

CORONERS COURT OF THE AUSTRALIAN CAPITAL TERRITORY

Case Title: AN INQUEST INTO THE DEATH OF
TAHADESSE (TAD) KAHSAI

Citation: [2018] ACTCD 9

Date of findings: 4 May 2018

Dates of hearing: 10-13 and 16 April 2018

Before: Coroner L.E. Campbell

Findings:

1. Tahadesse Kahsai died sometime on or after 30 December 2015 and before 2 January 2016 in bushland bordered by Ginninderra Drive, Agar Street and Masterman Street, in Bruce in the Australian Capital Territory;
2. The manner and cause of Mr Kahsai's death is as a result of exposure and dehydration, preceded by alcohol withdrawal and a long history of chronic alcoholism, although a specific medical cause of death has not been established; and
3. Pursuant to the requirements of s 52(4)(a)(i) of the *Coroners Act 1997* I state that two matters of public safety arise in connection with this inquest.

Appearances:

Ms S Baker-Goldsmith as Counsel Assisting the Coroner
Mr H Chiu for the Territory instructed by ACT Government Solicitor
Mr C O'Neill for the Australian Federal Police instructed by AFP Legal and Clayton Utz
Mr B Buckland for the Kahsai family instructed by Meyer Vandenberg

File Number: CD 76 of 2016

Reasons for findings

Jurisdiction

1. A Coroner is required to hold an inquest into the manner and cause of death of a person who dies violently, or unnaturally, in unknown circumstances.
Tahadesse Kahsai, who at the invitation of his family was referred to as Tad during the hearing, was a 61 year old man whose remains were located in bushland surrounding the Calvary Public Hospital (the hospital) campus in Bruce, ACT, on 2 April 2016.

Formal findings

2. Under subsection 52(1) of the *Coroners Act* 1997 (the Act), a Coroner holding an inquest must find, if possible:
 - (a) the identity of the deceased; and
 - (b) when and where the death happened; and
 - (c) the manner and cause of death.

The Coroner must record her findings in writing: s 52(3).

3. Mr Kahsai's body was discovered by two CIT students on the Masterman Street side of a bushland reserve in Bruce on 2 April 2016. Life was declared extinct at the scene by Forensic Medical Officer Dr Catherine Brogan. AFP Crime Scene Investigator Dr Michelle Weir also attended at the scene and took a sample of skin from Mr Kahsai's left palm. His identity was confirmed by way of a match of that skin to fingerprints held in police records. Dr Paul Luckin, a specialist anaesthetist with particular experience and expertise in search and rescue operations, gave the opinion that Mr Kahsai most likely died in the place where his remains were found.
4. While the evidence surrounding Mr Kahsai's departure from the hospital, to which he had been admitted voluntarily a few days before, will be discussed in considerable detail below, it is sufficient at this point to observe that he left the hospital without the involvement of anyone else and that he was ultimately located in bushland which was within two kilometres of the hospital. It is apparent his body had been in that location for some time prior to its discovery. A thorough police investigation did not identify any suspicious circumstances.

5. I am satisfied Mr Kahsai died at the location in which his remains were found. That is that Tahadesse Kahsai died in bushland bordered by Ginninderra Drive, Agar Street and Masterman Street, in Bruce in the Australian Capital Territory.

Manner and cause of death

6. The pathologist who conducted a post mortem examination at my direction, Associate Professor Sanjiv Jain, was unable to form an opinion as to the cause of Mr Kahsai's death.
7. However the thrust of Dr Luckin's evidence was that Mr Kahsai most likely became severely and fatally dehydrated relatively shortly after wandering away from the hospital. This was, in all probability, from a combination of the hot temperatures recorded in Canberra during the days of 31 December 2015 to 1 January 2016 and the effects of severe alcohol withdrawal. There is no evidence before me supporting any more likely cause.
8. Accordingly I make a finding as to manner and cause of death on the balance of probabilities as follows:

Tahadesse Kahsai died as a result of exposure and dehydration, preceded by alcohol withdrawal and a long history of chronic alcoholism, although a specific medical cause of death has not been established.

Date of Death

9. Dr Luckin also concluded that it was most probable that Mr Kahsai did not survive for longer than three days after leaving the hospital. There is no evidence before me supporting any more likely date of death. Certainly the state of Mr Kahsai's remains support a conclusion that Mr Kahsai died some lengthy time before the discovery of them.
10. Accordingly I make a finding as to the date of death on the balance of probabilities as follows:

Tahadesse Kahsai died sometime on or after 30 December 2015 and before 2 January 2016.

Relevant findings of fact

11. The investigation into Mr Kahsai's death was extensive and the records exhibited with the court are voluminous. In terms of the key facts, I adopt the findings of fact suggested by Counsel Assisting with some small alterations. The findings of fact I make are as follows:

Admission to hospital

- a. Mr Kahsai was brought by ambulance into the hospital on 26 December 2015. He was admitted through the Emergency Department and the Medical Assessment and Planning Unit before being accommodated in ward Four East (4E) in room 11. He was treated primarily for alcohol withdrawal and related conditions.
- b. Ward 4E is 'u' shaped with rooms one to eight on one side and rooms nine to eleven on the other side. There are four beds in each room. There can be between 20-36 patients at any one time within the ward. There was no Closed Circuit Television (CCTV) within the ward when Mr Kahsai was there. The nurses' station was located front and centre in the ward. The ward has two entry/exit points and is normally locked with a keypad for access, however the code is written above the keypad as the ward is not considered to be a secure ward. A voluntary patient is not prevented from leaving although the keypad is designed to prevent someone not of clear mind from exiting.

