CORONERS ACT, 2003

SOUTH *AUSTRALIA*

FINDING OF INQUEST

An Inquest taken on behalf of our Sovereign Lady the Queen at Adelaide in the State of South Australia, on the 18th, 19th, 21st and 25th days of August 2008 and the 24th day of October 2008, by the Coroner's Court of the said State, constituted of Anthony Ernest Schapel, Deputy State Coroner, into the death of Damien Paul Dittmar.

The said Court finds that Damien Paul Dittmar aged 35 years, late of 24 Dartmouth Street, West Croydon, South Australia died at West Croydon, South Australia on the 16th day of May 2006 as a result of neck compression due to hanging. The said Court finds that the circumstances of his death were as follows:

1. Introduction and reason for Inquest

1.1. Damien Paul Dittmar was aged 35 years. He died on 16 May 2006. He had hung himself in the shed situated at premises that he occupied with his grandmother at 24 Dartmouth Street, West Croydon. He died at the scene. A post-mortem examination was conducted in respect of Mr Dittmar's remains and the cause of death was found to be neck compression due to hanging. I find that to be the cause of Mr Dittmar's death. It is clear that at the time of his death Mr Dittmar was a profoundly disturbed individual. There is no doubt that the act of hanging himself was accompanied by an intention to end his own life. There was no involvement of any other person in Mr Dittmar's death.

1.2. On 15 May 2006, the day before his death, Mr Dittmar had presented at the Queen Elizabeth Hospital (QEH) Emergency Department in a significantly intoxicated condition. During the course of that afternoon he was detained under the Mental Health Act 1993 (the Act). He remained in the Emergency Department for a good part of that afternoon but, while still under detention, left the hospital without

permission and proceeded to the premises of a male friend in whose company he remained for the rest of the night. The police were notified of the fact that Mr Dittmar had absconded, but enquiries conducted that night failed to establish Mr Dittmar's whereabouts. In the daylight hours of the following morning he returned to his premises at Dartmouth Street, West Croydon and then proceeded to hang himself in the shed. His body was located later in the morning and a police investigation was conducted. The matter has been investigated as a death in custody as contemplated under the Coroners Act 2003.

1.3. In the weeks leading up to Mr Dittmar's death he had been detained under the Act on one earlier occasion. That period of detention had taken place between 19 April 2006 and 4 May 2006. He was discharged and the existing detention order was revoked. This earlier period of detention had followed an unsuccessful attempt on Mr Dittmar's part to take his own life. He was ultimately to succeed twelve days later on 16 May 2006. A question has been raised as to whether his discharge from detention on that earlier occasion had been untimely or otherwise inappropriate. In this Inquest, I investigated that issue and as well, I examined the circumstances as to how later on 15 May Mr Dittmar was allowed to escape from his place of detention and remain undetected and at large until he took his own life.

1.4. Before discussing the circumstances of Mr Dittmar's detention, escape and death, I should explain briefly the regime of detention that the Act provides for. Section 12(1) of the Act enables a medical practitioner to make an order for the immediate admission and detention of a person in an approved treatment centre where the medical practitioner is satisfied that the person has a mental illness that requires immediate treatment, that such treatment is available in an approved treatment centre and that the person should be admitted as a patient and detained in an approved treatment centre in the interests of his or her own health and safety or for the protection of other persons. Section 12(2) of the Act provides that such a detention order expires 3 days after the day it is made unless earlier revoked. However, a person so detained must be examined by a psychiatrist within 24 hours of the patient's admission to the approved treatment centre or, where that is not practicable, as soon as is practicable after that admission. The examining psychiatrist must consider whether the continued detention of the patient is justified or not. If the psychiatrist is not satisfied that the continued detention of the patient is justified, the psychiatrist

must revoke the order. Otherwise, the psychiatrist will confirm the order. If the order is confirmed this has the effect of continuing the 3 day period that had been enlivened by the original detention order. At the end of that 3 day period further orders for detention of periods of up to 21 days, but not exceeding two such periods, may be imposed. Further detention after the expiry of two such 21 day orders would need to be imposed by the Guardianship Board. A 21 day order is an order for the further detention of the patient not exceeding 21 days. It will therefore be seen that an order for such detention may be made for periods less than 21 days. In addition, a person may be discharged from that order before the 21 day period has expired.

1.5. There are two circumstances that may enliven the necessity to make a detention order under the Act, namely the interests of the patient's own health and safety or the need for the protection of other persons, which of course would include the general public.

1.6. There is provision within the Act[1] for a detained patient to be granted leave of absence subject to conditions.

1.7. Section 23 of the Act empowers a member of the police force to apprehend a person who has escaped from the place of detention or who is otherwise at large. In such circumstances the police officer has a duty to return the person to the approved treatment centre in which the patient had been detained.

1.8. I have already referred to Mr Dittmar's earlier period of detention. On that occasion Mr Dittmar had been detained in Crammond Clinic which is essentially the psychiatric ward of the QEH. As described earlier he was again detained on 15 May 2006, the day before he committed suicide. On both occasions he had voluntarily attended at the QEH prior to his detention and on both occasions had not exhibited any resistance to the detention at the time of its imposition. On the first occasion he had exhibited no inclination to abscond or otherwise fail to comply with any aspect of his treatment.

2. <u>Mr Dittmar's background</u>

2.1. Evidence as to Mr Dittmar's background, personality and his sociological difficulties was provided for the most part by his sister, Ms Leah Settre. Her statement was

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[1] Section 17

tendered to the Inquest[2] and she also gave evidence. Ms Settre was approximately two years younger that Mr Dittmar.

2.2. Ms Settre describes certain behavioural difficulties that Mr Dittmar experienced as a teenager. He was subject to mood swings and from time to time would leave the family residence and stay out, sometimes at his grandmother's residence. Ms Settre described an occasion when a friend of Mr Dittmar's committed suicide. This had a profound influence on her brother. She also described Mr Dittmar's drinking problem and difficulty with smoking marijuana. Mr Dittmar had difficulty holding down a job and displayed aggressive behaviour from time to time. Ms Settre described Mr Dittmar's behaviour as 'highly unpredictable'.

2.3. Mr Dittmar had relationships with women that were not entirely satisfactory.

2.4. He also intimated on occasions that he wanted to take his own life. He became paranoid and aggressive when he drank and smoked marijuana.

2.5. After his relationship with a woman ended in 2000, Mr Dittmar returned to live with his grandmother at the Dartmouth Street, West Croydon address. From that point onwards Mr Dittmar's contact with other members of his immediate family became infrequent to the point where, in the ensuing years, Ms Settre saw her brother on very limited occasions. She became aware that he had formed a new relationship with another woman and that for a time they lived together at Mr Dittmar's grandmother's residence. In late 2005 it appears that Mr Dittmar's relationship with this person ended and this precipitated another period of instability.

