QUEENSLAND COURTS

CORONERS COURT OF QUEENSLAND

FINDINGS OF INVESTIGATION

CITATION:	**Non-inquest findings into the death of Mr T.**
TITLE OF COURT:	Coroners Court
JURISDICTION:	CAIRNS
DATE:	02nd May 2025
FILE NO(s):	2021/5579
FINDINGS OF:	Melinda Zerner, Coroner
CATCHWORDS:	CORONERS: Vulnerable Persons, Abandoned Vehicles, Department of Transport and Main Roads, Local Government Association of Queensland

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Introduction

1. Mr T was born on 24 January 1972 and died sometime between 4 August 2021 and 19 May 2022. He was 49 years old.

2. Initially, the Queensland Police Service (Police) reported Mr T as a missing person who was suspected as deceased. His suspected death therefore became a matter for coronial investigation under the *Coroners Act 2003*. One of Mr T's bones was subsequently located in May 2022.

3. Mr T suffered a significant mental illness and was a vulnerable member of the community. The circumstances surrounding his death have been thoroughly investigated.

4. This case has revealed an issue with the reporting of abandoned vehicles in Queensland. There is no standard process and no centralised database. Mr T's vehicle was identified as an abandoned vehicle on 6 August 2021 and towed from the site to a holding yard on 14 September 2021. The Police were not notified that Mr T's vehicle had been located and towed. Mr T had been reported as a missing person on 25 August 2021. Police commenced a full Missing Person investigation with no success until his bone was found in May 2022.

5. The anguish of Mr T's family and the use of intensive Police resources for many months could of perhaps have been avoided if Police were aware of Mr T's abandoned vehicle. I have written and liaised with the Local Government Association of Queensland, the Police, and the Department of Transport and Main Roads. **I am hopeful further discussions will occur and a robust system of reporting abandoned vehicles can be established in Queensland to avoid a similar situation from occurring again**.

The Role of a Coroner

6. The role of a Coroner is to investigate reportable deaths to establish, if possible, the cause of death and how the person died. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability. An investigation is about attempting to find the root cause of the incident that precipitated the death and in appropriate circumstances to analyse systemic failures that contributed to the death and to design remedial responses.

7. In making my findings, they are based on proof of relevant facts on the balance of probabilities. I am not able to make adverse findings against, or comments about individuals, unless the evidence provides a comfortable level of satisfaction that they caused or contributed to the death.

8. I express my sincere condolences to Mr T's son and the rest of his family and appreciate their patience throughout this coronial investigation. I have sought the consent of Mr T's family to publish these findings.

Circumstances of the Death

9. Mr T had a mental health history of Schizophrenia. He was prescribed Clozapine and was under the care of a regional mental health continuing care team. Mr T was also known to the Cairns, Hervey Bay, and others mental health services.

10. Mr T was a heavy user of Cannabis and abused alcohol. He had been living in a Department of Housing unit in Nambour. He was receiving Centrelink payments but also worked as a concreter in various locations.

11. Mt T was reported missing on 25 August 2021. He had been last seen on the Sunshine Coast on 29 July 2021 at 6pm when he attended the Clippers basketball stadium in Buderim to watch his 14-year-old son play basketball. He left the stadium after giving his son a 'big hug'.

12. Mr T's son was in foster care and Mr T kept in regular contact with his son's foster carer to speak with his son. His son had been with the same foster care since he was two years of age. According to the foster carer Mr T had been estranged from his family for a long time. He was known to become quite erratic and unstable when he was off his medication. It would often result in emergency services intervening. When she saw Mr T on 29 July 2021 at the basketball, she thought he was 'off' as he was standing up shadow boxing. She says she could tell he was off his medication and that he had been off it for some time.

13. The foster carer tried to call Mr T the following day, but he would not answer his phone or return any of her calls.

14. On 31 July 2021, Mr T spoke with his son on the telephone at which time they had an argument. This was Mr T's last known contact with his son. Mr T was on speaker phone during the conversation. The foster carer advised Police Mr T was quite verbally abusive towards his son, angry with the world and quite erratic. She heard Mr T's son tell Mr T that he needed to get some help, but Mr T ended the phone call.

15. On 25 August 2021, the foster mother of Mr T's son reported Mr T missing to the Police. She has advised Police that Mr T called his son every night up until the day he went missing. She advised his disappearance was out of character. She says Mr T lived for his son and would never turn his back on him.