30 December 2015

- c. About 3.10 am Nurse Dayrit observed Mr Kahsai as "alert and independent". Initially he was talking to himself then eventually he just watched TV quietly. Although she did not fill out the formal Alcohol Withdrawal Scale (AWS) chart, she recorded an AWS score of 1-2 in his progress notes.
- d. At about 5.10 am Nurse Dayrit noted that Mr Kahsai had a sudden onset of paranoia: he said that patients in the same room were pointing a laser beam, he raised his voice and cursed and demanded to be moved out of his room. Although she did not fill out the formal AWS chart, she noted an AWS score of 7 in his progress notes. She administered Oxazepam to Mr

Kahsai. Oxazepam is a standard medication used in the treatment of alcohol withdrawal.

- e. At about 6.05 am Nurse Dayrit noted that Mr Kahsai seemed to be calmer and observed him to be sitting in the corner of the corridor, occasionally talking to himself and reading a magazine.
- f. About 7.00 am Nurse Cho commenced his shift at ward 4E and received a handover of patients from Nurse Dayrit. Mr Kahsai was one of eight patients in the handover. Nurse Cho formally took over his care at about 7:30 am.
- g. Nurse Cho undertook a ward round at 8:00 am. He recorded Mr Kahsai as having breakfast. Nurse Cho conducted an AWS assessment which resulted in a score of 11. As required by the hospital AWS policy, he notified the medical team of the high score and requested that a medical officer review Mr Kahsai. Nurse Cho believed he notified Dr Parker, the junior medical officer on ward 4E, but by the time of the hearing Dr Parker had no recollection of this. Nurse Cho said at the hearing that he considered administering Oxazepam at this time but not enough time had elapsed since Mr Kahsai's last dose. He decided to return later to administer the medication.
- h. Nurse Cho went on another ward round at 9:00 am. At this time Mr Kahsai was not in his room. Nurse Cho considered that Mr Kahsai may have been in the kitchen or toilet but he had no concerns that he might have left the hospital.
- i. Indeed, at about 9:15 am, Nurse Cho saw Mr Kahsai returning to his room. Nurse Cho undertook another AWS assessment.
- j. Nurse Cho went on another ward round at 10 am. Mr Kahsai was in his room. Mr Kahsai refused to allow Nurse Cho to take routine observations (pulse rate, temperature, blood pressure etc.). Notwithstanding this Nurse Cho undertook another AWS assessment which resulted in a score of 15 (the numerical score was actually 14 but Nurse Cho made an error of addition when recording the score). Nurse Cho made the decision to administer medication and to notify the medical team again of the high AWS score as required by the AWS policy. Nurse Cho did not recall with

which medical officer he spoke, but he obtained an order to recommence Oxazepam from a member of the medical team. He then administered Endone (for pain) and Oxazepam (for agitation) to Mr Kahsai at about 10:10 am. Mr Kahsai took the medication without objection.

- k. This was the last observation of Mr Kahsai on the ward. He was not reviewed by the medical team before he left as they had not yet reached him on their rounds. At no point prior to his departure did Mr Kahsai act in a way which raised concerns that he might unexpectedly leave the hospital.
- l. At about 10:27 am Mr Kahsai left ward 4E unseen by nurses or medical staff. CCTV captured Mr Kahsai leaving the Xavier (main) building of the hospital around 10:28 am. While there are natural limitations to the frame rate and resolution of the video footage Mr Kahsai appeared to be walking normally.
- m. At about 10:30 am Mr Finch, a wardsman, observed Mr Kahsai walking quickly on the footpath next to Mary Potter Circuit and opposite the Calvary Clinic. Mr Kahsai was heading north and Mr Finch assumed he was heading towards a nearby bus stop. Mr Finch said that were it not for the patient identification bracelet he observed on Mr Kahsai's wrist he would not have thought that he was a patient. He had a conversation with Mr Kahsai along the following lines:

Finch: "Oh, where are you from?"

Mr Kahsai kept walking.

Finch: "Look, any chance you'd want to go back and talk to a doctor?"

Kahsai: "I'm not going back, you can't stop me."

Mr Kahsai pointed his finger at Mr Finch and continued walking. He then slowed his pace, held his hand up and out and said:

Kahsai: "Have you got any bus money?"

Finch: "No"

Mr Kahsai resumed his walking pace and kept walking north along Mary Potter Circuit. Mr Finch said that there was nothing about Mr Kahsai's presentation which caused him to doubt Mr Kahsai's competence. There was nothing to suggest he should consider restraining him.