2.6. There is little to suggest from Mr Dittmar's history that he had sought out or received any meaningful assistance in relation to his behavioural difficulties, in particular with his excessive consumption of alcohol and drugs, until he was 35 years of age. Even then, help was sought only after he had made the unsuccessful attempt on his own life in April 2006. Much of Mr Dittmar's personal plight was revealed in what he told QEH staff on 19 April 2006, the day Mr Dittmar presented himself at the QEH after that first attempt on his life. He told medical staff that he had a chronic history of depression that had been especially acute in the previous two weeks after his girlfriend of 6 years had left him. It is recorded in the clinical notes of 20 April 2006

[2] Exhibit C26

that he said he wanted to be dead and that there was no point in living[3]. He described a very serious drinking problem of the order of 4 litres of wine per day over a number of years.

3. Mr Dittmar's detention order at the QEH on 19 April 2006

3.1. Aside from Mr Dittmar's rather worrying longitudinal history, it was also evident on 19 April that he was acutely and seriously disturbed at that time. He said that he wanted to hang himself but could not get enough rope. He still felt suicidal at that stage but had no clear plan. He was detained that day. Mr Dittmar is described in the clinical note of 20 April 2006 as being a 'quite high suicide risk with alcohol dependence and an amphetamine habit'. He had originally presented at the QEH Emergency Department some time during the evening of 19 April 2006, but he was still within the Emergency Department on the afternoon of the following day. It is recorded that he was 'awaiting open bed'. Therefore on 15 May 2006 Mr Dittmar was no stranger to the experience of waiting for a long time in the QEH Emergency Department for transfer to a psychiatric ward.

3.2. The form under the Mental Health Regulations 1995 (Form 1) that was compiled when Mr Dittmar was detained on 19 April 2006 states that the grounds for his detention were:

> '- suicide attempt to hang himself with a rope
> - unable to guarantee safety for himself/others in hospital emergency'

The initial detention was confirmed the following day. The confirmation record (Form 2) states as part of the basis for the decision to confirm the original order that Mr Dittmar was experiencing:

> 'Ongoing suicidal ideation, heavy alcohol abuse'

3.3. On 22 April 2006 a 21 day detention order was imposed upon Mr Dittmar and the relevant form (Form 3) again records the suicide attempt by hanging and the lack of any immediate resolution to Mr Dittmar's difficulties. It also refers to a history of previous suicide attempts.

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[3] Exhibit C25b

4. Mr Dittmar's first period of detention at the QEH

4.1. Mr Dittmar remained in the QEH Crammond Clinic from 19 April 2006 until his discharge on 4 May 2006. He was subject to detention under the Act for the whole of that period. I received in evidence a number of statements of clinical staff who had been responsible for Mr Dittmar's welfare. In particular, I received the statement of Dr Rohanjeet Dhillon[4]. Dr Dhillon also gave evidence to the Inquest. Dr Dhillon's statement sets out his interaction with Mr Dittmar and provides an analysis in respect of Mr Dittmar's possible diagnoses and treatment. In his statement Dr Dhillon refers to the fact that Mr Dittmar's clinical psychiatric diagnosis was not entirely clear, but what seems to be reasonably plain is that an alcohol abuse and dependence disorder was well identified as was probable clinical depression, the major symptoms of which could be exacerbated by alcohol abuse and dependence. Mr Dittmar was commenced on antidepressant medication and received counselling within the Clinic. He was also placed under observation to ensure that he did not endure alcohol withdrawal. Dr Dhillon's statement points out that antidepressant medication can take some time to take effect and a full antidepressant response can take several weeks to months.

4.2. In the course of Mr Dittmar's fortnight at the Crammond Clinic he had daily counselling. Abstinence from alcohol use was naturally imposed. He showed a complete and rapid response recovering quickly from his depression. This indicated that it was likely that he did not have a clinical or major depressive disorder after all, but had a transient reactive depression likely triggered by an acute life event and exacerbated by the effects of chronic alcohol abuse.

4.3. In assessing his suitability for discharge, Mr Dittmar was identified as having no ongoing acute risk issues, although he had some chronic risk factors for suicide in the future that were related to his use of illicit drugs and alcohol which would have a negative effect on his mental health. As well, his personality disorder meant that he had both impulsive tendencies and limited coping abilities to deal with stressful events. He was told that he would have a poor prognosis for the future if he did not address his illicit drug use and alcohol abuse and make major lifestyle changes. He was detoxified from alcohol while in hospital and was visited by a counsellor from Drug and Alcohol Services and Alcoholics Anonymous. Mr Dittmar agreed to attend Alcoholics Anonymous to maintain his abstinence from alcohol.

[4] Exhibit C27

4.4. Although Mr Dittmar appeared to improve while he was at Crammond Clinic, Dr Dhillon suggested that Mr Dittmar lacked insight into the extent of his drug and alcohol problem and that his motivation to make major lifestyle changes was questionable.

4.5. The salient feature of Mr Dittmar's progress at Crammond Clinic was the assessment that towards the end of his time there he was no longer depressed nor suicidal and did not require specialised outpatient mental health services.

4.6. Both Ms Settre and Mr Dittmar's father, Michael Dittmar, who provided a statement[5], raised matters that demonstrate some disquiet on their part in respect of Mr Dittmar's release. Mr Dittmar senior said that he was angry that his son was being released at a time when his family thought that he might be receiving some meaningful help at last. His father believed that Mr Dittmar was a danger to himself and to anyone he came into contact with and he states that he expressed these views to a Dr Jason Chan at Crammond Clinic. For her part, Ms Settre said that she had explained to Dr Chan that because her brother had recurring problems for the previous 20 years, two weeks of hospitalisation was not going to fix him. There was also some debate around the time of Mr Dittmar's release as to whether or not it was appropriate for him to resume habitation with his grandmother. It appears, however, that both Mr Dittmar and the grandmother both wanted Mr Dittmar to stay at her residence and this indeed did take place on his release. Shortly before Mr Dittmar's discharge he was seen by a social worker by the name of Marion Croser whose statement was tendered at the Inquest[6]. Ms Croser saw Mr Dittmar in her office. Support outside of the hospital within the community was arranged for Mr Dittmar, particularly in relation to an outstanding civil court matter. Mr Dittmar also indicated to Ms Croser on this occasion that he had a job working for VIP Lawns and that he aspired to pay off his debts with the extra hours of work that he would be able to secure through that firm.

4.7. On 3 May 2006, the day before his discharge, the clinical record[7] reveals a long psychiatric assessment by Dr Dhillon that concluded with a recommendation that he be discharged the following day and that a follow-up be arranged through a General Practitioner, Dr James.

[5] Exhibit C5a
[6] Exhibit C37
[7] Exhibit C25b

4.8. The notes reveal that Mr Dittmar was also seen on 3 May 2006 by Dr Chan. Dr Chan's note records a conversation that he had with Mr Dittmar's father who at that stage was upset at the prospect of Mr Dittmar's imminent discharge. Dr Chan has recorded that he explained to the father that there were 'no further therapy goals for Damien in Crammond'. It appears that Dr Chan also spoke to Ms Settre and that he explained the same thing to her. It is recorded that Dr Chan said to her that although they understood the difficult social circumstances faced by Mr Dittmar's family, their needs fall beyond the services that Crammond Clinic was able to provide.