16. Following investigations Police established Mr T had a white ford falcon utility. The last sighting of the vehicle was with a single occupant believed to have been Mr T, on 1 August 2021. He was travelling on the Bruce Highway near the Wongi State Forest, Maryborough.

17. Police conducted searches of the Wongi State Forest area to no avail. The vehicle was not sighted again and the registration on the vehicle had expired by at least 9 December 2021. The searches included water police searching the local dam.

18. Police checked Mr T's Medicare, Centrelink, and Bank of Queensland account. There have been no notifications on any of the accounts since Mr T went missing. Police have made mobile telephone checks and enquires with local mental health facilities and hospitals. There is no record of Mr T presenting to any facility or hospital. Mr T's phone had not been used after 30 July 2021.

19. Police conducted a search of Mr T's unit. They did not locate any notes. Most property was taken from the unit.

20. Police made enquiries with family members. There had been no contact with Mr T.

21. Police issued media releases through news outlets and the internet but there was no response.

22. Mr T had not been charged with any offence and was not a suspect in any police investigation.

23. Police from the Missing Persons Unit advised,

> *The Missing Persons Unit has reviewed this missing person file throughout the investigation and the completion of a Coroner's report. All evidence of life checks made with financial institutions, interstate police agencies and other Government departments, including Mental Health, Medicare and Centrelink have failed to produce any evidence to indicate that the missing person Mr T is alive.*

Medical Records

24. Mr T's medical records have been obtained. He lived with Paranoid Schizophrenia and had been on Clozapine (an antipsychotic drug) since 21 February 2014. This required him to attend a Clozapine clinic. He was on a Treatment Authority.

25. In the weeks leading up to his disappearance Mr T had been prescribed 200mg of oral Clozapine three time a day.

26. On 24 June 2021, Mr T attended the Nambour Adult Community Mental Health Service Clozapine clinic. He advised he had been working a lot. He only briefly engaged in conversation. He appeared a little dishevelled. The clinician recorded,

> *Rapport superficial throughout. Good eye contact, frequently tapping foot, looking around anxiously (not suspicious/paranoid)*
> *Speech increase in rate, normal tone*
> *Mood 'good'*
> *Affect agitated*
> *No formal thought disorder. Some superficial conversation about his plan which involve 'work' and 'not going back …f**'em' ?er: recent travel to FNQ.*
> *Denies suicidality/paranoia/thought to harm self/others*
> *No obvious delusional content*
> *Perception ongoing auditory hallucinations, chronic, refractory*
> *Insight limited*
> *Judgement limit*
>
> *Impression:*
> *Schizophrenia – appears to be more agitated - ?non-compliant/affected by stimulants*
> *-Denying any change to symptoms of psychosis (chronic voices) but limited engagement in review*

27. Mr T did not present for his next appointment. Various attempts were made to contact Mr T to assess him,

    a. On 7 July 2021, a cold call home visit to Mr T's residence was made as he had not responded to phone calls or messages. There was no reply.

    b. On 12 July 2021, a phone message was left for Mr T to contact the Continuing Care Team.

    c. On 13 July 2021, a cold call home visit again was made. Mr T was not home.

d. On 13 July 2021, an Involuntary Patient and Voluntary High Risk Patient Summary was completed. It was noted Mr T required medication. The form included the statement,

**Consideration of risk or potential risks to be assessed at time of attempted visit to ascertain if 2 clinicians needed or if police assistance required (if police assistance required – email COMCO requesting QCAD for request for police assistance and complete MHA form 'Request for police assistance')*.

e. On 15 July 2021, a cold call home visit was completed. Mr T was not home.

f. On 22 July 2021, Mr T did not attend the Clozapine clinic for his usual appointment. He called to say he would be late and would arrive at around 12-12.30pm. He did not arrive. Phone calls and messages were left on his phone requesting he call the mental health service. A text message was also sent to Mr T's mobile phone.

g. On 23 July 2021, a phone message was left for Mr T asking that he attend the Clozapine clinic for bloods and requested he call them back.

h. On 23 July 2021, the mental health service rang the foster carer looking after Mr T's son. She advised,

    i. She had seen Mr T the night before

    ii. He had been working long days concreting

    iii. He was 'reasonable' and she had no acute concerns

    iv. He was not the same since May when he got back from Cairns

    v. He had been struggling with cleanliness

i. The foster carer was asked to get in contact with Mr T and ask that he present to the clinic for blood tests and a script. The importance of his attendance was emphasised.

