IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2017 2115

FINDING INTO DEATH WITH INQUEST

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

Deceased:	Duncan Stuart SPARKE
Delivered on:	2 May 2023
Delivered at:	Coroners Court of Victoria, 65 Kavanagh Street, Southbank
Hearing dates:	21 December 2022
Findings of:	Coroner Sarah Gebert
Counsel assisting the Coroner:	S. Brown Principal Inhouse Solicitor, Coroners Court of Victoria
Counsel for the Chief Commissioner of Police:	R. Ajzensztat instructed by Victorian Government Solicitors Office
Counsel for Alfred Health:	D. Foye instructed by Alfred Health
Keywords:	*Death in care, missing person*

INTRODUCTION

1. Duncan Stuart Sparke, born on 24 September 1968, was 48 years old at the time of his death. He is survived by his children Holly and Jack from his marriage to his former wife Rachel Sinclair, as well as his brother Russell Roberts, sister Lee and stepfather Andrew Gilmartin. Mr Sparke's mother Yvonne sadly passed away after Mr Sparke's death.

2. Mr Gilmartin described his stepson, who he loved and admired, as a talented tradesman who was a lifelong learner with a *very sharp mind*. Mr Sparke loved his cars and had a passion for Holdens. He was also an avid Carlton supporter and enjoyed indoor cricket.

3. On 6 May 2017, Mr Sparke was found deceased by police at his apartment in Albert Park following a request by his brother for a welfare check. At the time, Mr Sparke was subject to a Temporary Treatment Order under the *Mental Health Act 2014* (**MHA**) and had absconded from the Alfred Hospital's psychiatric inpatient unit on the afternoon of 24 April 2017. He was subsequently reported missing and Victoria Police had commenced a missing person investigation in response.

THE CORONIAL INVESTIGATION

4. Mr Sparke's death was reported to the Coroners Court as it fell within the definition of a reportable death in the *Coroners Act 2008* (Vic) (**the Act**) because his death appeared to have been unexpected, unnatural or violent or to have resulted from accident or injury.[1]

5. In addition, his death was also reportable because he was a person who immediately before his death was a '*person placed in custody or care*'[2] as he was subject to compulsory psychiatric inpatient treatment.

6. Coroners independently investigate reportable deaths to find, if possible, identity, cause of death and the surrounding circumstances of the death. Cause of death in this context is accepted to mean the medical cause or mechanism of death. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death.

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[1] Coroner Darren Bracken (as he then was) initially had carriage of this investigation which was transferred to me in November 2021.

[2] (i) under the definition of *person placed in custody or care* means: *a patient detained in a designated mental health service within the meaning of the **Mental Health Act 2014**;*

7. Under the Act, coroners have an additional role to reduce the number of preventable deaths and promote public health and safety by their findings and by making comments and or recommendations about any matter connected to the death they are investigating.

8. When a coroner examines the circumstances in which a person died, it is to determine causal factors and identify any systemic failures with a view to preventing, if possible, deaths from occurring in similar circumstances in the future.

9. In the coronial jurisdiction, the standard of proof applicable to findings is the balance of probabilities.[3]

Mandatory inquest

10. As Mr Sparke's died whilst *in care*, an inquest was mandatory under s52(2)(b) of the Act, unless the death had been due to *natural causes*.

11. I determined the inquest scope to be as follows: Clarification of the circumstances which led to the death of Mr Sparke on 6 May 2017, including:

    a. Mr Sparke absconded from the Low Dependency Unit of Alfred Health's Acute Psychiatric Inpatient Unit on 24 April 2017,

        i. What was known by Alfred Health about Mr Sparke's likely method of escape as a risk at the Low Dependency Unit proximate to 24 April 2017?;

        ii. What changes have been made to the security arrangements since that time?; and

        iii. What changes have been made to Alfred Health policies and procedures relating to absconding patients from the psychiatric inpatient unit since that time?

    b. Victoria Police received a missing person's report from the Alfred Hospital following Mr Sparke absconding from the Low Dependency Unit of Alfred Health's Acute Psychiatric Inpatient Unit on 24 April 2017,

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[3] Subject to the principles enunciated in *Briginshaw v Briginshaw* (1938) 60 CLR 336. 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 as to those matters taking into account the consequences of such findings or comments.
"The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding, are considerations which must affect the answer to the question whether the issues had been proved to the reasonable satisfaction of the tribunal. In such matters "reasonable satisfaction" should not be produced by inexact proofs, indefinite testimony, or indirect inferences …". (pages 362-363)

i. Did the Victoria Police response to the missing person's report comply with applicable Victoria Police Manual policies and/or guidelines at the time?; and

ii. What changes, if any, have been made to Victoria Police Manual policies and/or guidelines regarding missing person's reports, which may be relevant to the circumstances of Mr Sparke's death.

Sources of evidence

12. As part of the coronial investigation, Detective Senior Constable Nicholas Williams[4] prepared a coronial brief. The brief comprises statements from witnesses including Mr Sparke's family members, clinicians from the Alfred Hospital (**The Alfred**), the forensic pathologist who examined him and investigating officers as well as other relevant documentation.

13. Following receipt of the coronial brief, the Court also obtained Mr Sparke's medical records from the Alfred and further statements from Alfred Health which included information about the security arrangements applicable to compulsory psychiatric patients at the inpatient unit. In addition a statement was obtained from a representative of the Chief Commissioner of Police (**CCP**) which included information about the missing person investigation undertaken to locate Mr Sparke and whether the investigations undertaken complied with applicable Victoria Police policies or guidelines.

14. As part of the investigation, I also referred the case to the Mental Health Team of the Coroners Prevention Unit (**CPU**) to undertake a review of Mr Sparke's clinical management proximate to his death.[5]

15. At a Directions Hearing on 2 August 2022 I outlined the following which set out the conclusions of the CPU review:

- the clinical management and care provided to Mr Sparke by The Alfred proximate to his death appeared appropriate;

- issues regarding Mr Sparke's access to exit points in the mental health acute inpatient unit at The Alfred had been addressed by Alfred Health. That is, the relevant exit point

[4] Detective Senior Constable Natalie Gataric subsequently undertook the role of Coroner's Investigator.
[5] The CPU was established in 2008 to strengthen the prevention role of the coroner. The CPU is a multidisciplinary unit of case investigators and data analysts who work in teams based on experience. One such team is the Mental Health Team which is staffed by investigators with clinical backgrounds relevant to mental health management.

have been modified to allow exit only by means of a staff swipe card since Mr Sparke's death; and

- Alfred Health policies and procedures relating to absconding patients of the psychiatric inpatient unit had been reviewed and amended since Mr Sparke's death. That is, they now include time frames within which to report missing patients and clinical escalation inclusive of risk management.