- n. Mr Finch went to ward 4E to enquire if any patients were missing. Nurse Cho confirmed Mr Kahsai was missing. Mr Finch returned outside to try to intercept Mr Kahsai on the northern side of Mary Potter Circuit and searched that vicinity for about 45 minutes until he was paged to undertake another job.
- o. Nurse Liu, the Clinical Nurse Coordinator for ward 4E, and Dr Parker in consultation with others including Dr Sivakumaran, a treating consultant on the ward, located a Missing Patient Report form. Dr Parker completed the written form and she and Nurse Liu made a call to ACT Police Communications. The call was answered by Ms Chan (a civilian call taker). Relevantly, the Missing Patient Report included the detail that Mr Kahsai was "not competent" and was "delirious". These details were verbally conveyed to Ms Chan by Dr Parker together with a reference to the possibility of police taking action under "the Mental Health Act".
- p. Ms Chan was not very experienced in her role at the time and appropriately sought advice from Detective Sergeant Dean as to how to handle the call. Detective Sergeant Dean was the Operations Sergeant on duty. He assumed that Mr Kahsai had absconded from a mental health facility at the hospital and therefore treated the case as relating to an 'absconder' rather than a 'missing person'. On that basis, the hospital was advised that no police file would be opened until a Missing Patient Report was completed by a doctor and received by the police. Detective Sergeant Dean anticipated that a police response would be necessary, but in accordance with the procedure for dealing with absconder cases he did not log a job onto the CAD (Computer Aided Dispatch) system pending the receipt of the Missing Patient Report.
- q. As Dr Parker had never seen or treated Mr Kahsai, she relied on oral advice and her review of the patient file to complete the document relating to Mr Kahsai. Nurse Liu attempted to email the Report to AFP Communications but misspelled the email address. As a consequence the

email was not received by Police. Nurse Liu did not receive a 'bounce back' report of the email failure but nor did she receive any confirmation of receipt.

- r. Sometime later that morning Dr Parker spoke further about the matter with Dr Sivakumaran and others. As a consequence of that discussion Dr Parker changed her view and determined that restraint under relevant mental health legislation was not an available option. However she did not make a contemporaneous note of this meeting nor did she convey her changed opinion to Police.
- s. While Detective Sergeant Dean was monitoring the AFP Communications email inbox he did not follow up with the hospital when a Missing Patient Report was not received. In hindsight he offered a number of reasonable explanations for this: the pressure of other work, the possibility that Mr Kahsai had been located by the hospital and thus there was now no need for a report to be sent, and the expectation that the hospital would itself follow up the report if there was no contact by Police.

31 December 2015

- t. About 9.45 am, Dr Parker called ACT Police Communications to enquire about the Missing Patient Report (which had not in fact been received by the AFP). The call was taken by Constable Jesberg.
- u. About 9.48 am, Constable Jesberg approached Sergeant Holland, the Operations Sergeant, to foreshadow that the hospital would soon resend a Missing Patient Report. The report was received at 9:51 am.
- v. About 10.14 am, Sergeant Holland commenced an email conversation with Nurse Liu. He asked, "Is (sic) there immediate concerns for his welfare from yesterday?" Nurse Liu responded, "Yes, due to his confusion. This email was sent to a wrong address yesterday."
- w. About 10.30am, Sergeant Holland created a Missing Person case on CAD to be dispatched to a police patrol. As a missing person case the CAD system automatically assigned a priority to the matter of category 2 with a corresponding response time of no more than 20 to 30 minutes. However, Sergeant Holland downgraded that automatically allocated priority category

to category 3. He sent the patrol to Mr Kahsai's residence as the first point of enquiry rather than the hospital. Sergeant Holland testified that the primary reason for downgrading the priority and sending the patrol to Mr Kahsai's residence was that as Mr Kahsai had already been missing for over 24 hours it was unlikely, in his experience, for him to still be in the vicinity of the hospital. A lesser consideration was that a category 2 job required a police attendance within 27 minutes and at that time there were no patrol cars available to take the job.

- x. Constable Salleo, who was on patrol that day, accepted the tasking and became the case officer for the job. About 1.30 pm he and Constable Wise attended Mr Kahsai's residence. They knocked several times on the front door however they were unable to raise anyone. At the same time the occupant of a neighbouring unit, Mr Wallace, approached Constable Salleo. They had the following conversation:

Salleo: "Hi mate, I am trying to find Tahadesse Kahsai, he's not in any trouble with us, but we need to check on his welfare. When is the last time you saw him?"

Wallace: "I heard him last night."

Salleo: "What do you mean by that?"

Wallace: "I heard him talking, using the toilet, banging and crashing things in his unit."

Salleo: "How certain are you that it was Mr Kahsai?"

Wallace: "I'm certain, you hear everything through these walls".

- y. Constable Salleo undertook further investigative actions, including conducting a cursory search of Mr Kahsai's residence, completing an AFP Missing Persons Form and conducting a risk assessment in respect of Mr Kahsai which he did in conjunction with then acting Sergeant Hoyer. He also attempted to contact Mr Kahsai's next of kin. Constable Salleo completed his shift and then was away from work until 9 January 2016. There was no formal handover of the case to another case officer.