j. The foster carer called back after she spoke with Mr T at about 3pm that day. Mr T had advised he had 'enough Cloz to last over the weekend'. He appeared slightly angry to her, but she thought this was due to the follow up while he was trying to work.

k. On 26 July 2021, Mr T still had not made contact with the mental health service. A further cold home visit was made. Mr T was not home. The plan was to discuss at the Multi Disciplinary Team (MDT) meeting and to 'escalate'.

l. On 27 July 2021, a further home visit was attempted. A neighbour advised while Mr T had not been home over the weekend, he was home the previous day. The clinician waited around for about 20 minutes to no avail.

m. On 29 July 2021, a clinician records,

> *Phone call out to Mr T this 0945hrs as follow up; as did not attend clozapine clinic last week and has not responded to attempts to make*

contact via daily phone calls by author and cold home visits. Collateral indicates Mr T has been working long hours as concreter. Mr T did arrive to clinic on Tuesday 17th July late afternoon whilst clinician was out of office (as was attempting to make contact via home visit) and Mr T advised admin that he would attend clinic Thursday 29th July for clozapine clinic. He presented at his baseline (according to admin) and he also stated that he had enough clozapine at this time.

n. On 29 July 2021 at 9.45am, in addition to the phone message, a text message was sent,

> *Hi Mr T, please call Nambour CCT urgently to arrange a clinic appointment today for clozapine monitoring as this is a requirement of treatment. Please contact* [redacted] *to arrange. CCT Nambour.*

o. On 29 July 2021 at around 2.35pm, Mr T attended the Clozapine clinic. He quickly escalated and threatened the clinician on several occasions. He was intimidating and ended up leaving the clinic. Police were called regarding the personal threat. It was noted Mr T had a history of aggression when he was unwell. The clinician records, "*As we have been unable to see Mr T over the last week AWA paperwork to be commenced as have been unable to locate*".

28. There then were numerous attempts by the clinicians and the Police to locate Mr T and return him to the hospital for assessment and treatment.

a. At around 3.40pm, the foster carer was contacted by the mental health service. She advised,

i. Mr T was having really poor self care

ii. He 'rocked up' Tuesday unannounced

iii. He had been worse lately and more difficult to speak with and that he was unable to reason

iv. Likely attending his son's basketball later that day.

b. The clinician records, 'Awaiting QCAD number currently'.

c. On 29 July 2021 at 5.05pm, the mental health service was advised Police would not attend on their own but would assist with a joint visit. The clinician records, 'Have requested QPS reconsider their decision'. In the email from the Police, the author states,

> *After reading your application, The request for us to transport has been denied as Mr T did turn up to Mental Health Clinic today for his medication. I acknowledge that he did threaten yourself and your staff though, so am happy to approve a Police Assistance CAD job 2088. Please just do up Police Assistance document and forward through…Please let us know when you have an available Mental Health team to attend and provide Mr T with his daily dose and we will assist in case he is violent.*

d. In response the mental health service wrote,

Thanks, but please reconsider the ATAP [Authority to Transport Absent Person]

The issue is not to do with him not turning up for medication. He is currently unwell with psychosis and threatening to harm people imminently. We have been unable to locate him at his residence. We are more than happy to assist QPS with this case however he has not been at his residence on the 4 occasions we have been there and now we are concerned that he has a heightened risk of violence due to psychosis.

We can try and see Mr T again tomorrow with police however I suspect we will be requesting an ATAP again within the next 24 hours.

It is difficult to ask for police assistance when we do not believe Mr T is at his home.

e. The Police responded,

MR T has been away at Slade Point (Mackay) and spoken to twice by police on the 24th of July. So I dare say that he does live at the address you've provided, but just has been away. We're happy to attend with you guys tomorrow sometime with Police Assistance paperwork to be filed by you guys. You're still the lead agency for mental health related jobs and QPS are only to be utilized for transport (ATAPS) as a last resort. If we attend tomorrow and find that no one resides there, I'm happy to upgrade to an ATAP.

f. The clinician responded, *Sounds like a good plan. Will do request in the morning.*

g. On 30 July 2021, the mental health service sent 'Comco' (Police) a 'Request for Police Assistance for Mr T. The clinical plan was for Mr T to present to the Emergency Department for physical observations, to check his Clozapine level, to perform a Urine Drug Screen and to assess his mental state. He was to be admitted for a short stay admission if required to re-titrate his Clozapine and to stabilise his mental health.

h. On 30 July 2021 at 1.15pm, Mr T's case manager wrote to the same Police representative who declined the request the previous day. He stated,

I am reaching out (as I don't have your phone number) as the current mental health case manager of Mr T.