4.9. It is recorded that on that day Mr Dittmar was given leave to be absent from the clinic for a number of hours. He returned late that afternoon and indicated that he was feeling better, was thinking clearer and that his leave had gone well. The nursing note reveals that on the afternoon of 3 May 2006 Mr Dittmar denied any suicidal ideation.

4.10. Mr Dittmar was discharged the following day when his detention was revoked. He indicated on that day to Ms Croser that he was 'feeling quite well'.

4.11. Mr Dittmar was prescribed his medications and was advised of an appointment that had been made with his General Practitioner, Dr James, on 9 May 2006 at 9:45am.

4.12. As part of his discharge plan, Mr Dittmar had been visited in the clinic by Drug and Alcohol Services who had provided counselling in relation to his substance abuse issues. It appears from the statement of Dr Jorg Strobel, who also gave evidence, that Mr Dittmar indicated that he would contact Drug and Alcohol Services to follow-up for counselling and support after his discharge. It is not known whether or not he did in fact contact Drug and Alcohol Services after his discharge.

4.13. I received in evidence the statement of Dr Gavin James[8] who is a General Practitioner at the Croydon Medical Clinic in Elizabeth Street, Croydon. Dr James had seen Mr Dittmar on a number of occasions in 2003 to 2005, the last consult with him being on 20 September 2005. In July 2005 it was apparent to Dr James that Mr Dittmar was experiencing problems coping with alcohol and drug abuse and was suffering from seizures and stress. In September 2005 it appeared that he was still drinking heavily, using methamphetamine and was depressed. On this occasion Dr James had provided him with a prescription for an antidepressant. On about 5 May 2006 Dr James

[8] Exhibit C34

received a facsimile from the QEH. This consisted of a separation summary related to Mr Dittmar's discharge from Crammond Clinic and indicated that an appointment had been made to see Dr James on 9 May 2006. According to Dr James' records Mr Dittmar did not keep the appointment.

4.14. Although Mr Dittmar was discharged from Crammond Clinic at a time before his 21 day detention had expired, there is in my view simply no basis to say that his discharge was inappropriate or otherwise contra-indicated. It seems clear from the evidence that I heard, and from the clinical record, that Mr Dittmar had a desire to be discharged and was apparently in a frame of mind whereby that desire was not unreasonable. It will be remembered that detention under the Act must have as its basis the interests of the patient's own health and safety or the protection of other persons. The practitioners involved in Mr Dittmar's welfare at Crammond Clinic were clearly of the view that by 4 May 2006 the underlying legal basis for Mr Dittmar's continuing detention did not exist. If Mr Dittmar wanted to leave, as appears to have been the case, there was no legal basis to keep him there against his wishes and his discharge from the facility was not only appropriate but inevitable. There is no warrant for any conclusion that Crammond Clinic should have pressed Mr Dittmar into staying voluntarily.

4.15. I asked Dr Dhillon what he would say in response to the question posed by Ms Settre, namely how could they fix such a deep-seated problem in two weeks. Dr Dhillon said this:

> 'Firstly I would be telling the family that I'm not fixing Mr Dittmar's alcohol problem, that basically this is the start of the process of recovery from an addiction and that really ultimately good outcomes are only achieved based on a person's level of motivation and insight about the significance of the problem. So, no matter how good the therapy is or the setting is, if a person does not want to change a lifestyle or does not want to engage with an ongoing treatment then their prognosis would be poor. So, I think it's very important to stress to families and individuals that really the onus of responsibility also lies with the individual in terms of accepting the help that can be offered to them and also following through with that help and we could put - in fact, most drug and alcohol facilities they like the client to actually call them for an appointment rather than the doctor to make the appointment because if they're not willing to even make the appointment then they're unlikely to show up for the appointment. So, they want to sort of test the level of motivation of the client. So, really that suggests that the good outcomes only is achievable in those individuals that really accept they have a problem and want to do something about it. They choose not to want to do something about it or accept they have a problem then they are a very difficult management problem no matter

> how good facilities you have to manage them or the expertise involved in those facilities.' [9]

4.16. There is one matter about Mr Dittmar's management that I should specifically deal with. One of the concerns that have been voiced by Mr Dittmar's family is that Mr Dittmar may have been coming in to possession of and consuming illicit substances while he was in Crammond Clinic. Mr Dittmar was to tell his sister on 15 May 2006, during the journey to the QEH on that occasion, that he had been using drugs during the period of hospitalisation in Crammond Clinic that I have been referring to. I heard some evidence about whether or not his coming into possession of drugs in Crammond Clinic would have been feasible. I do not need to go into this evidence in any great detail other than to say that there were circumstances in which a patient might possibly come into possession of drugs at the Clinic. If Mr Dittmar had come into possession of or had consumed any drugs, there is no evidence that this was known by any Crammond Clinic staff. There is certainly no clinical evidence of it such as a noticeable change in Mr Dittmar's demeanour. While it has to be acknowledged that in an environment where Mr Dittmar was meant to be detoxing and was undergoing treatment that was designed to ameliorate any risk that he presented to himself and to others, any opportunity that he may have had to possess or consume alcohol or drugs would have been extremely undesirable. However, there is simply no evidence that this had taken place. Mr Dittmar's comments to his sister may or may not carry any truth and in my view it would be inappropriate to give those comments a weight that they may not deserve. They may possibly be true but they bear all the hallmarks of a boast. Either way, the evidence is clearly insufficient for me to be able to draw any conclusion about whether or not Mr Dittmar had been consuming drugs whilst in the Crammond Clinic.

5. Events leading to Mr Dittmar's second presentation to the QEH

5.1. I have already referred to the fact that Mr Dittmar did not attend the appointment with Dr James on 9 May 2006. It appears from the statement of Mr Brett Joyce[10] who was a friend of Mr Dittmar, that after Mr Dittmar was discharged from Crammond Clinic he continued to drink alcohol and was using amphetamines. Mr Joyce had visited Mr Dittmar whilst the latter had been in Crammond Clinic. Mr Joyce asserts that he had not seen any signs of Mr Dittmar drinking alcohol or using drugs while he was in

[9] Transcript, pages 102-103
[10] Exhibit C6b

hospital. It was to Mr Joyce's residence that Mr Dittmar would flee on 15 May 2006 after leaving the QEH Emergency Department.

5.2. On 15 May 2006 Ms Settre and Mr Dittmar's mother were at Mr Dittmar's grandmother's residence. There Mr Dittmar exhibited some disturbing behaviour. He was crying and upset and made the comment:

> 'I wonder every fucking day why I was born.'

It was decided that Mr Dittmar should be taken to the QEH and it does not appear that Mr Dittmar had any particular objection or put up any resistance to that suggestion. Ms Settre drove him to the QEH Emergency Department and it was during the course of that journey that Mr Dittmar made the claim that he had been using drugs during his previous stay in Crammond Clinic. He also said on this occasion that the staff of Crammond Clinic were all stupid and that he only told them what they wanted to hear.