16. I indicated at that time that I accepted the advice of the CPU on these matters and therefore the clinical management of Mr Sparke at The Alfred, which included his placement and monitoring, would not form part of the scope at inquest.

17. The inquest heard evidence from the following witnesses:

    (a) Associate Professor (**A/Prof**) Simon Stafrace, Program Director of Alfred Mental and Addiction Health, Alfred Health; and

    (b) Acting Inspector (**A/Insp**) Anthony Combridge, Officer in Charge, Missing Persons Squad, Victoria Police.

18. Following completion of the inquest, I received written submissions from Counsel Assisting and Counsel for Alfred Health and the CCP.

19. This finding is based on the entirety of the investigation material comprising of the coronial brief of evidence including material obtained after the provision of the brief, the statements and testimony of those witnesses who gave evidence at the inquest and any documents tendered through them, any documents tendered through counsel and any written submissions following the conclusion of the inquest. All this material, together with the inquest transcript, will remain on the coronial file and comprises my investigation into Mr Sparke's death. I do not purport to summarise all the material and evidence in this finding, but will refer to it only in such detail as is relevant to comply with my statutory obligations and necessary for narrative clarity.

RELEVANT BACKGROUND

20. Mr Sparke's brother described their upbringing as *horrendous,* noting that their father *was an abusive and violent drunk.* He said that his brother,

struggled to find who he was as a result of [their] *upbringing, due to a lack of guidance and a role model. I think he had self-esteem issues.*

21. A former girlfriend also said that Mr Sparke *never dealt with those issues* [referring to *a very traumatic childhood and an abusive drunken father*] *and … that's where his problems stemmed from.*

22. Mr Sparke had a history of suicidal ideation having been admitted to The Alfred Psychiatric Inpatient Unit on three prior occasions in 2016. Those admissions were from:

    a. 6 to 9 September 2016 with depressive symptoms and suicidal ideation following referral from a psychiatrist. He was discharged with Crisis Assessment and Treatment Team (**CATT**) follow-up. His former girlfriend said that the CATT attended frequently but Mr Sparke *kept trying to avoid them*;

    b. 23 to 28 September 2016 which followed a suicide attempt by drowning in the bath whilst intoxicated (as well as drugs) at the Grand Hyatt Hotel. He was continued on antidepressants and discharged into the care of his general practitioner (**GP**) with plans to attend with a hypnotherapist and private psychiatrist; and

    c. 28 to 30 November 2016 which followed a threat of self harm while intoxicated where police were notified by his brother. A suicide note was located at the time. He was diagnosed with an adjustment disorder, his antidepressant medication was continued with follow-up by his GP, private psychiatrist and psychologist.

23. Mr Sparke engaged with GP Dr Noel Leon between 13 August and 1 December 2016 at which time he reported symptoms of depression and suicidal ideation. Dr Leon suggested counselling (which was initially declined), prescribed antidepressants and made a referral to a psychiatrist due to Mr Sparke's ongoing suicidal ideation. Psychiatrist Dr Sarabjit Loyal referred Mr Sparke to The Alfred on 6 September 2016. Further attempts by Dr Leon to engage with Mr Sparke for review were made in early 2017 but were unsuccessful.

24. Mr Sparke engaged with a hypnotherapist/counsellor between 6 June and 7 December 2016.

25. Mr Sparke had a scheduled appointment with psychiatrist Dr Michael Maloney on 6 January 2017 which he did not attend.

CIRCUMSTANCES OF DEATH

26. On the 20 April 2017, Mr Gilmartin asked police to perform a welfare check after Mr Sparke's mother Yvonne, received a text message indicating an actual or attempted suicide by Mr Sparke.[6] When police attended Mr Sparke's home, they found a noose attached to a beam in the living room and Mr Sparke heavily alcohol affected. Mr Sparke expressed suicidal thoughts, a plan and intent and he was arrested pursuant to section 351 of the MHA. He was transported to The Alfred Emergency Department (**ED**) for psychiatric assessment.

27. At around 4.30pm, Mr Sparke was reviewed by an ED physician. His vital observations were normal, he had a Blood Alcohol Content (**BAC**) of 0.276% and presented with suicidal ideation. He was then reviewed by the Emergency Psychiatric Service (**EPS**) with a plan for a further psychiatric assessment when he was sober.

28. At 6.15pm, a Code Grey[7] was called when Mr Sparke absconded from the ED; he was found at a nearby 7/11 store and was returned to The Alfred by security staff.

29. At about 10.30pm, Mr Sparke was reviewed by a psychiatric registrar at which time his BAC was 0.06%. He was noted to be alert and was 'reluctantly accepting' of a voluntary admission to the Brief Intervention Short Stay Unit (**BISSU**) of the ED. Level 4 nursing observations were commenced,[8] which meant a nurse maintained constant visual observations from within an arm's length of Mr Sparke, and it was documented that there was a 'low threshold' for an Assessment Order[9] if Mr Sparke tried to abscond given his risk of suicide.

30. At about 11.35am on 21 April 2017, Mr Sparke was reviewed by EPS consultant psychiatrist Dr Evan Symons whose provisional diagnosis was Major Depressive Illness or/and Alcohol Induced Mood Disorder. Dr Symons offered Mr Sparke a voluntary psychiatric admission, but this was refused.

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[6] The text read, *This is a dead man's switch. If you are reading this, I have passed away…'*

[7] Code grey: A hospital-wide coordinated clinical and security response to actual or potential aggression or violence (unarmed threat). Code grey activates an internal alert or emergency response.

[8] Specialling was maintained until Mr Sparke's transfer to the first floor psychiatric unit at 12.40pm on 21 April 2017.

[9] An assessment order is an order made by a registered medical practitioner or mental health practitioner that enables a person who is subject to the assessment order to be compulsorily (a) examined by an authorised psychiatrist to determine whether the treatment criteria apply to the person; or (b) taken to, and detained in, a designated mental health service and examined there by an authorised psychiatrist to determine whether the treatment criteria apply to the person.