I have forwarded a request to yourself and COMCO for police assistance in attending Mr T's residences to assess his current mental state.

We are requesting your assistance due to his verbal threat to harm the clinical nurse consultant yesterday whilst at the clinic.

I must stress that the way he presented was not within his normal baseline mental state and collateral from sources close to him indicate that he is most probably experiencing acute psychosis.

I am awaiting your reply to this request.

i. On 30 July 2021 at 3pm, the clinician records,

> *Phone call out to Police COMMS and Nambour Police Station to attempt to escalate Request for Police Assistance with both numbers not taking calls at this time. Multiple attempts made to* [redacted].

j. The clinician called the Police Mental Health number for Brisbane. He was advised there was a request in the system and QPS advised it would escalate to the local officers.

k. At 4.05pm, the police called mental health services. The case had been handed over to the Acute Care Team after hours. Police were provided the details for the ACT and asked to contact them.

l. On 30 July 2021 at 4.24pm, the consultant psychiatrist recorded,

> *I was asked to see Mr T yesterday (on the 29/7/21) ad-hoc as he turned up to the Clozapine clinic after the registrar left. However, it was reported to me by senior clinicians that Mr T was extremely agitated and psychotic in the waiting area. Mr T walked outside, had a smoke and was seen talking to himself, being restless and agitated. Senior clinicians felt he required immediate admission. QPS was notified but, as we later learnt, declined to attend to the patient. Previously, Mr T failed to attend his appointments on more than one occasion. Possible-compliant.*
>
> *Pan:*
> *Admission for safety, containment, assessment of mental state*
> *Organic screen, FBC, Clozapine level. UDS*
> *Clozapine 200mg TDS (his regular dose)*

m. On 30 July 2021 at 5pm, a clinician records,

> *PCI from QPS confirming arrangement to meet at Mr T's house.*
> *Discussion with MHHAT – have had communication for CCT regarding potential admission.*
> *Discussion with Psychiatric Registrar on call, Dr* [redacted] *provided her with information, including that Mr T usually is very psychotic and requires containment in MHICU when returned to hospital.*
> *Advised that Mr T remains under Treatment Authority Community, note written by Dr* [redacted] *stating intention of admission.*
> *Dr* [redacted] *to complete change of Category to inpatient.*
> *Advised that if Mr T not located tonight that the* (sic) *may attend home of his son* [redacted] *who lives with his long term foster mother,* [redacted] *tomorrow for planned access visit.* [redacted] *aware that Mr T had deteriorated and will call Police if Mr T attends her home.*
> *Dr* [redacted] *advised preference for Mr T to be brought to SCHU as inpatient bed available there and nil beds at Nambour.*
> *Attended Mr T's home at 6.20pm, Police officer climbed to first floor verandah* (sic) *– nil sign of Mr T at the residence, nil lights on and all locked up. Resident in unit 8 attended to front door open security door, and state that he had seen Mr T yesterday, Mr T usually out until late at night. Nil answer to knock on door.*

PLAN to attend with Police later tonight at 9PM,
-to attempt by PACER to bring the time forward and QPS unable to,
-email to COMCO to advise that Mental Health unable to attend at 9pm
PLAN – try with QPS next day.

n. On 31 July 2021, clinicians attempted a home visit with two Police officers. The officers advised they had located Mr T's car overnight at the Mt Coolum car park. Mr T could not be found.

o. An ATAP was completed and sent to COMCO. The Involuntary Treatment Order (ITO) was changed from community to inpatient. A clinician spoke with the foster carer who advised Mr T had spoken with her and that he was very angry.

p. On 1 August 2021, the Police attended Mr T's residence twice with no success. The foster carer was contacted to keep her up to date.

q. On 2 and 3 August 2021, a clinician spoke with the foster carer who had had contact with Mr T on Saturday. He 'lost the plot' and was yelling over the phone. The foster carer was advised the Police were attempting to locate Mr T to return him to the hospital. A clinician phoned Mr T and went to Mr T's residence and to the Mount Coolum car park to locate Mr T, to no avail.