1 January 2016

- z. Acting Sergeant Hoyer and Constable Wise attended Mr Kahsai's residence to try to locate him. They spoke again with Mr Wallace. They also attempted to contact Mr Kahsai's next of kin but again were unsuccessful. Acting Sergeant Hoyer completed his shift and was then absent from work until 22 January 2016.

Thereafter

- aa. No police activity occurred on the case between 2-5 January 2016 inclusive, 7-9 January inclusive, 17-21 January 2016 inclusive or 26 January 2016 primarily due to Constable Salleo's absence from work.
- bb. When he was at work Constable Salleo continued to conduct investigations including:
- attempted to contact Mr Kahsai's phone numerous times;
 - attempted to contact, or contacted, persons connected with Mr Kahsai including:
 - i. Addam Kahsai
 - ii. Mr Coxhead
 - iii. Lenore McGregor
 - iv. Krystina Kielich;
 - provided a case briefing to Sergeant Smith on 9 January 2016;
 - conducted a door knock of Mr Kahsai's unit;
 - contacted S/C Barry Dobson from the ACT Missing Person Unit;
 - contacted the hospital and the Canberra Hospital;
 - requested enquiries by external agencies (and followed up on those enquiries);
 - requested CCTV footage from the City Watch House of Mr Kahsai;
 - redistributed a "Look Out to be Kept For" form; and
 - requested a media release.

- cc. On 27 January 2016 Acting Station Sergeant Uhe reviewed the file. She promptly determined that a search should be undertaken for Mr Kahsai and she recalled Constable Salleo to duty. Constable Salleo contacted the hospital to request further information and to access relevant CCTV footage and he was finally able to make contact with friends and family members of Mr Kahsai.
- dd. With the assistance of the State Emergency Service police conducted a search of the surrounds of the hospital on 28-31 January 2016 inclusive. Police received advice from Dr Luckin that were Mr Kahsai still alive he would be located near a supply of water and under basic shelter. Given weather forecasts for the following few days Dr Luckin said there was no realistic prospect of Mr Kahsai being alive beyond 31 January 2016. As explained in court, the search methodology used followed accepted national and international guidelines, however Mr Kahsai was not located. The area in which his remains were ultimately found was searched by Leading Senior Constable Coutts. He had concentrated on examining points of possible shelter such as buildings.
- ee. On 5 February 2016 Station Sergeant Cook of AFP Search and Rescue determined that the search would be formally suspended pending further information. Search and Rescue would continue to review the operation as time and resources permitted.
- ff. Constable Salleo continued to undertake investigative activities in relation to Mr Kahsai in the period 1-12 February 2016 including:
- attempted to contact/contacted the following:
 - i. Narya Reeves
 - ii. Mr Coxhead
 - iii. Jindabyne Police Station
 - iv. Murrays Buses
 - v. Greyhound Buses
 - vi. Deans Transit Group
 - vii. The hospital and the Canberra Hospital
 - viii. NSW Mental Health

ix. Panya Saengaket;

- attempted to obtain/obtained CCTV footage from Calvary Haydon Retirement Village and bus services (including Action Buses);
- attended Mr Kahsai's unit and located his mobile phone;
- investigated potential sightings of Mr Kahsai;
- followed up on and arranged for review of telephone records;
- conducted a door knock search near Mr Kahsai's residence;
- attended Mr Kahsai's unit to obtain items for DNA sampling; and
- briefed Sergeant Smith on enquiries to date.

gg. On 12 February 2016 Sergeant Smith determined that all investigative avenues had been exhausted. Further planned enquiries were stopped although Constable Salleo was to continue to deal with ad hoc enquiries in the matter as they arose.

hh. A further day of searching was scheduled for 23 March 2016 however it was cancelled because of smoke hazard from a controlled burn on the previous day.

ii. Mr Kahsai's remains were located on 2 April 2016.

Contested facts

12. While there were some discrepancies in the oral evidence given by witnesses at the hearing most of the differences were not material to my task and therefore I will deal with them only briefly.
13. I am satisfied that Nurse Liu called Addam Kahsai on 30 or 31 December 2015 to notify Addam of his father's leaving the hospital and that she had a short conversation with him.
14. I am satisfied Constable Salleo called Nurse Liu on 31 December 2015 to discuss Mr Kahsai's case and that the content of that conversation was substantially as he said. However I do not think that this conversation had any material impact on the subsequent actions taken by the police. Dr Parker gave evidence that in filling out the Missing Patient Form she took a cautious (generous) approach in assessing the risk to Mr Kahsai. Constable Salleo gave similar evidence. He too took a cautious approach in assessing risk in

completing the police risk assessment. Further I note that the change in the assessment of Mr Kahsai's state from "not competent" to "competent and capable" referred to by Nurse Liu in the conversation with Constable Salleo is not reflected in the AFP Missing Persons Form completed by Constable Salleo. Constable Salleo's evidence was that the only discernible effect the changed information had on his actions was that it added more weight to his belief that Mr Kahsai would have returned home after leaving the hospital. Of course police require accurate information in order to perform their duties but I consider this change in perspective of Mr Kahsai's competency had little practical consequence to their actions. This is so particularly in light of the other information they took into account - most importantly the apparently credible information given to police by Mr Wallace.