5.3. Ms Settre took Mr Dittmar straight to Crammond Clinic. However, they were told that they had to proceed in the first instance to the QEH Emergency Department. The Emergency Department effectively acts as a gateway for psychiatric patients who may in due course be admitted to Crammond Clinic. This is so because a presentation to the QEH will not of necessity ultimately involve an admission to the psychiatric ward. This will naturally depend on the patient's assessment within the QEH Emergency Department and also depend in some measure upon whether or not the patient is detained. Crammond Clinic has both detained and voluntary patients.

5.4. It is worthwhile noting here that Mr Dittmar on this occasion willingly went to the QEH and there is no suggestion that at any time he was resisting any form of assessment or treatment. Ms Settre left Mr Dittmar in the vicinity of the triage counter at the QEH and that was the last she saw of her brother. Mr Dittmar was later that night to abscond from the Emergency Department having been detained. He hung himself the following morning.

6. <u>Mr Dittmar's assessment at the QEH Emergency Department on 15 May 2006</u>

6.1. It appears from the clinical record that Mr Dittmar was triaged at about 2:45pm on 15 May and was seen by a Dr Pathinathan, as she then was, at 3:15pm. In these findings I will refer to her by her married name of Benedict. Dr Benedict performed a physical and mental state examination of Mr Dittmar which at about 6:15pm culminated in his

detention under the Act. Dr Benedict formed the view that Mr Dittmar appeared to be depressed and in a depressed mood at the time and had both suicidal and homicidal ideation. He mentioned his previous attempt at hanging himself. He also mentioned that he would hurt anyone that looked at him in the wrong way. Dr Benedict felt uncomfortable as far as her own personal safety was concerned and even went to the lengths of having Mr Dittmar's bag searched for weapons. A breath alcohol test taken at some point revealed a level of 0.257 which represents a very high level of intoxication.

6.2. At one point Dr Chan from Crammond Clinic attended and expressed the view that because Mr Dittmar was still under the influence of alcohol, it would not be appropriate for him to make a psychiatric assessment at that time and that the assessment would have to wait until Mr Dittmar was sober. Dr Chan stated that he had known Mr Dittmar from the latter's previous admission at Crammond Clinic and that it would be safe to keep Mr Dittmar in the Emergency Department overnight in order for him to sober up. At that point in time Dr Benedict had not yet detained Mr Dittmar. Dr Chan intimated that the patient need not be detained because he was already a voluntary patient. Based on her own assessment of Mr Dittmar, having observed him for some time that afternoon, Dr Benedict was not comfortable with this approach and she detained him at 6:15pm.

6.3. Although at one point before his detention Mr Dittmar left the Emergency Department to have a cigarette, he was accompanied by another member of the hospital staff. This occurred without any adverse incident.

6.4. The Form 1 that was completed at the time of Mr Dittmar's detention states as the reason for his detention:

> 'Suicidal ideation + alcohol intoxication (BAC 0.25) pt also stated that he may hurt others "anyone who looks at me the wrong way".' [11] (pt = patient)

It will be noted that part of the reason for Mr Dittmar's detention was the level of concern about the possibility that if released he might present as a danger to the community.

6.5. The plan at the time of Mr Dittmar's detention was that he would be kept within the Emergency Department overnight, in particular in Consult Room C which was in

[11] Exhibit C28a

close proximity to one of the nurses' stations. This room had a bed in it. In the morning he would be psychiatrically assessed within 24 hours of Dr Benedict's original decision to detain Mr Dittmar as was required under the Act.

6.6. Mr Dittmar did not evince any adverse reaction to his detention on this occasion and it is fair to say that he gave no hint of any intention not to remain. Mr Dittmar did ask again to be allowed to leave the Emergency Department for a cigarette. Dr Benedict's expectation was that the nursing staff would arrange for a guard to come to the Emergency Department and guard Mr Dittmar. Dr Benedict told Mr Dittmar that as soon as the security guard arrived he would be able to go and have his cigarette. Dr Benedict had no further involvement with Mr Dittmar after this. She was in due course advised by nursing staff that he had absconded and she liaised with the police about that.

7. Events following Mr Dittmar's detention

7.1. Mr Dittmar was detained at about 6:15pm. He made it reasonably clear following his detention that he wanted to go out and have a cigarette.

7.2. An arrangement was made through the security office situated at the front of the Emergency Department that a security guard from an external source would be tasked to come to the hospital to look after Mr Dittmar. Chubb Security provided a number of guards for the QEH. As it transpired that evening there were not enough guards or regular patient minders available to deal with Mr Dittmar's detention. Hence, the need to obtain assistance from outside the hospital. Chubb Security personnel made that arrangement.

7.3. At one point Mr Dittmar repeated his request to be allowed to go outside and have a cigarette. He mentioned this to a Registered Nurse, Ruwyda Booley. This took place in Consult Room C not long after Ms Booley had been advised by the doctor that Mr Dittmar had been detained. At that stage Ms Booley, who gave evidence in the Inquest, noticed that Mr Dittmar appeared to be fine. In response to Mr Dittmar's request to be allowed to go outside, Ms Booley told him that he would have to wait for an escort and that she would arrange one for him. Mr Dittmar was alone in Consult Room C at that stage. The security guard whose attendance was being arranged by Chubb had not yet arrived. Ms Booley believes that she informed the on duty security guards that there was a patient who had requested to be taken out for a

cigarette. She believes that at that time they informed her that they were busy but would get to Mr Dittmar as soon as they could.

7.4. At 6:45pm Ms Booley gave Mr Dittmar some vitamin B supplement in the light of his heavy consumption of alcohol. Mr Dittmar appeared to be fine on that occasion, although he had not yet had his cigarette.

7.5. At about 7pm a Chubb Security officer by the name of Carlo Vozzo, who also gave evidence in the Inquest, was asked by one of the nursing staff whether he was available to take Mr Dittmar out for a cigarette. At that point Mr Vozzo was on his way to an unrelated security task and this meant that he did not have time to attend to the nurse's request. He indicated to the nurse that he would do so when he had an opportunity. In fact, Mr Vozzo went to Consult Room C and spoke to Mr Dittmar and told him that. Mr Dittmar appeared to be quite happy to wait for Mr Vozzo to return. Mr Vozzo was fairly confident when he gave his evidence that the time at which this encounter occurred was very close to 7pm because he had since checked Chubb Security records and they had revealed that the tasking that he was on his way to occurred at about that time.

7.6. We know, therefore, that Mr Dittmar was in Consult Room C at least until 7pm. Thereafter, the exact whereabouts of Mr Dittmar are less clear. What seems reasonably certain is that Mr Vozzo returned to Consult Room C at approximately 7:15pm. At that time the additional Chubb Security guard, who by then had been tasked to oversee Mr Dittmar, had also arrived at the room. Mr Dittmar was not there. It appears, therefore, that Mr Dittmar left Consult Room C sometime between approximately 7pm and 7:15pm. At all material times prior to his leaving the room Mr Dittmar had been alone except on the occasions that I have identified.