31. Mr Sparke was made subject to an Assessment Order under section 29 of the MHA having met all criteria for compulsory treatment. He was admitted to the Acute Psychiatric Inpatient Unit of The Alfred with 15-minute [Category 2] nursing observations.

32. On 22 April 2017, Mr Sparke was assessed by consultant psychiatrist Dr Rosaria Forlano. Dr Forlano considered the incident on 20 April 2017 to be a potentially serious suicide attempt that had been interrupted by police. Mr Sparke continued to deny that he needed mental health treatment and asked to be discharged. Her differential diagnosis included Major Depressive Illness, Alcohol Induced Mood Disorder or Dysthymic Disorder with personality vulnerabilities; the most significant risk identified was an impulsive suicide attempt during a period of alcohol intoxication.

33. Dr Forlano determined that Mr Sparke continued to meet all criteria for compulsory treatment under section 5 of the MHA and placed him on a Temporary Treatment Order. This order would last for 28 days, unless revoked earlier, and required Mr Sparke to remain as a compulsory inpatient in The Alfred's Acute Psychiatric Inpatient Unit.

34. Mr Sparke was placed in the Low Dependency Unit (**LDU**), with 15-minute observations and no authorisation to leave the unit. The conditions of his confinement were required by the MHA to be the least restrictive intervention available.[10] Observations at these intervals meant that Mr Sparke was considered to be a high risk patient. Observations of a patient are intended to involve engagement with the patient, in part, to foster a therapeutic relationship. At the time, there was one nurse for every five patients in the LDU.

35. Mr Sparke's contact nurse for the morning shift on 24 April 2017 noted that he was pleasant to staff and patients but guarded about the reasons for his admission and that he was 'frustrated' by his ongoing containment and that he would not have a psychiatric review that day.

36. Mr Sparke's contact nurse for the afternoon shift, saw him during the handover for the change of shift around 2.45pm. The nurse recalled that Mr Sparke disengaged from conversation with him when he was told that he would not be reviewed for a change of management that day. The following further information was provided,

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[10] A/Prof Stafrace stated that, *these are really tricky decisions because every decision you make in the direction of restrictiveness has an impact on the therapeutic relationship and so you're always trying to sort of, …, work towards the least restrictive set of interventions as you can*. T27 L23-28

I commenced my afternoon shift and was allocated Mr Sparke as a patient. Prior to this, the morning contact nurse, …, had completed her handover of Mr Sparke to me. I had the opportunity to meet Mr Sparke during the handover stage and I attempted to engage with him. Rather than engaging with my direction or conversation, he was fixated on asking if he would see a doctor and he appeared mildly frustrated by his containment (perceived frustration in his tone of voice and general restlessness). As documented in the morning nursing medical record entry, the treating team were not available to review Mr Sparke at that time. When I informed Mr Sparke that he was not going to be reviewed for a change in his management today, he disengaged from any further conversation with me and would not discuss or receive psychotherapy or pharmacotherapy to address his understandable frustration of a potential perceived extension of his restrictive environment.

37. The afternoon nurse said that Mr Sparke did not present with any obvious or overt symptoms of being a safety risk to himself or others, and instead appeared to self-isolate as a form of dealing with his feedback.

38. Mr Sparke was documented to be in the communal/TV area of the LDU at 2.45pm. At the next observation at 3.00pm, Mr Sparke was noted to be missing from the ward. According to Mr Sparke's contact nurse, it was 'several minutes' after 3.00pm that he was told that Mr Sparke was 'not visible in the Unit'.

39. A search for Mr Sparke was immediately undertaken, which included all areas of the inpatient unit – rooms, alcoves, balcony and courtyard – clinical areas and areas near staff exits. Staff entering/leaving the inpatient unit and other potential witnesses were asked if they had seen Mr Sparke.

40. There were no reported sightings of anyone leaving over the courtyard walls or going through the locked front doors. When Mr Sparke could not be located, the Nurse in Charge and the Mental Health Triage Team were alerted and Mr Sparke's next-of-kin was notified.[11]

41. At about 5.00pm on 24 April 2017 nurse Taylah Powell reported Mr Sparke's absence from the inpatient unit without leave to Senior Constable (**SC**) Simon Fenton of Victoria Police

[11] Nursing note made at 8.50pm recorded that NOK notified that Mr Sparke was AWOL [mother as the first contact NOK; brother as the second contact].

stationed at Southbank Police Station (**Southbank**). During their telephone call, the nurse provided information about the circumstances leading to Mr Sparke's compulsory psychiatric admission, when he was last seen, his contact details and address, and a physical description.

42. Additional information was sent to Victoria Police by fax including a Missing Patient Notification Form which noted that Mr Sparke had threatened suicide, was perceived to be an '*immediate and imminent risk to* [him]*self*' and at risk of self-harm, suicide and alcohol use given his current mental state. In the 'Mental Health Act Legal Status' section of the form, the 'yes' box was ticked under a direction that the missing patient is a compulsory patient and a MHA 124 Form ('Apprehension of Patient Without Leave' form) was faxed with the Notification Form to the police station.[12]

43. It was later discovered that whilst in the LDU Mr Sparke detailed to a family member his plans of how he was going to escape the unit.

<u>24 April 2017</u>

44. On 24 April 2017, SC Fenton commenced a missing person investigation by compiling a missing person report, which was recorded on Victoria Police's Law Enforcement Assistance Program (**LEAP**)[13] with a hard copy file kept at Southbank. Both the LEAP record of the investigation and the physical file were updated to record actions taken to locate Mr Sparke, but were not identical records.

45. In the hour between taking the report that Mr Sparke was missing and the end of his shift, SC Fenton:

- obtained a photograph of Mr Sparke from VicRoads;
- called Mr Sparke's mobile phone, which diverted to message bank;
- spoke with Mr Sparke's mother, daughter, ex-wife and brother;
- requested a police unit attend Mr Sparke's address to ascertain if he was at home; and
- requested triangulation of Mr Sparke's mobile phone but this request was denied on the basis it would be of no value if message bank was activated.

