b) Mr Taouk died between 23 and 24 December 2015 from 1(a) *Carbon Monoxide Poisoning* in the circumstances described above;

c) Despite the concession made by ESTA in relation to the management of the Triple Zero call made by Anna Peake on 23 December 2015, there is no causal connection between the management of the Triple Zero call and Mr Taouk's death;

d) Despite the concession made by the CCP in relation to the welfare check conducted as a result of the Triple Zero call made by Anna Peake on 23 December 2015, there is no causal connection between the conduct of the welfare check and Mr Taouk's death; and

e) I accept the advice of the Office of Chief Psychiatrist that the action of St Vincent's Hospital in response to Mr Taouk absconding on 23 December 2015 was appropriate in the circumstances.

RECOMMENDATIONS

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

1. With the aim of improving public health and safety and preventing like deaths, I recommend that the Office of Chief Psychiatrist develop a guidance tool to assist clinicians with the interpretation of the requirements of 3.1.1/3.2 (*Urgent Request for Police Attendance which required a Triple Zero call*) and 3.4.1 (*Request for Police to Apprehend*) of the Department of Health and Victoria Police – Protocol for Mental Health 2010, and in particular to clarify,

    a. In what circumstances would both 3.1.1/3.2 and 3.4.1 be applicable;

    b. The limitation of a Triple Zero call with respect to a police investigation in relation to a patient who has absconded, and

    c. That the outcome of a Triple Zero call is not automatically communicated to a health service unless a specific request is made for that advice to be given.

2. With the aim of improving public health and safety and preventing like deaths, I recommend that St Vincent's Hospital ensures that it has appropriate policies and guidelines applicable to community based settings which clearly sets out the requirements for clinicians to follow in circumstances where a patient absconds from a community setting and is made absent without leave, and there is an urgent requirement for police to attend as well as a requirement for police to apprehend the patient.

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:

a) Mona Taouk, Aunty of Paul Taouk

b) Chief Commissioner of Police

c) St Vincent's Hospital

d) Emergency Services Telecommunications Authority

e) Senior Constable Renee Brogan, Coroner's investigator

Signature:

AUDREY JAMIESON

CORONER

Date: **28 June 2019**