7.7. Consult Room C was in close proximity to one of the Emergency Department's nursing stations, namely Nurse Station A. I was told in evidence that the interior of Consult Room C can be seen from Nurse Station A. Consult Room C has what was described as a stable door involving the lower half of the door and the upper half of the door having the ability to close and open separately from each other. On this particular night the upper half of the door was open and so, it is said, Mr Dittmar could be seen from Nurse Station A. It seems that until such time as a patient minder or security guard was made available to oversee Mr Dittmar, the responsibility for the

same fell upon the nursing staff. I was told that a security guard who had to be fetched from the general pool of Chubb personnel might take one or two hours to arrive. In the event, the Chubb Security guard was obtained by about 7:15pm. However, there was a significant hiatus between Mr Dittmar's detention at 6:15pm and the arrival of the guard at 7:15pm.

7.8. Ms Booley's shift concluded at 7pm which was about the time that Mr Vozzo spoke to Mr Dittmar in Consult Room C. At 7pm Ms Booley commenced her handover to Registered Nurse Tamara Dewick who came on duty at that time. The nursing handover is an important function. It serves to impart important information from the members of one nursing shift to another. One can imagine that this procedure would involve the undivided attention of the nursing staff involved. That in fact was the case here. Mr Dittmar was not the only patient that was in that part of the Emergency Department on the night in question. The handover took place at Nurse Station A and took approximately 10 minutes, concluding at about 7:10pm. At that time Ms Booley left the hospital to go home and Ms Dewick, who was at the beginning of her shift, remained. There was some dispute between Ms Booley and Ms Dewick, who also gave evidence before me, as to the precise whereabouts of Mr Dittmar during the handover. The difference essentially amounts to this. Ms Booley was adamant in her evidence that during the handover Mr Dittmar was still in Consult Room C and could be seen from the nurse station where they were conducting the handover. Ms Booley said that Ms Dewick would have seen Mr Dittmar during the course of the handover. For Ms Dewick's part, she emphatically denied that she sighted Mr Dittmar at all that evening and said that she was told by Ms Booley that Mr Dittmar had gone out of the Emergency Department to have a cigarette. Ms Booley denied that she said any such thing to Ms Dewick and denied the suggestion that she had allowed Mr Dittmar to leave, or had acquiesced in his leaving, the Emergency Department to have a cigarette. For Ms Booley, Mr Dittmar remained at all times in Consult Room C. One thing is clear and it is that whatever version is to be preferred, Mr Dittmar left the room either during the 10 minute handover process or shortly thereafter because at 7pm he was still there and by 7:15pm he was found to be missing.

7.9. I do not need to resolve the dispute between Ms Booley and Ms Dewick. In my view this is not a case where blame needs to be accorded to any particular person. It was not as if either of the nurses were not acting with due diligence at the time Mr Dittmar

left. They were engaged in a very serious and important procedure and the fact that this distraction may have enabled Mr Dittmar to leave without detection was not a situation of their making. It would have been far better if a patient minder or a security guard had been available to oversee Mr Dittmar at the time of, or very soon after, his detention.

7.10. I heard much evidence about what in an ideal world should have happened after Mr Dittmar was detained as far as his scrutiny was concerned. Insofar as a burden is cast upon nursing staff to oversee a detained patient and to ensure that the patient remains, in my view that burden is misplaced. One only has to ponder what would happen if a detained patient who was utterly determined to leave tried to leave and the only person there to stop him was a member of the nursing staff untrained in physical restraint. That would hardly be a desirable situation.

7.11. It is not known by which exit Mr Dittmar left the hospital building. CCTV cameras that overlooked, and recorded activity near, the main public entrance / exit did not reveal Mr Dittmar leaving by that means. However, it is possible that he left by way of another door that leads from the public area near the main exit into the ambulance bay. There were other doors by which he may have left the Emergency Department. Some of these would have enabled him to access the hospital building proper and then to leave by some other exit.

7.12. There is no evidence that Mr Dittmar was seen by any person to leave the hospital. In addition it is not known whether when Mr Dittmar left he had originally intended to return to Consult Room C, say after having had a cigarette, or whether at the time he left Consult Room C and the building he had the intention of not returning. What is known, however, is that when he left Consult Room C he took with him his belongings that consisted of a bag and its contents. This would be consistent with him having left the room with the intention of not returning. In any event, there is no evidence as to the precise means by which he left the building and no evidence that he was seen at any time thereafter. Accordingly, it is not known in which direction Mr Dittmar headed in the first instance. Another associated issue is whether or not Mr Dittmar may have secreted himself in the building for a time before ultimately leaving. There is no evidence one way or the other about that issue. In the nature of things, it may well be that Mr Dittmar left the hospital as quickly and as quietly as he

could and once having left the building, made his way out of the hospital grounds with the same haste.

8. The 'Search'

8.1. I heard from a number of witnesses as to the efforts, or lack of effort, involved in trying to locate Mr Dittmar once it was discovered that he was not in Consult Room C. While it must be conceded that there is no material from which a conclusion can be drawn that had there been intensive efforts to locate Mr Dittmar he would inevitably have been located, one thing is clear and that is that no serious effort was mounted in an endeavour to locate him. There was a conspicuous lack of vigour all round. For instance, there is no evidence that the hospital building or the hospital grounds and their environs were searched. The expectation was that, according to the nursing policy manual in relation to absconded and missing patients[12], nursing staff would make a thorough search of the immediate patient care area and notify the security control room. That done, the Chubb Security guards were, by virtue of the same policy manual protocol, meant to instigate a wider search and to initiate appropriate measures to return the patient to the ward if the patient was located. Section 23(2) of the Act empowers authorised employees in an approved treatment centre to apprehend a detained patient who is unlawfully at large and to return the person to the centre. The position would, of course, be different if the patient was a voluntary patient who had chosen to leave.

8.2. Mr Vozzo told me that he conducted a search of the hospital environs that he had some responsibility for, but I did not understand this to be in any sense a thorough search of the hospital. It appears that a search was conducted just outside the main entrance to see if Mr Dittmar was still in that vicinity but, again, I did not understand there to have been a thorough search of the hospital grounds.

8.3. Mr Leif Wilson, who was then a Chubb Security guard and had been on duty in the control centre since 6pm on the night in question, told me that at about 6:30pm he had received a phone call in the security office from one of the nursing staff who was asking for a patient minder for a patient. This, of course, was Mr Dittmar. He had then taken the necessary steps to organise a minder through Chubb. If the time of 6:30pm is correct, the communication from the nurse occurred at a time after Mr

[12] Exhibit C35c

Dittmar had been detained. Mr Wilson told me that he had the impression that the patient under discussion had still been a voluntary patient at that time, but that the patient was going to be detained in due course. In my opinion there was no basis upon which such an impression could have been given or entertained because the nursing staff were clear on Mr Dittmar's status as a detained patient at 6:30pm. Mr Wilson told me that it later became apparent to him that the patient was not in Consult Room C where he was meant to be. Mr Wilson said that even then he did not have a clear understanding that the patient was actually detained, a claim which I found to be moderately astonishing if not improbable. He also emphasised quite firmly that there had never been any formal request from nursing staff for security personnel to conduct a proper search. I am not certain what such a request would have consisted of, but if it was understood that Mr Dittmar was a detained patient, that he was missing and that clinical staff wanted him located, then security should not have needed any further invitation or any other impetus to mount a search. Mr Wilson told me that a proper search would have consisted of a search conducted by an Emergency Response Team that would have gathered at the control room, received a briefing and then would 'fan out across the campus and do their best to locate the patient'[13]. Mr Wilson said that the searching teams were 'usually pretty good'[14]. They would go into and through the external areas and right through the main buildings. The thoroughness of the search would of course depend upon perceptions as to how long the patient may have been absent. It is clear that no search of the kind described occurred on this particular occasion. In this regard, in my opinion the procedures that were in place in order to activate a search for a detained patient left much to be desired in terms of the level of communication that was required to activate it.