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[12] No completed MHA 124 Form appears in Mr Sparke's Alfred Health records or in the Missing Person file compiled by Victoria Police, though both contain the Missing Patient Notification Form.
[13] A database accessible by all police members.

46. Before finishing his shift, SC Fenton briefed the incoming shift's section sergeant about the investigation.

47. At about 9.52pm, the divisional van patrolling the Port Phillip area attended Mr Sparke's home in response to the request. The divisional van members attended Mr Sparke's front door, knocked several times and listened for signs of occupation, but received no response. About 15 minutes later, the members left as it was determined that Mr Sparke was not present, and updated the reporting member.

48. Around 11.00pm, Mr Sparke's ex-wife contacted police to advise that her daughter was contacted by Mr Sparke at about 9.30pm after which he turned off his phone (*I am good speak later. I escaped couldn't handle it. I'm okay. Need to turn off phone cause tracking*.[14]) Police were also provided names of two former girlfriends with whom Mr Sparke may be in contact and details of his car, being a Holden sedan.

25 April 2017

49. On 25 April 2017, Mr Sparke's brother contacted police to inform them that his partner had received a text message from Mr Sparke indicating he was actively avoiding police so that he wouldn't be returned to hospital, that he was 'OK' and would be switching off his phone.

26 April 2017

50. On 26 April 2017, two police members on duty at the Southbank police station were tasked with making further enquiries to locate Mr Sparke. These enquiries included:

- contacting Mr Sparke's daughter who advised that she had been in phone contact with her father who said he was staying at an un-named friend's house in Toorak and driving a borrowed Mercedes;
- contacting Mr Sparke's ex-wife twice; she provided Mr Sparke's bank details;
- contacting Mr Sparke's sister-in-law twice; she advised that Mr Sparke blamed his brother for calling the police, and the police for 'locking him up for his thoughts' and, pending a property settlement in a few days' time he intended to 'hand himself in' on 1 May 2017;

[14] That is, text messages similar to.

- contacting several hotels in the Melbourne CBD on the basis of information that Mr Sparke had attempted suicide in a hotel in September 2016; Mr Sparke was not registered at any of those checked;
- notifying Melbourne Criminal Investigation Unit (**CIU**), who 'did not have further concerns' at that time;
- contacting Uber to ascertain if Mr Sparke had used his ride-share account but there was no response to the enquiry; and
- contacting Mr Sparke's bank which confirmed that the most recent transaction was a $450 withdrawal made in the CBD on 24 April 2017.

51. At 2.00pm, SC Fenton attended Mr Sparke's home but was unable to gain access to the building and received no response when he buzzed his apartment from the front entrance. A patrol of the area did not reveal any sign of the car registered to Mr Sparke.

27 April 2017

52. On 27 April 2017, a police member at Southbank received a call from Mr Sparke's sister-in-law who reported receiving Facebook messages from Mr Sparke which suggested he was avoiding using his mobile phone. Mr Sparke had confirmed his intention to 'hand himself in' on 1 May 2017.

53. Later in the afternoon, police telephoned The Alfred inpatient psychiatric unit to ascertain whether he had returned and left Mr Sparke a voice mail asking that he contact police to confirm his welfare.

28, 29, 30 April and 1 May 2017

54. There were no further enquiries recorded on LEAP or the hard copy file located at Southbank to suggest that police made further inquiries to establish Mr Sparke's whereabouts on 28, 29, 30 April or 1 May 2017.

2 May 2017

55. On 2 May 2017, a police member contacted Mr Sparke's ex-wife who advised that her daughter had exchanged text messages with Mr Sparke on 1 May 2017 but had received no response to a text message sent to him on 2 May 2017.

3, 4 and 5 May 2017.

56. There were no further enquiries recorded on LEAP or the hard copy file located at Southbank to suggest that police made further inquiries to establish Mr Sparke's whereabouts on 3, 4 or 5 May 2017.

57. Mr Sparke's fob was last used at the main entry of his building at 2.43pm on 3 May 2017.[15]

6 May 2017

58. On 6 May 2017, Mr Sparke's brother became 'very concerned' that Mr Sparke had uncharacteristically not been on Facebook for three days. Mr Roberts obtained a key to Mr Sparke's home from a family member and went to the apartment but was unable to open the door because the lock appeared to be jammed. He called for police assistance.

59. At about 3.20pm, divisional van members arrived at Mr Sparke's home and spoke to Mr Roberts who outlined his concerns. Police also attempted to gain entry to Mr Sparke's apartment using the key but were unable to do so. They called the building manager who advised of the last time Mr Sparke's fob was used and then police checked the basement car park and found Mr Sparke's car.

60. The police members attended the apartment of Mr Sparke's neighbour to obtain access to Mr Sparke's apartment via the adjacent balconies. Upon gaining entry, Mr Sparke was found deceased inside his apartment. The front doorknob had been removed from the inside and a pair of pliers jammed into the lock so that it couldn't be operated from the outside.

61. Police found a hand-written note from Mr Sparke in the living room which appeared to be a suicide note.

IDENTITY OF THE DECEASED

62. On 6 May 2017, Russell Roberts identified his brother Duncan Stuart Sparke, born on 24 September 1968.

63. Identity is not in issue and required no further investigation.

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[15] This was established on 6 May 2017, the day Mr Sparke's death was discovered.

CAUSE OF DEATH

64. On 8 May 2017, Dr Matthew Lynch, specialist forensic pathologist at the Victorian Institute of Forensic Medicine (**VIFM**), conducted an external examination and prepared a written report dated 9 May 2017.

65. Toxicological analysis of Mr Sparke's blood detected the antidepressant Fluoxetine in a therapeutic quantity.

66. Dr Lynch formulated the cause of death as "*1(a) Hanging".*

67. I accept Dr Lynch's opinion as to the cause of death.

EXAMINATION OF ISSUES

Alfred Health

<u>The Alfred's Acute Psychiatric Inpatient Unit</u>

68. The Acute Psychiatric Inpatient Unit is situated in a separate building on The Alfred campus but is connected to the 'main hospital' building by a corridor. It was designed, and constructed in about 1998, as an 'open unit'. However, according to A/Prof Stafrace this proved 'difficult to sustain' and the doors of the wards were soon after secured to manage the unauthorised exit of patients and unauthorised entry of contraband. It was noted that whilst the Alfred Health Guideline titled *Locking Doors to Open Wards in Mental Health settings* designates the LDU as an "open" ward[16], A/Prof Stafrace said that the policy 'reflects aspiration' while the 'daily locking of the ward reflects pragmatism'. He further noted that mental health services are not designed as prisons and were never intended to operate with equivalent type security.