15. I find no irresolvable discrepancy between the observations of Mr Kahsai's mental state as described by Nurse Cho, who said that Mr Kahsai was aggressive and agitated at 10 am, and Mr Finch, who detected no signs that caused him to doubt Mr Kahsai's competence at 10:30 am. I note that at 10.10am Nurse Cho administered Endone and Oxazepam to Mr Kahsai and I consider it likely that by 10:30 am the medication had the intended and expected effect of quelling Mr Kahsai's agitation. As Dr Luckin opined the dose of Oxazepam improved Mr Kahsai's symptoms, but only for a short period of time. His outward physical demeanour may have belied his underlying irrational mental state.

The 'snowball' effect and lost opportunities

16. I adopt the submissions of Counsel Assisting that this is a case where each key decision which materially influenced the ultimate outcome was open to the decision maker on what was known to them at the relevant time. I also accept that with the benefit of hindsight some of these were not the most appropriate choices. The consequences, however, of each of those decisions snowballed and ultimately resulted in Mr Kahsai not being located early enough to prevent his death.
17. Specifically:
 - a. It was open to the medical staff undertaking rounds on 30 December 2015 to decide in the context of their other duties that Mr Kahsai would be seen as part of their usual morning round rather than as a matter of priority.

- b. It was appropriate for the treating nurses and doctors to have not expressly turned their minds to the possibility of Mr Kahsai leaving the ward or for the potential need for some form of physical restraint. Before the point at which Mr Kahsai actually absconded there were no grounds in fact or law for them to believe that there was a heightened risk of his absconding or that restraint was necessary.
- c. It was appropriate for Mr Finch to form the opinion, on the observations that he made of Mr Kahsai, that there were no grounds in fact or law to restrain Mr Kahsai.
- d. It was open to Dr Sivakumaran to delegate the task of reporting to the police that Mr Kahsai was missing to Dr Parker as a training opportunity for Dr Parker.
- e. In light of the conflicting instructions contained in the Memorandum of Understanding on absconders entered into between ACT Policing and ACT hospitals, and the AFP National Guideline on Missing Persons, and without the benefit of the full Missing Patient Report, it was open to Detective Sergeant Dean to have assessed Mr Kahsai as an absconder rather than a missing person. Accordingly it was also open to him to have waited for the Report to arrive from the hospital before logging a CAD job on the AFP computer system (and thereby dispatch a police patrol).
- f. In light of the 24 hour delay in police becoming aware of Mr Kahsai leaving the hospital, and based on his personal experience of missing person cases, it was open to Sergeant Holland to downgrade the priority of the CAD job he created, and to task a patrol to attend at Mr Kahsai's residence rather than at the hospital.
- g. In light of the (erroneous) information provided by Mr Wallace it was open to Constable Salleo to have formed the belief that Mr Kahsai had returned home after walking out of the hospital.
- h. On the basis that police first entered Mr Kahsai's residence under emergency powers, it was appropriate for them to conduct only a very limited search of the premises, notwithstanding that the early location of Mr Kahsai's mobile phone, which was inside, may have influenced subsequent investigative strategies.

- i. It was open to Constable Salleo to rely on guidance from his team leader in relation to handovers and conduct of the investigation, notwithstanding the comparative lack of experience of then acting Sergeant Hoyer.
18. As Mr Kahsai's next of kin were uncontactable, despite considerable efforts by police to make contact with them, police could not obtain their permission to issue a media release seeking information about Mr Kahsai whereabouts. Further the hospital had originally indicated that it objected to a media release (based on the usual privacy grounds for their patient). Accordingly the police decision not to issue such a release in the early stages of the investigation was not inappropriate.
19. I consider that there were a number of otherwise random elements which contributed to Mr Kahsai's death which in and of themselves were not causative but which contributed to the snowballing chain of events. I include in this consideration the following:
 - a. Nurse Liu's typographical error in the AFP Communications email address to which the Missing Patient Report was sent;
 - b. Mr Kahsai's unobserved departure from ward 4E;
 - c. The lack of training and experience of Constable Salleo and acting Sergeant Hoyer in handling the investigation into Mr Kahsai's disappearance; and
 - d. The misleading and conflicting process documents of both the AFP and the hospital relating to the handling of missing person cases.
20. Each of these instances represents a lost opportunity to break the chain of events which ultimately resulted in Mr Kahsai's death. As Counsel for the AFP stated Mr Kahsai fell through a number of holes in the 'swiss-cheese' model of accident causation. It cannot be said, however, that any one of these decisions or events individually resulted in Mr Kahsai's death. No individual action or decision was wrong or improper simply because alternatives to those taken existed. In that sense, it would not be proper to attribute blame for Mr Kahsai's death to any one individual – rather, as illustrated by the 'swiss-cheese' analogy, his death is the result of a number of systems failures combined with some bad luck.
21. I remind myself that what is clear in hindsight is rarely clear before the fact. Doctors, nurses and police officers do not act recklessly. They make mistakes,

often on the basis of incomplete, ambiguous or misleading information. Often decisions or actions, the appropriateness of which are debated for some time in a court room many months or years later, will have been made by someone who had a few seconds to decide what they should do.