9. Mr Dittmar's movements after he left the QEH

9.1. It is known that Mr Dittmar made his way to the home of his friend Brett Joyce[15] who lived at 21 Grebe Street, Semaphore Park. Mr Joyce found Mr Dittmar in his front yard. Mr Dittmar was in possession of a couple of bags and appeared depressed. Mr Joyce told Mr Dittmar that he could stay with him for a couple of weeks. This encounter occurred at about 9pm.

[13] Transcript, page 367
[14] Transcript, page 368
[15] Exhibit C6a

9.2. Mr Joyce told Mr Dittmar that he could stay with him for a couple of weeks to give himself some space. That night, Mr Joyce and Mr Dittmar spent some time at the home of one of Mr Joyce's relatives. After that, Mr Dittmar spent the night on a couch at Joyce's home and awoke at about 7am, saying that he had not slept. Mr Joyce drove Mr Dittmar to his grandmother's premises, arriving just before 8am. Mr Joyce did not remain at the premises, but before he drove away he observed Mr Dittmar's grandmother come into the front yard and then tell Mr Dittmar that the police had been looking for him. As will be seen in a later section of this report, during the previous evening a police patrol had attended at these premises. They had been looking for Mr Dittmar. As well, police had later telephoned Mr Dittmar's grandmother. Although Mr Dittmar's grandmother had been asked to contact the police if Mr Dittmar were to return, she did not do so.

9.3. In his statement[16] Mr Joyce states that Mr Dittmar had told him the night before that 'he had done a runner from his doctor' who had wanted to commit him. It is also clear from Mr Joyce's statement that at that time he knew of Mr Dittmar's history and in particular of his recent long admission in Crammond Clinic. He also knew from the grandmother's comment that the police were looking for Dittmar. Mr Joyce did not inform anybody of Mr Dittmar's whereabouts. When Mr Joyce dropped Mr Dittmar off, he told him that he would return in about an hour and a half to see if Mr Dittmar wanted to come back and stay at his house.

9.4. Mr Joyce returned to the West Croydon address at about 9:30am. Meanwhile, according to the statement that was taken by Senior Constable First Class Horgan from Mr Dittmar's grandmother, Mr Dittmar had at one point been walking around the house and pacing up and down in the rear yard. Mr Dittmar told his grandmother to go back inside the house. Later that morning, at about the time that Mr Joyce returned, she discovered Mr Dittmar's body hanging by an electric cord tied to a roof beam in the shed. Mr Joyce managed to get Mr Dittmar down and perform CPR, but to no avail. Mr Dittmar had died at the scene. The ambulance was called and arrived as did several police officers in due course.

10. The police response

[16] Exhibit C6b

10.1. The police were notified of the fact of Mr Dittmar's departure from the QEH by way of a phone call that was made by Nurse Dewick to police communications. The call was made at 7:47pm. I listened to a tape of the call. It tends to confirm that Ms Dewick had not seen Mr Dittmar at any time before his departure.

10.2. Following this communication, the matter was classified by SAPOL as one involving a Missing Person with High Priority[17]. Acting Senior Sergeant Geoffrey Rodda (as he then was) who was the Port Adelaide Shift Manager, was informed shortly before 8pm of the situation by way of an internal SAPOL communication. The information imparted to him was that the deceased had been detained under a Form 1 and that he had suffered from depression and alcoholism. Information received a minute or two later suggested that the deceased was threatening self-harm and was going to jump in front of a train. The information was that the deceased had also threatened to harm others. Information about Mr Dittmar's background was essentially limited to the fact that he had lived at 24 Dartmouth Street, West Croydon with his grandmother. A description of the deceased was also given. Transport SA was advised of these developments having regard to the threat to jump in front of a train.

10.3. Later that evening two police officers attended at the Emergency Department. They were Constable Pearson and Probationary Constable Morrison. Dr Benedict believed that she had spent approximately 15 or 20 minutes with the officers during which time she gave them as much information as she had about Mr Dittmar's possible whereabouts which, in the event, was limited to the address of his grandmother at 24 Dartmouth Street, West Croydon. Dr Benedict believes that she gave the officers a copy of the Form 1 detention order, whereas there is no evidence from the police that it was received into their possession at any time. The statement of Constable Pearson[18] suggests that although he asked to see the detention order it was unable to be located, at least in the first instance. In any case, the information that was imparted to the officers was that Mr Dittmar was both suicidal and aggressive. These descriptions are contained in notes that Constable Pearson made of his encounter with staff at the QEH. Even if the two officers were not informed fully about Mr Dittmar's statements that he might endanger someone who looked at him the wrong way, the clear message to police was that Mr Dittmar was aggressive and it will be observed

[17] Exhibit C14c
[18] Exhibit C15a

that the computerised record that was made in relation to the recording of initial information about Mr Dittmar made reference to his having threatened to harm others.

10.4. In short, from Mr Dittmar's presentation during the afternoon of 15 May 2006 there was very good reason to believe that Mr Dittmar, so long as he remained at large, would present as a possible danger to himself as well as to others. This information was available to the police and it was clear from that information that Mr Dittmar's recapture and return to the QEH should have been a matter of significant priority. As will be seen later in these findings, it is my view that that matter was not accorded the correct measure of priority.

10.5. It is pertinent to discuss here the extent of police powers in respect of detained patients who absent themselves without leave from their places of detention. As seen previously, Section 23(2) of the Act empowers a police officer, who has reasonable cause to believe that a person who has been detained in an approved treatment centre is unlawfully at large, to apprehend the person using only such force as is reasonably necessary for the purpose and to return the person to the centre. Clearly in this case this power was enlivened and had Mr Dittmar been located at any time prior to his death, he stood to be apprehended and returned to the QEH from where he had absconded, and forcibly so if it came to that.