69. The High and Low Dependency Units occupy separate areas of the same ward of the inpatient psychiatric unit. In 2017 one security staff member was employed to be available across the high and low dependency wards, ground and first floor psychiatric unit, 7 days per week between 8am and 8pm.

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[16] According to that policy t*he mental health inpatient units are to remain open wards unless there is a 'collaborative treatment team decision' to lock the doors to the wards for patient safety. In 2017. the front door to the Psychiatry* Building *was unlocked between 7am and 9pm; the doors locked automatically afterhours.*

70. At the time of Mr Sparke's admission, there were CCTV cameras in place outside the psychiatric unit but none were located inside the ward. The LDU was locked throughout his admission.

71. There are several entrance/exits from the High Dependency Unit (**HDU**) but all except one – a fire evacuation exit - lead into the LDU. There are two main entrance/exit points onto the LDU. The first is the main entrance to the ward which is opened using a staff swipe card (**Main Door**) on either side or without a swipe card by using a doorbell to alert nursing staff who could admit the person seeking entry.

72. The second entry/exit point (**Door A)** connects the LDU and the staff room and, through a further door (**Door B**), links the staff room to the main hospital corridor. At the time of Mr Sparke's admission, Door A from the LDU to the staff room was operated by a staff swipe card from either side but Door B from the staff room to the hospital corridor could be opened by pushing a button (release button), and from the outside using a swipe card. These doors were used by staff, and on an infrequent basis, patients escorted by staff to and from the ED, other wards or areas within the main hospital.

73. The LDU also allowed access to a ground floor courtyard (via a door from a communal area of the ward). Once outside the LDU, an absconding patient could access other areas of the hospital campus via connecting corridors (on the first or ground floors) or leave the Psychiatry Building through the ground floor exit.

74. Following a review conducted by Alfred Health, 23 incidents of unauthorised departure or attempts to do so from the LDU were identified in the 12 months prior to Mr Sparke absconding, and of those, three involved Door A and Door B. Of the three incidents, one involved a staff member who had not ensured that Door A was properly closed, another involved a patient running past a doctor through Door A while being transferred to the HDU, and the last involved a patient pushing past a hospital staff member who was entering through Door A. Each incident resulted in the patient later returning or being returned to the psychiatric unit (after 15 minutes, one day and three days).

75. At inquest, A/Prof Stafrace explained that Alfred Health's initial response to incidents of unauthorised departure though Door A was by clinical practice improvement such as improvements to visual observations guidelines/practice, risk categorisation or patient

engagement including education with staff rather than change to infrastructure.[17] The rationale for this approach was an acknowledgement that '*every decision ... in the direction of restrictiveness has an impact on the therapeutic relationship*' and that clinicians aim to use the least restrictive intervention to manage psychiatric patients and to '*reverse restrictive orders as quickly as possible*.'

What was known by Alfred Health about Mr Sparke's likely method of escape as a risk at the Low Dependency Unit proximate to 24 April 2017?

76. As Mr Sparke was not witnessed absconding from the LDU, the precise circumstances of how he left cannot be known. The available methods at the time appear to have included pushing past staff at exits and forcing their way out, being accidentally let out by a staff member who may not work on the ward regularly, leaving through Door A after it had been used and was still ajar, or by scaling structures to leave the ward.

77. Alfred Health considered that it was most probable that Mr Sparke left through Door A (and then Door B). Given the available evidence, I agree that this was the most likely method of departure noting that there is no evidence of Mr Sparke pushing past a staff member or scaling a wall and that he likely waited for Door A to be ajar after being used by a staff member.

What changes have been made to the security arrangements since that time?

78. At inquest, A/Prof Stafrace indicated that after Mr Sparke absconded on 24 April 2017, Alfred Health concluded that further practice changes weren't necessarily going to make a difference and the locking mechanism of Door B was changed in about June 2017 resulting in 'two levels of security' (i.e. swipe access at Doors A and B) or 'control measures' to manage absconding. A/Prof Stafrace considered that the changing of the lock was not a complete answer, given that patients continued to abscond after the lock was changed, but he said it was 'another measure' to address the 'small risk' associated with the previous locking mechanism.

79. A/Prof Stafrace further stated that although plans were already underway earlier in 2017, after Mr Sparke's absconding a 'reception' area staffed by security and administrative

[17] A/Prof Stafrace said, *And the response had been to sort of bolster up our observational guidelines and really to look at practice - practice changes and practice improvements as opposed to physical - you know, changing the physical environment that was the pathway that was being followed at the time*. (T41 L4-9)

personnel was established on the ground floor of the Psychiatry Building. The role of the reception staff is to 'manage entry and exit' throughout the day and evening. He said that it is no longer possible to exit the building without a swipe card and so people exiting without a swipe card require the assistance of the reception staff to leave. As such the building had become more secure as a result.

What changes have been made to Alfred Health policies and procedures relating to absconding patients from the psychiatric inpatient unit since that time?

80. It is apparent that two hours elapsed between Mr Sparke being identified as missing from the ward and a missing person report being made to police. When asked to account for the length of time taken to notify police that Mr Sparke had absconded, Alfred Health stated that though no specific reason for the lapse of time could be identified, it was considered likely due to the searches undertaken by staff and, potentially, waiting 'a short period of time' to see if Mr Sparke would return voluntarily. According to Alfred Health, it was not 'unreasonable or uncommon' in practice for there to be a lapse in time of this kind, unless there is an 'immediate concern' for that person or another's safety.

81. As outlined by Counsel Assisting regarding policy changes, Alfred Health's absconding patients policies have been revisited several times between 2017 and 2022. The first iteration following Mr Sparke's death introduced a distinct procedure for missing/absconded psychiatric patients, collaborative decision making about the patient's risk level (which informed the staff response), time frames for notification of police (including mandatory notification when a compulsory patient has absconded) and CATT follow up to supplement the police missing person response. The rationale for these policy changes was to clarify the response required of staff.