Resolved issues

22. I am required by section 52(4) of the Act to make findings as to whether a matter of public safety arises in this inquest. Ultimately I have determined that there are two such matters. A number of other potential issues in this regard were initially raised for consideration by Mr Kahsai's family and Counsel Assisting. However, during the course of the hearing it became clear from the evidence and from the submissions of Counsel, that some matters were no longer of concern. I will deal with those matters shortly.

Diagnosis and treatment plan

23. On arrival at the hospital Mr Kahsai was diagnosed with a number of conditions but the primary issue was that he was suffering from the symptoms of extreme alcohol withdrawal. Dr Sivakumaran gave evidence as to the treatment provided to Mr Kahsai and of his treatment plan. There was nothing to suggest that either of these was inappropriate.
24. I do not accept that Mr Kahsai's unobserved departure from ward 4E is a failing worthy of criticism. Mr Kahsai was last observed 20 minutes prior to his departure when Nurse Cho administered medication to him. That morning Mr Kahsai was being observed on an hourly basis. There were neither the resources, nor the necessity, to observe Mr Kahsai on a more frequent basis. To have had him under constant observation might well have constituted an unlawful interference with his human rights in the absence of proper grounds to warrant it. On a busy ward, at a busy time of day, the failure to observe Mr Kahsai's departure does not warrant any adverse comment.

Mental State Assessment

25. It is apparent that no formal mental state assessment, in the sense of a formal competency test was undertaken by a psychiatrist or psychologist during Mr Kahsai's admission to hospital. However, Mr Kahsai was subject to regular assessment under the Alcohol Withdrawal Scale (AWS) policy, elements of which included an assessment of his anxiety, orientation and whether he was suffering from hallucinations. There was no objective basis to require a formal

mental health assessment of Mr Kahsai. The taking of AWS scores was appropriate and adequate.

Accommodation in ward 4E

26. Mr Kahsai was admitted as a medical patient not as a mental health patient. The evidence across the board from the nurses and doctors was that Mr Kahsai was being treated for medical conditions. Accordingly his accommodation in ward 4E was appropriate.

Availability of restraint

27. It is clear that Dr Sivakumaran and Mr Finch were aware in general terms that some ability existed for them to restrain patients in emergency-type situations, and that both of them were prepared to invoke restraint in appropriate circumstances. Mr Finch gave evidence that it was part of his role to physically restrain patients if required to do so; whereas Dr Sivakumaran (a senior and experienced specialist) said that he had never found it necessary to restrain a patient although he was aware generally of the circumstances in which he could do so. He stated that in circumstances where he was aware that a patient wanted to discharge themselves against their best medical interests he would try to persuade them to return to the ward voluntarily, often with the assistance of supportive family.
28. I consider that at no time were there any grounds to justify anyone physically restraining Mr Kahsai. The evidence of Dr Sivakumaran and Nurse Cho was that before the point at which Mr Kahsai left ward 4E, there was nothing to suggest that he was refusing medical treatment in circumstances where he was not competent to do so. Mr Finch's evidence was that when he saw Mr Kahsai outside the hospital there was nothing about his presentation or demeanour which suggested to him that Mr Kahsai was not competent. There is nothing to suggest that the assessment of these persons was founded on improper grounds or that they should have formed a different conclusion.
29. It is clear that Dr Sivakumaran and Dr Parker were aware of the existence of a mental health emergency apprehension power. Dr Parker never actually saw or treated Mr Kahsai and therefore was not in a position to actively consider using the power. Dr Parker's initial suggestion to police that mental health powers might be available as a means of detaining Mr Kahsai was based on a less than fully informed understanding of Mr Kahsai's condition and in circumstances where she was a junior doctor with no direct experience of his

treatment. I infer she was tailoring her communications to police in a way to emphasise the urgency of the matter to get police to engage in the search for Mr Kahsai. When Dr Parker was able to seek advice and become better informed as to Mr Kahsai's condition, specifically after her discussion with her supervising consultant, her opinion altered.

30. Whether it assists me to consider the hypothetical case is doubtful. Had Mr Kahsai been located by police or doctors in the act of leaving the hospital it would have been a decision for those in attendance to decide whether an emergency apprehension power was available and appropriate. To go much beyond this is too highly speculative and contingent on the facts to be of great assistance.

Attempted contact with next-of-kin

31. There is evidence that a number of attempts were made to contact Mr Kahsai's next of kin. Although Ms Kielich was erroneously recorded as a next of kin, it was quickly recognised that his son Addam Kahsai was also recorded as a next of kin on hospital records and attempts were made to contact both him and Ms Kielich. As discussed above, I have found that Nurse Liu had a conversation with Addam Kahsai on 30 or 31 December 2015 to inform him of his father's disappearance and that numerous unsuccessful attempts to speak with him were made thereafter by police via different communication methods. The police were not contacted by anyone reporting Mr Kahsai as missing over the Christmas 2015/New Year 2016 period.