10.6. During the course of the Inquest I raised with counsel for the Commissioner of Police whether an escape by a detained patient from the detainee's place of detention was an offence and whether the police should investigate it as such. Certainly within the four walls of the Act there is no offence of escaping, absconding or departing from an approved treatment centre without leave. The only offence that relates to an absconding from an approved treatment centre is that proscribed by Section 33 of the Act which renders it an offence for a person without lawful excuse to remove a detainee from, or aid the detainee to leave, an approved treatment centre. There is no suggestion that this has any applicability here. There is no provision within the Act itself that would render it an offence to harbour an absconded detainee or to assist such a person to remain at large. If the law criminalised escaping from or remaining at large from detention under the Act, or criminalised the act of any person who harboured or assisted a person to remain at large, it could only be found within Section 254 of the Criminal Law Consolidation Act 1935 (CLCA). This provision renders it an offence for a person subject to lawful detention to escape from custody

or to remain unlawfully at large. As well, it is an offence knowingly to harbour such a person or to assist the person to remain unlawfully at large. Clearly in an inquiry of this nature I do not have to decide whether Section 254 of the CLCA would have any applicability to patients detained under the Act. However, it may well be that the answer lies in the use of the word 'custody' in Section 254 of the CLCA. Section 254 replaced and repealed corresponding provisions within the Correctional Services Act 1982 and the Summary Offences Act 1953 which related to offences of escaping from prison custody and police custody respectively. Arguably, Section 254 of the CLCA is restricted to those same custodial circumstances and has no applicability to detention under the Mental Health Act which seems to eschew the concept of custody altogether. Moreover, the fact that police officers are granted specific powers under the Act to apprehend patients who are unlawfully at large, combined with the existence of the obligation to return them to their place of detention, might suggest that the usual processes of the criminal law, including arrest and the consequent obligation to bring the arrested person to a police station and to a court, have no applicability. The matter is not free from difficulty and it would, in my view, be appropriate for the Commissioner of Police to seek advice from the Crown Solicitor on the issue.

10.7. Whatever the legal position may be, it is my recommendation that the act of knowingly assisting an absconded detained patient to evade apprehension should be criminalised. The legislature might quite understandably be reluctant to criminalise the mere harbouring of a detained patient because the activity might be undertaken for purely compassionate motives and in what are thought to be the best interests of the patient. However, it is difficult to see why the criminal law should be coy about punishing a person who knowingly and deliberately sets out to assist a detained patient to avoid being apprehended and returned to his or her place of detention. Having regard to the underlying reasons that lead to a person being detained under the Mental Health Act, one would have thought that such activity ought to be heartily discouraged.

10.8. As seen from Section 23(2) of the Act, a member of the police force may apprehend a detained patient who is unlawfully at large. Although this provision is couched in discretionary terms, it would seem to me that the apprehension of a detained patient and the forcible return if necessary to the place of detention would be the norm.

There is an implication also that the Act imposes upon the police a duty to seek out patients who are unlawfully at large and not wait until such time as they may next come under police attention. In my view the position of a detained patient at large is to be distinguished from that of a missing person who is not unlawfully at large. Plainly, the level of police resources that might be deployed to locate a detained patient who is unlawfully at large would depend on all of the circumstances. However, what needs to be constantly borne in mind is that a detained patient has been detained for a reason that has a statutory basis, namely the interests of his or her own safety or the protection of the public, or both. One would have thought that this would be the underlying assumption in respect of a detained patient unlawfully at large upon which the police should act. Detained patients who are unlawfully at large are not just missing persons, especially when it is also borne in mind that, unlike with the situation of a detained patient, there is no legal basis that would enable the police to apprehend a person who is simply said to be 'missing', let alone forcibly return that person to their usual domestic circumstances.

10.9. I return to what happened here. In this particular case, a general radio communication was broadcast drawing the attention of mobile patrols to the fact that a detained patient was missing, although I do not understand that all patrols were generally tasked to actively look for the deceased. At about 8:29pm a uniform mobile patrol that consisted of two Probationary Constables, David Stasic and Kirsten Disalvio, were tasked to attend at 24 Dartmouth Street, West Croydon, the only known address of the deceased. The only person at that location at that time was the deceased's grandmother. The deceased himself was not present and, so it appears, he had not returned to the premises since he had absconded from the QEH. The patrol remained at the premises for about half an hour until about 9:12pm. In that time they spoke to the deceased's grandmother and unsuccessfully searched the house. The deceased's grandmother, Ms Eileen Coombes, was then approximately 87 years of age. She is since deceased. Attached to the affidavit of Senior Constable First Class Horgan[19], the officer who investigated this death, is an undated statement of Ms Coombes that was apparently taken on 16 May 2006, the day that Mr Dittmar died[20]. Although the statement of Ms Coombes deals with matters that include reference to the events of that morning after the deceased had finally showed up there, it does not deal with her

[19] Exhibit C1
[20] Exhibit C1a

interaction with the police patrol that attended her premises the night before. Unfortunately, therefore, it is not known what Ms Coombes' reaction was to the suggestion made by officers that she should contact the police if Mr Dittmar returned to the premises, or indeed whether she took that suggestion on board. What is known is that Mr Dittmar ultimately did return the following morning at about 7:55am, if the statement of his friend Brett Joyce[21] is to be accepted, and that Ms Coombes, who was aware that he had returned, did not contact police or any other member of his family.

10.10. The patrol that consisted of Probationary Constables Stasic and Disalvio constituted the only police attendance at the Dartmouth Street premises before the deceased's death. The statement of Disalvio[22] states that although Ms Coombes was aware of the fact that Mr Dittmar was not home at that time, Ms Coombes was 'confused and did not comprehend what we were asking', namely Mr Dittmar's whereabouts.

10.11. Probationary Constable Stasic gave evidence before me. Constable Stasic did not agree with the observation made in Disalvio's statement that Ms Coombes was confused. He thought that although she was surprised that police were there and that initially she did not appear to have any knowledge of the fact that her grandson was missing from hospital detention, when the reason for their visit was explained to Ms Coombes, she appeared to gain a good understanding about that. Constable Stasic told me that he would have told Ms Coombes that the police were concerned about her grandson's welfare and that it would have been stressed that he was not in any trouble or in danger of being arrested and taken to a lock up. Constable Stasic regarded his brief as being simply to attend at the premises and establish whether or not Mr Dittmar was there. He thinks that they may have asked Ms Coombes whether she had any idea as to where he might be, but in the event it was clear that she could not have imparted any useful information about that.

10.12. The entry relating to this attendance which made its way onto the missing persons investigation diary records that the occupant of the premises had been 'vague as to whether MP was home'. There is no other reference to her frame of mind. It is recorded that Ms Coombes was advised to contact the police should Mr Dittmar return. Constable Stasic did not recall what, if anything, Ms Coombes said in

[21] Exhibit C6 and C6a
[22] Exhibit C16 and C16a

response to that, 'but she seemed to understand'[23]. Constable Stasic told me that he felt comfortable with the matter being left on that basis.

10.13. Later that evening, as already observed, Constables Pearson and Morrison attended at the QEH Emergency Department. At about 9:25pm they spoke with Nurse Dewick. They also spoke with Dr Benedict. The officers requested to sight the Form 1 detention order. It was not clear to me on the evidence whether or not that was sighted. There was information on that document of course which would have led the police to believe that Mr Dittmar may have been a danger not only to himself but also to the public at large. Certainly the surface would not have needed to be scratched too deeply for SAPOL to come to the realisation that Mr Dittmar's speedy return to the hospital was of some importance for divergent but compelling reasons. There does not appear to have been any further information about Mr Dittmar imparted by QEH staff that police did not already know or that was of any particular use. As it happens, these officers telephoned Ms Coombes some time before 10:17pm. This occurred at a time after Constables Stasic and Disalvio had attended 24 Dartmouth Street. Ms Coombes advised these officers over the telephone that Mr Dittmar was not at the address and indicated that she would phone police if he returned. This was the second occasion within the space of about an hour that Ms Coombes gave police that indication.