82. I note in particular that compulsory psychiatric patients who have absconded require that a missing person report be made to police within 30 minutes, consultation with the nurse in charge and medical practitioner, followed by steps to be taken over particular time periods (for example, within 48 hours, between 48 and 72 hours).

83. The most recent policy highlights and provides greater guidance about risk assessment at the point of a patient's unauthorised departure from the health service.

Victoria Police Response to Missing Person Report

84. Victoria Police has developed policies, procedures and guidelines for its members to inform decisions made in the course of their various duties, including when conducting missing person investigations. Those policies and procedures are contained primarily in the Victoria Police Manual – Procedures and Guidelines, *Missing Persons Investigations* (**VPMG – Missing Persons Investigation**). In addition, other relevant policy documents include Victoria Police *Initial Action Guide*, Victoria Police *Crime Investigative Guidelines* and Victoria Police Manual - *Escapees and absconders* (**VPM - Escapees and Absconders**).[18]

85. The VPMG – Missing Persons Investigation:

- defines who is a missing person as a person reported to police whose whereabouts are unknown and there are fears for the safety or concern for the welfare of that person;
- designates the responsibilities of the 'reporting member' – that is the police member to whom the person was reported missing; and the responsibilities of that member's 'supervisor' and those of the 'work unit manager';
- sets outs out that the responsibility of the investigating member which includes to maintain the LEAP case progress narrative to ensure that the narrative reflects all relevant information and enquiries undertaken and is updated regularly, including to the CIU *update of risk assessment and categorisation after 7 days*;
- establishes a regime to 'check' all active missing person reports at particular intervals, which specifically includes at intervals of 3, 7, 14, 30 and 60 days; and
- contains instructions specific to certain types of missing persons including for compulsory mental health patients reported missing referring members to the VPM Escapees and Absconders, where the health service holds genuine fears for the welfare of the patient and of others.

86. The VPM - Escapees and Absconders requires members to whom a mental health patient is reported missing to obtain information about:

[18] There is a difference between how the policy documents work together. I note that there is an expectation that police officers abide by the Victoria Police Manual (**VPM**), which is issued by the Chief Commissioner of Police, pursuant to s.60 of the Victoria Police Act 2013. Failing to comply with the VPM may render an officer subject to disciplinary or management action. Whereas Victoria Police also issue the 'Victoria Police Manual – Procedures and Guidelines' which are not mandatory per se in the same way as the VPM, but are instead issued to support police officers in their conduct and decision-making by providing interpretation and application of relevant rules and responsibilities. Where the Procedures and Guidelines state that officers must have regard to their content, it is mandatory for officers to consider the content of the relevant Procedures and Guidelines document in reaching decisions about the application of the rules.

- the person's legal status as a voluntary or compulsory patient and any date of expiration of a compulsory assessment or treatment order;
- any triggers or behaviours or communication strategies that police could use to approach the person;
- whether the person poses a risk to themselves or others; and
- the contact details of the mental health service.

87. This VPM also provides guidance to members about the power to apprehend compulsory patients absent from a mental health facility without leave that are conferred by section 352 of the MHA and how this should be exercised.

88. In addition, I note that the VPM – Procedures and Guidelines – *Apprehending persons under the Mental Health Act* provides guidance to members about when and how to exercise the power of entry conferred by section 353 of the MHA. Specifically, section 353(2)(a) provides power for a police officer to enter premises at which she or he has reasonable grounds for being satisfied that the person may be found. The policy states that members should conduct a risk assessment and unless urgent entry is necessary, obtain authority from a sub officer before using force.

89. Relevant to this section it was noted on behalf of the CCP that the fact that Mr Sparke ordinarily resided at an address was not, in and of itself, sufficient to establish reasonable grounds for being satisfied that the person may be found at those premises as without that, the power under s 353(2) is not enlivened. It was further noted that the power to enter premises under s 353(2) is not a power that can be exercised for other purposes, e.g. for the purpose of obtaining information in order to progress a missing person investigation.

90. A/Insp Combridge further commented with respect to exercising this power,

Additionally, police officers are expected to also take into account a number of other considerations in determining whether to exercise the power under s 353(2). Forcible entry to private premises invariably causes physical damage to the building, such that additional police resources are required to render the premises secure. This causes additional delays because attending members must wait at the premises until they can be made secure. Moreover, the conferral of power by s 353(2) must be seen together with community expectations and in particular the right of people not to have their homes or other premises forcibly entered by police or damaged by forcible intrusion, without there being a reasonable basis for that action.

Risk Assessment

91. A missing person report should include an assessment and categorisation of the level of risk posed to the missing person or members of the public. The purpose of the risk assessment is to determine Victoria Police's operational response.

92. The reporting member assigns a risk rating at the commencement of the investigation and the supervisor will validate the risk assessment and ensure that the appropriate resourcing and response has been initiated. The evidence suggests that SC Fenton recorded Mr Sparke's risk rating as *high* at the commencement of the investigation.

93. Ongoing the supervisor responsibilities are to ensure that the matter is being progressed and that the risk assessment is still valid.

94. The guidance to police notes that,

> *Whilst the member compiling the initial report of a Missing Person undertakes an initial risk assessment, members are reminded that the risk assessment is an on-going and dynamic process. Continual re-assessment is required as the investigation progresses and is particularly important as new information and evidence becomes known.*

95. Any alterations to the categorisation of risk, including the reasons for any change and related actions taken, must be recorded by police.

Statement on behalf of the Chief Commissioner of Police

96. The Court raised specific questions with the CCP related to the timeliness and adequacy of the response to the missing person report and whether the response complied with relevant Victoria Police requirements following which a statement from A/Insp Combridge was filed with the Court on his behalf.

97. A/Insp Combridge qualified the opinion he provided in a number of ways. Firstly, that he did not have the benefit of knowing specific details about the demand on the resources of the relevant Victoria Police members and stations at the time, which he said is highly likely to have had a significant impact and influence on resourcing and prioritisation of tasking.

98. In addition, that not all investigative enquiries and efforts made with respect to the missing person investigation for Mr Sparke may be reflected in the documents contained in the coronial brief which is often due to the demands on the time of members tasked with

undertaking particular enquiries. Whilst he noted that *of itself this not generally acceptable, the relevance of this observation for the purposes of my statement is that it would not be possible, or fair, to conclude that the absence of documentation of investigative effort at particular points in time means that no such effort was undertaken.*

99. A/Insp Combridge further noted that as he had not spoken to the relevant police members, he was not in a position to confirm whether an apparent absence of documentation is indicative of an absence of investigative effort.