Relevance of information supplied by neighbour

32. It is clear that the misinformation from Mr Wallace, that he had heard Mr Kahsai in his flat on the same night that he had left the hospital, had a profound result on the direction of the investigation. It directed police attention away from the hospital to a "rest of world" search scenario. There was no reason or objective evidence at the time for Constable Salleo to have doubted the accuracy of Mr Wallace's information. It was open to Constable Salleo to have formed the belief that Mr Kahsai had returned home after leaving the hospital. .

Thoroughness of the first physical search of Mr Kahsai's residence

33. Neither the first search of Mr Kahsai's residence by Constable Salleo on 31 December 2015, nor the second search by then acting Sergeant Zaganelli on

27 January 2016 located Mr Kahsai's mobile phone. Constable Salleo ultimately found the phone during a search on 3 February 2016.

34. However, Constable Salleo provided an explanation for the lack of thoroughness of these earlier searches. He said that on the two earlier occasions police entered Mr Kahsai's residence under the authority of emergency powers – I infer that this is a reference to s 190 of the *Crimes Act 1900* or possibly some residual common law power – merely to ascertain if Mr Kahsai was injured or deceased inside the premises. Accordingly they had no legal authority to conduct a more thorough search. I agree.
35. Senior Constable Callaghan suggested that had police located Mr Kahsai's mobile phone in a timely way this may have had an impact on triangulation and considerations for Search and Rescue deployment. This is undoubtedly true but there is little reliable evidence as to what impact this could have had. There are too many variables at play and the level of speculation involved takes the matter to a point where it would not be of assistance to me.

Appropriateness of searches undertaken by Search and Rescue

36. Significant evidence was led at the hearing as to how the search for Mr Kahsai was conducted and the basis for the various decisions taken as part of that process. There was no substantive challenge to this evidence save for some questions as to the issue of delay. It is unfortunate that the searches undertaken did not in fact locate Mr Kahsai, and that insufficient time and resources existed to conduct a thorough search of the area in which he was ultimately located. However, it is clear that sound bases existed for the decisions that were made, although with the benefit of hindsight it is clear that more information being known at the time may have led to different decisions being made.

Delayed deployment of Search and Rescue teams to search bushland

37. It was an inevitable consequence of the way in which the investigation was conducted that AFP search and rescue experts were not consulted until late January 2016 and well after Mr Kahsai went missing. In light of Dr Luckin's evidence that Mr Kahsai probably died before 2 January 2016 however, I cannot conclude that the delayed conduct of searches had any impact on Mr Kahsai's survival. Again, while it might have made a difference, there are too many other variables in play and the level of speculation involved takes the matter to a point where it would not be of assistance to me.

First matter of public safety: failures in the notification process

38. As Senior Constable Callaghan identified in his brief the evidence supports (and I make) the following findings:
- a. Preliminary information about Mr Kahsai's disappearance, initially reported by the hospital to police via a phone call was not recorded on the police database awaiting dispatch. This resulted in there being no initial police record of the incident being kept and created a situation of individual memory reliance instead of the priority-based accountable computer aided dispatch system.
 - b. Police waited for the Missing Patient Report form to be received before they took any action. This resulted in police inactivity in the hours after Mr Kahsai left the hospital.
 - c. An error was made by Nurse Liu entering an incorrect police email address when sending the Missing Patient Report to the police. The hospital believed that police were investigating Mr Kahsai's disappearance however as the police had not received the report they were not.
 - d. Different police received the Missing Patient Report a day later. They interpreted the delay between Mr Kahsai's leaving the hospital and the report being received as indicating a lack of urgency. The dispatch priority was changed to less urgent. This resulted in a police patrol being dispatched non-urgently. The responding patrol acknowledged the job but continued to conduct enquiries in relation to a previous disturbance. Thirty seven minutes after being dispatched the patrol conducted their first enquiry at Mr Kahsai's residence rather than at the hospital. The assumption was drawn that Mr Kahsai would have returned home by then.
39. It is clear that fault in this regard lies with the processes of both the hospital and the AFP. However as I have already indicated I make no adverse comment or finding against any individual.
40. As will be discussed later, both the hospital and the AFP have recognised their shortcomings in policy and procedures and moved quickly to rectify them.

Second matter of public safety: police handling of the missing person investigation

Appropriateness of police risk assessment

41. In late 2015 Constable Salleo and acting Sergeant Hoyer were inexperienced in conducting their respective roles in a missing person investigation. Mr Kahsai's case was their first as case officer and team leader respectively. While it was certainly open to them to have sought advice from other colleagues, it is clear that they relied heavily on the AFP National Guideline on Missing Persons to direct them in the investigations they should take and the timeframes which applied in respect of certain actions which were to be undertaken. Constable Salleo agreed that aspects of the National Guideline were confusing and acting Sergeant Hoyer acknowledged that he could have, and in hindsight should have, sought advice from more experienced colleagues.
42. Senior Constable Callaghan has suggested, and I agree, that the current risk assessment process which is required as part of the completion of the AFP Missing Person Report is inadequate. In Mr Kahsai's case the assessment process resulted in a critical decision, namely the determination of whether an incident was a 'high risk' matter, resting in the discretion of a 'Team Leader'. In this case that officer was an inexperienced acting Sergeant not a more experienced officer or an on-call Search and Rescue specialist.
43. The AFP have acknowledged the inadequacy of the process outlined by the National Guideline then in operation, including the process of risk assessment, and have moved quickly to rectify these shortcomings.