10.14. No further police patrol attended the Dartmouth Street address at any time prior to the discovery of Mr Dittmar's body. Nor, I infer, was any further telephone communication made to that premises in order to establish whether or not Mr Dittmar had returned. I draw this inference because no such communication or attempted communication appears in the missing persons investigation diary relating to Mr Dittmar. The only other entry in the investigation diary that was made at a time prior to the discovery of Mr Dittmar's body was that relating to a call from Mr Dittmar's father at 8:10am the following morning in which Mr Dittmar's father imparted information that a person called 'Jim' was in the habit of loitering outside the premises at Dartmouth Street. He could provide no further information.

10.15. On the assumption that Mr Dittmar returned at about 7:55am as Mr Joyce states, by 8:10am, the time of the father's call to police, the deceased was already back at the Dartmouth Street address.

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[23] Transcript, page 412

10.16. Acting Senior Sergeant Rodda gave evidence before me. As seen, he had been the Port Adelaide Shift Manager on the evening of 15 May. His shift concluded at 11pm. He had been monitoring communications relating to the missing persons report. Acting Senior Sergeant Rodda had been made aware that Constables Stasic and Disalvio had not been able to locate Mr Dittmar at the Dartmouth Street address. He was not aware of the telephone call that had been made by the other patrol to Mr Dittmar's grandmother. Acting Senior Sergeant Rodda described the nature of police activity that should then normally have taken place, having regard to the so far unproductive attempts to establish whether Mr Dittmar had returned to the Dartmouth Street premises. He said:

> 'As I've mentioned, our shift would have been replaced by nightshift at 2300 and we pass on any missing person reports to the next shift for their on-going attention. What would happen, they would revisit the home address to see if he has returned there, because it's quite common practice that missing persons return to the home addresses. Further to that, the occupants never advised the police so we may have outstanding missing persons that have returned home without us being advised. So we regularly check, phone or visit the house to see if they have returned and further to that matter of investigating if there's any associates or friends, or other addresses, where the person might go.' [24]

None of what Acting Senior Sergeant Rodda had described in that answer took place on this particular occasion. There was no further visit to the Dartmouth Street premises prior to the discovery of Mr Dittmar's body. Nor was there any further telephone call made to the premises. As it transpired Ms Coombes did not notify police that Mr Dittmar had returned and no attempt was initiated by police to establish whether he had returned at any time. I saw no evidence of any enquiries made about Mr Dittmar's known associates or any enquiries made about other family connections. In fairness, however, police had no means of knowing that Mr Dittmar was in Mr Joyce's company and there is no evidence that he was at any location that police could have known about other than the grandmother's premises.

10.17. I do not know of the reason why police did not re-attend the grandmother's premises or make any further telephone investigation. If reliance had been placed upon assurances or indications from Ms Coombes that she would call the police if Mr Dittmar returned, then in my opinion confidence in that regard was utterly misplaced. I do not make that observation with the benefit of hindsight. It would have been naïve to have placed reliance on anyone's assurance in those circumstances. For all the

[24] Transcript, page 462

police knew Ms Coombes might have had her own agenda and have been motivated to positively conceal the fact if her grandson was to return to the premises. I do not say that this was in fact the case, but it was a possibility that had to be considered and guarded against. Be all that as it may, the lack of communication from Ms Coombes could hardly give rise to any safe conclusion that Mr Dittmar had not returned to the premises. The only reliable way to establish whether Mr Dittmar had returned was to visit the premises. That did not take place beyond the visit the night before. In this context it perhaps ought to be re-emphasised that this was not a case of a missing person simpliciter where the person may have had valid reasons for remaining at large. Rather, this was a case where the missing person had absconded from lawful detention and who stood to be returned to that place of detention and, if need be, by force. Beyond Constable Stasic's attendance and the subsequent phone call that was made by the other patrol to the Dartmouth Street premises, nothing of substance was undertaken by police in order to locate and return Mr Dittmar to his place of detention.

10.18. Mr Golding on behalf of the Commissioner of Police invited me to consider whether the reason for the failure of police to re-attend the premises arose from workload exigencies that may have existed at the time. It was also suggested during the course of the Inquest that there may have been a natural reluctance on the part of police to disturb Ms Coombes during the night. Even if there had been such a reluctance, it would not have precluded the police from attending the premises at first light or later. In this regard it will be observed that if the police had attended first thing in the morning they may well have located Mr Dittmar. If they had attended, there is little doubt that he would have been apprehended and returned to the QEH. As to the submission that perhaps the police did not have the resources to make any further visit to the Dartmouth Street premises beyond that which had taken place the night before, I note that no less than four uniformed officers from three separate patrols attended at the premises after the discovery of Mr Dittmar's suicide. As well, two plain clothes officers were present as was a crime scene investigator. A misleading but unfortunate impression is thereby created that police prefer to accord greater priority to investigating a death in these circumstances than to preventing it.

10.19. In making the above observations, particularly in relation to the fact that no further visits were made to the Dartmouth Street premises, I am not in any sense critical of any of the officers who I have named herein as their shifts concluded at 11pm and their responsibilities in relation to this investigation effectively concluded at that time.

11. Recommendations

11.1. Pursuant to section 25(2) of the Coroner's Act 2003 I am empowered to make recommendations that in the opinion of the Court might prevent, or reduce the likelihood of, a recurrence of an event similar to the event that was the subject of the inquest.

11.2. I make the following recommendations.

1) That the clinical staff of the Queen Elizabeth Hospital Emergency Department and the relevant current contractors for the provision of security services to the Queen Elizabeth Hospital continue to develop protocols and policies that will ensure that a patient detained under the Mental Health Act 1993 will not be left unobserved for any period of time following that person's detention and whilst that person remains within the confines of the Emergency Department;

2) That the clinical staff of the Queen Elizabeth Hospital Emergency Department and the relevant current contractors for the provision of security services to the Queen Elizabeth Hospital continue to develop strategies to more efficiently and effectively instigate searches for persons detained under the Mental Health Act 1993 who have absconded or are otherwise be found to be missing;

3) That if it is determined that Section 254 of the Criminal Law Consolidation Act does not apply to the act of absconding from detention under the Mental Health Act 1993, the Attorney-General and the Minister for Mental Health consider introducing legislation that would render it an offence to knowingly assist an absconded detainee under the Mental Health Act 1993 to avoid apprehension;

4) That the Commissioner of Police take the necessary steps to ensure that (a) detained persons under the Mental Health Act 1993 who have left their places of detention without permission are not regarded as missing persons simpliciter, but are regarded as persons who are unlawfully at large and liable to be apprehended under the law and that (b) the necessary vigour is brought to bear in order to facilitate the return of a detained person to his or her place of detention.

Key Words: *Death in Custody; Psychiatric/Mental Illness; Emergency Departments; Hospital - Security*

In witness whereof the said Coroner has hereunto set and subscribed his hand and

Seal the 24th day of October, 2008.

Deputy State Coroner

Inquest Number 24/2008 (0649/2008)