100. Examples of additional investigative efforts which could have been undertaken but not recorded by Victoria Police members include, additional enquiries or supervisory checks may have been made between 27 April 2017 and 6 May 2017, or members may have recorded additional enquiries undertaken in a notebook or Official Police Diary.

<u>24 to 27 April 2017</u>

101. With the above qualifications made, A/Insp Combridge said that based on the documents contained in the coronial brief, the missing person investigation between 24 April 2017 and 27 April 2017 was generally conducted in accordance with the relevant guidance provided in the policy documents and to a standard expected of Victoria Police members.

102. He noted however that the exceptions to this in his opinion included:

a. It was an expectation under section 2.2 of the VPMG – Missing Persons Investigation that a supervisor conduct regular reviews/checks of the investigation at particular intervals, including on Day 3 and that the coronial brief does not reveal a check on 27 April 2017, which was Day 3.

b. It is unclear how the relevant supervising sergeant allocated responsibility for the conduct of the investigation whilst the reporting member was not at work.

c. The LEAP entry does not contain a clear statement of the assessment of Mr Sparke's risk, when the investigation commenced and subsequently.

<u>Post 27 April 2017 to 6 May 2017</u>

103. With respect to the period after 27 April 2017, A/Insp Combridge said that with the benefit of hindsight, he identified some aspects of the missing person investigation, which could have been handled differently noting that the documents contained in the coronial brief tend

to suggest less investigative action from Victoria Police (again noting the qualifications above).

104. He stated that from his review of the coronial brief, it does not appear that any further follow up, tasking or supervisory review was conducted in relation to the enquiries on 2 May 2017 and that the following additional enquiries could have been made by investigating members (however, as was submitted on behalf of the CCP, he made it clear at the Inquest that these were steps that *could* have been taken, not that these measures *should* have been taken – aside of course from any step which would have been indicated by the relevant policy):

a. attendance at Mr Sparke's premises again;

b. attempting to speak with Mr Sparke's neighbours;

c. attempting to access CCTV for the apartment building and attempting to canvass neighbouring buildings for CCTV to ascertain Mr Sparke's movements;

d. attempting to speak with the building manager of Mr Sparke's apartment block;

e. a CIU update after seven days;

f. use of the missing person Media Authority to arrange for a photograph and written approval from the next of kin, relative or concerned person to release information to the media;

g. further supervisor reviews/checks as per section 2.2 of the VPMG – Missing Persons Investigation which would have resulted in a supervisor check on 1 May 2017 (Day 7);

h. a KALOF ("Keep A Lookout For") being issued for Mr Sparke's vehicle;

i. updated review of Mr Sparke's bank account movements, given the passing of time since the withdrawal on 24 April 2017; and

j. further checks via the RMS system to attempt to locate Mr Sparke's mobile phone.

105. A/Insp Combridge said however that even if the above enquiries had been made, there is no guarantee or certainty that this would have resulted in Mr Sparke being located prior to 6 May 2017.[19]

106. I agree with this conclusion and also forecast that this was my view at the Directions Hearing on 2 August 2022.

Evidence of Acting Inspector Combridge at Inquest

107. At inquest A/Insp Combridge commented on the following features of Mr Sparke's investigation having already indicated in his statement that each missing persons investigation is *idiosyncratic*, depending on the individual circumstances of the case:

- Mr Sparke's indication that he had turned his phone off and was evading police - it was *a very difficult investigative scenario where you've got somebody …who's got some level of operational awareness …in how we might actually try to find them and is actively taking steps to avoid us, but it also presenting as high risk*.[20]

- Mr Sparke's indication that he would be handing himself in - in his view, when a person has plans for future activity, that probably mitigates a little of the risk, in that it may take away the immediacy of any planned self-harm, but ultimately it remained a high risk situation.

- Mr Sparke advising his family that he was *ok* probably wouldn't change the risk assessment.

- Mr Sparke not following through on an indicated plan (such as handing himself in) - would cause a *level of concern.*

108. As outlined by Counsel Assisting in her submissions, A/Insp Combridge noted the following at the Inquest in relation to the police response (with the qualifications outlined at paragraphs 97, 98 & 99):

a. record-keeping throughout the missing person investigation was a cause for concern;

[19] As also put in submissions on behalf of the CCP.
[20] T115 L19-24

b. the poverty of the documentary record overall made it difficult to determine whether investigative actions were taken but not documented or investigative actions were not performed;

c. between 24 and 27 April 2017, the documentation met expectations and the 'initial response' to Mr Sparke being reported missing was 'adequate' but it possibly wasn't their best work;

d. for the period 24-27 April 2017, contrary to the Victoria Police Manuals, the following did not occur or was not documented:

- supervisor check on Day 3 of the investigation;
- allocation of investigative responsibility;
- *clear* statement of risk categorisation;

e. after 27 April 2017, the 'lack of documentation [was] not desirable' nor did it meet expectations, and it was unclear whether, contrary to the Victoria Police Manuals, any of the following occurred:

- supervisor check on day 7 of the investigation;
- CIU update/review after Mr Sparke was missing 7 days;
- criticisms relating to allocation of investigative responsibility and risk categorisation in the initial phase of the investigation persist;

f. the lack of documentation/documentation of investigative effort around 27 April 2017 appeared to coincide with when police were told Mr Sparke would 'hand himself in on Monday' (1 May 2017). While the planned action might mitigate risk, the fact that Mr Sparke did not hand himself in, would raise risk again; and

g. following up what occurred "on Monday" there was an 'obvious' line of inquiry for which the 'assigned investigator' had responsibility and in his/her absence, it was incumbent on the supervisor to reallocate the task.

109. Other possible lines of inquiry which in hindsight may have been useful included that a family member had a key to Mr Sparke's apartment and, that the building manager could

provide information about Mr Sparke's use of his fob to enter his apartment (both matters apparently only coming to light on 6 May).

What changes, if any, have been made to Victoria Police Manual policies and/or other guidelines for the management of missing persons, which may be relevant to the circumstances of Mr Sparke's death?