Handover of investigation and case officer protocols

44. The circumstances in this case appear to have been that Constable Salleo as case officer did not hand over the case on 31 December 2015 to another colleague as he understood then acting Sergeant Hoyer was continuing to work on the case the following day. Similarly acting Sergeant Hoyer did not hand over the job to the next Sergeant on duty because there were no further avenues of enquires available that night and because he was planning to attend Mr Kahsai's address the following day.
45. It was open to Constable Salleo to have relied upon guidance from his team leader in relation to handovers and conduct of the investigation,

notwithstanding the comparative lack of experience of then acting Sergeant Hoyer. However, the outcome of his not handing over the job was that the investigation 'floated'. Only Constable Salleo actively worked on the case, and then only on the few days in January 2016 when he was actually at work.

46. Again the AFP have acknowledged the inadequacy of the process outlined by the National Guideline then in operation, including the impact of response taskings and shift allocations (including rostered days off) on case officers, and have moved quickly to rectify these shortcomings.

Recommendations

47. Senior Constable Callaghan proposed a number of recommendations for my consideration. During the course of the hearing it became clear that many of those suggestions have in fact already been taken up and were either already implemented or were under active consideration by the AFP and the hospital.
48. This reflects the quality and appropriateness of Senior Constable Callaghan's recommendations and the seriousness with which both the AFP and the hospital have taken them. I am greatly reassured by the approach taken by both the hospital and the police in responding to the recommendations.
49. Coroners are not experts in the administration of organisations such as hospitals or police forces so it is incumbent on me not to make recommendations that may be impracticable or inappropriate to implement. In all the circumstances I consider the only recommendations I need make about positive changes to processes and procedures are that:

I recommend the AFP and Calvary Public Hospital continue the reviews that are already ongoing with regard to the circumstances of Mr Kahsai's death having particular regard to the evidence in this matter and Senior Constable Callaghan's recommendations. I also **recommend** both agencies consider the recommendations contained in paragraph 14 of the immediate family's statement and submissions to the coroner to see if any of those recommendations might further inform future institutional changes.

50. One matter which arose tangentially was that Mr Kahsai's treating practitioners did not appear to have a good working knowledge of the applicable mental health provisions and possible powers of emergency apprehension. I accept the submissions of Counsel for the Territory that this may not indicate a general

deficit. However I consider it appropriate that **I recommend** that the director general of ACT Health, as the person with ultimate responsibility for mental health legislation, undertake an information campaign directed at persons in the health system who are likely to be asked to consider the possibility of emergency apprehension. This is to ensure that they are fully informed of the availability of powers under mental health legislation.

Comment

51. A recurring theme from the evidence of the witnesses was that there was an absence of good quality notes made contemporaneously by employees of both the police and the hospital in relation to various events or conversations. Detailed notes are so useful in corroborating an individual's memory of what actually occurred. Memory after all is notoriously unreliable especially when it is called upon so many years after an event. I am acutely conscious of the limitations of note keeping in emergency and clinical situations but I make a general comment by way of a reminder to all of the importance of good record keeping.

Conclusion

52. I will publish my findings, recommendations and comments on the ACT Coroners Court website, together with any further response I might receive from the Australian Federal Police or Calvary Public Hospital.
53. I thank the parties and their counsel for the cooperative spirit in which they approached their roles in this matter. This certainly made my task much easier and I am sure it assisted Mr Kahsai's family and his close friends in coming to terms with the events surrounding his death. Indeed this is apparent from the contents of the written statement the family provided through their counsel at the end of the hearing.
54. I also thank counsel assisting me, Sarah Baker-Goldsmith for all the work she has undertaken in relation to this inquest. She has been of enormous assistance to me. I know she worked very diligently and consistently to ensure that the inquest would provide as many answers as possible to Mr Kahsai's family about their concerns surrounding his death.
55. I also commend Senior Constable Callaghan on a thoroughly and impartially conducted investigation and the preparation of an excellent brief of evidence. The professional way in which he approached his task is of course evidenced

by his identification of systemic failures in practices and procedures in both the hospital and the AFP and the reception given to his recommendations for rectification of these failures by me and those agencies.

56. I extend my condolences to Tad Kahsai's family. Howard Conkey's long friendship with Tad, his enduring loyalty to him as well as his support of Tad's family in the coronial process, bear testament to the young man that Tad Kahsai must have been. Tad's support of his fellow Eritrean countrymen at a time of national crisis, the love he inspired in his family and his close friends as well as his ability to really enjoy life have been at the forefront of my mind during this inquest. I hope that the man he was has not been completely overshadowed by the sad circumstances of his later years and his death.

I certify that the preceding 56 numbered paragraphs are a true copy of the Findings of Coroner L.E. Campbell.

Associate:

Date: 4 May 2018