110. The CCP advised that the missing person investigation policy remains under review and that Victoria Police are in the process of implementing the following functions in LEAP:

- a prompt to members to consider whether risk categorisation remains valid when adding new information. That is, whenever police update their case progress narrative in the database it necessarily requires the person updating that database to validate the current risk assessment.

- rectification of 'subtle differences' between hard copy and LEDR Mk2 risk assessment documentation to resolve a 'transposition error;' and
- introduction of a 'pop up' explanation of the type of response required for missing persons categorised as presenting each category of risk to better align risk and (police) responses.

Conclusions

111. Mr Sparke was a compulsory inpatient at The Alfred when he absconded from the LDU, a locked psychiatric unit, shortly after 2.45pm on 24 April 2017. His method of exit was unwitnessed but based on the available evidence it is likely that he left via Door A which operated by way of a swipe card and then Door B which operated by way of a push button (at the time). The evidence suggests that Mr Sparke was distressed at his ongoing confinement, did not consider his treatment helpful and had advised a family member of his plans for escape.

112. Mr Sparke was being observed at 15 minute intervals and was first noticed missing at 3.00pm. Following a comprehensive search, Mr Sparke was reported as a missing person to Victoria Police at 5.00pm.

113. At the time, the relevant Alfred Health policy did not specify a time period within which a missing person report should be made to police. That policy was reviewed and amended after Mr Sparke's death and now, among other amendments, specifies that police should be

notified that a compulsory patient is missing within 30 mins of this being known. In addition, Door B has been altered from a push button to a swipe card mechanism.

114. Following Mr Sparke's missing person report the police commenced an investigation which was guided by relevant Victoria Police policies and/or guidelines. Mr Sparke's risk rating appeared to be categorised as high at the commencement of the investigation.

115. It was apparent that Mr Sparke took measures to avoid being located by police (such as turning off his phone) and not want to return to The Alfred for treatment. In addition, he indicated to his family that he had plans to hand himself in. Unfortunately, attempts undertaken by police to locate Mr Sparke were unsuccessful and he was found deceased in his home on 6 May 2017, having last used his apartment fob on 3 May 2017.

COMMENTS

Accordingly, pursuant to section 67(3) of the Act, I make the following comments:

116. During the course of the coronial investigation and on the information contained in the coronial brief, I endeavoured to clarify whether the police response to the missing person's report complied with applicable Victoria Police policies and/or guidelines at the time. On behalf of the CCP, A/Insp Combridge provided advice to the Court (by statement and evidence) which highlighted areas of potential concern regarding the missing person investigation undertaken but that advice was qualified on the basis that the evidence as to what the investigation comprised was *incomplete*. That is, further information regarding other resourcing pressures operating at the time was not known, the individual members had not been spoken to and not all activities and investigations were necessarily reflected in the documentation. That documentation included the coronial brief compiled by the Coroner's Investigator which enclosed the Victoria Police LEAP record and the hardcopy file held a Southbank.

117. It was apparent that on the basis of this material, it could not be said with respect to certain aspects of the response, whether investigative actions were taken but not documented or investigative actions were not in fact performed. Examples of these actions included whether there were ongoing risks assessments or whether there were supervisor checks at particular specified intervals.

118. To obtain accurate information of the type indicated by A/Insp Combridge many years after an event however would not have been possible and it is unfortunate that the records in the

Court's possession were not able to be relied on as comprehensive record of the investigations. I do however accept the advice of A/Insp Combridge regarding the missing persons investigation undertaken in relation to Mr Sparke and I note in any event that it cannot be said whether the outcome would have changed if the police response had been different in any way.

119. It will be important however for future coronial investigations that the Court ensures that all available information is compiled at an early date such that reliable evaluations can be made on what would be regarded as a complete record of a missing person investigation (and witnesses called where appropriate should an inquest be held). This is likely to include a statement of resource pressures operating at the time and the likely impact on the missing person's investigation, statements from all relevant supervisors and work unit managers (with particular focus on supervisor checks, risk assessments undertaken and assignment of tasks), and inquiries of all relevant police to canvas whether actions were taken during the period of investigation and not recorded (including a decision not to undertake a task and the reason why) but found in other locations (such as day book entries etc). I plan to work with the Police Coronial Support Unit to devise an appropriate brief request for this task.

120. In my view, this investigation highlighted the importance of ongoing risk assessments being made (and recorded) and the maintenance of records of a missing person investigation. This is especially so, where there are likely to be multiple local members contributing to the investigation on an ongoing basis (and maybe just for a shift), who rely on the central record of any investigations undertaken to ensure the continuity and efficiency of the investigative effort.

121. In addition, supervisors or work unit managers with broader responsibilities for the investigation may also change over the course of the investigation. I note that the ongoing risk assessment and categorisation is a requirement of the VPMs and is important because it determines the level of resources required in the police response to the missing person investigation.

122. Whilst acknowledging that there is ongoing work being done in this complex investigative area, the learnings from Mr Sparke's tragic death serve to highlight a need to ensure by way of training, policy/guidance, database enhancement or other means, that,

- Record-keeping of decisions and actions undertaken in missing person investigations is optimised;

- Tasking and allocation of missing person investigations is documented by supervisors or work unit managers;
- Allocated tasks that remain incomplete at the end of a shift/day are documented;
- Risk categorisation is (re)considered/validated/documented in response to information generated by a missing person investigation;
- Periodic supervisor checks of missing person investigations occur and are documented; and
- Periodic review(s) of missing person investigations by CIU occur and are documented and implement any such measure as soon as practicable.

FINDINGS

123. Pursuant to section 67(1) of the Act I find as follows:

(a) the identity of the deceased was Duncan Stuart Sparke born on 24 September 1968;

(b) Duncan Stuart Sparke died on or about 6 May 2017 at 13/156 Beaconsfield Parade, Albert Park, Victoria, from 1(a) *Hanging*; and

(c) the death occurred in the circumstances described above.

124. I convey my sincere condolences to Mr Sparke's family for their loss and acknowledge the tragic circumstances in which his death occurred.

125. Pursuant to section 73(1B) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

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

Holly Sparke, Senior Next of Kin

Victorian Government Solicitors Office on behalf of the Chief Commissioner of Police

Alfred Health

Detective Senior Constable Natalie Gataric, Coroner's Investigator, Victoria Police

Signature:

Coroner Sarah Gebert

Date: 02 May 2023

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