r. On 5 August 2021, a clinician drove by Mr T's residence to locate Mr T. It was noted the Police were still trying to locate him. The clinician called the foster carer to obtain some collateral information. She believed Mr T was in Cairns or Kenilworth. She was asked to contact mental health services if she heard from Mr T.

s. On 11 August 2021, a clinical contacted the foster carer about filing a missing person report. She advised she was happy to do that.

t. On 13 August 2021, a clinician drove by Mr T's residence to try and locate him. A neighbour advised they had not seen him for a while. The clinician recorded a missing person's report had been initiated with the Kawana Police last Friday.

u. On 19 August 2021, a clinician contacted the property manager for Mr T's unit to request entry to see if Mr T had left his belongings behind.

v. On 20 August 2021, a clinician contacted the Vulnerable Persons Unit who confirmed a missing person's report had not been activated for Mr T.

w. On 24 August 2021, two clinicians accessed Mr T's unit. His belongings and personal effects remained at the residence. The foster carer was contacted. She had thought in speaking with a Police officer, Mr T had been reported missing. She advised she would attend the following day to complete a report.

x. On 25 August 2021, a clinician contacted the foster carer to provide emotional support as she was having some difficulties with Mr T's son. The Police were also contacted and confirmed a missing person's report had been made.

y. The clinicians continued to drop by Mr T's residence to try and locate him and

to liaise with the Police. The primary clinician also maintained contact with the foster carer and helped in clearing Mr T's unit of his possessions.

z. On 24 January 2022, Mr T's case was discussed at the MDT meeting. The clinician records, '*currently considered: missing person, nil contact with son, nil access to bank finances'*. It was agreed the Treatment Authority could be revoked. Follow up was had with the Police and the foster carer to confirm there had been no new developments before the Treatment Authority was revoked.

aa. On 29 September 2022, the foster carer contacted the clinician to advise Police had located a part of Mr T's remains in Cape Tribulation. She expressed her thanks for the support she had received over the years with Mr T.

Response from QPS

29. I enquired with the QPS as to what occurred regarding the request from the mental health service to assist in bringing Mr T into the service.

30. I have received a detailed unsigned statement from a Sergeant from Maroochydore. He has advised,

a. The original request made by a triple zero call at 2.28pm wherein it was reported Mr T was threatening staff was no longer required as Mr T had left the premises and the risk to staff at the location no longer exited. The CAD job was therefore cancelled. Police were advised the health service would be applying for an ATAP (Authority to Transport Absent Person).

b. The ATAP was received and reviewed by the Senior Communications officer. The officer replied to the request identifying reasons why an ATAP would not be approved. That included Mr T had attended the mental health service by his own volition seeking assistance in obtaining his medication. That despite his voluntary attendance, an incident occurred whereby the consumer became agitated and elevated and verbally threatened a person.

c. In keeping with the directions of the Chief Psychiatrist Section 4 (least restrictive – most restrictive) an ATAP was not approved but the services were advised a Request for Police Assistance (RFPA) would be supported given the earlier verbal threat by Mr T. The officer requested a RFPA be completed and that an available time made for QPS to attend with the Mental Health Team to provide Mr T with his dose of medications. The officer advised the Police would assist in case Mr T was violent.

d. The officer states,

> *Given the deficiencies in the document* [ATAP]. *The conflicting versions around the patient's examples of behaviours of concerns. The lack of inclusion for attendance of other authorised and appropriate persons (practitioner, auth employee or Queensland ambulance officer).*
>
> *…*
>
> *The threshold for Queensland Police to act alone has not been met and no serious and imminent threat had been identified since leaving the clinic. With no attempt at all by mental health to make contact and*

attempt to persuade the consumer to attend and no least restrictive option being attempted despite the directions of the Chief Psychiatrists, [the Senior Communications officer] *has no option than to decline the document.*

e. The RFPA was approved on 30 July 2021. The Police from the Nambour unit attended Mr T's address finding the Mental Health staff absent from the scene. The officer states,

> *Section 16(4) of the Police Powers and Responsibilities Act 2000 states that before the police officer helps the public official, the public official must explain to the police officer the powers the official has under the authorising law. This means that when a health practitioner request assistance from police, the health practitioner must tell and explain the relevant powers under the MHA 2016 to the police officer.*
>
> *In the absence of authorised Mental Health Staff, QPS were not afforded the powers disclosure and in particular, the powers of entry were not able to be conveyed to QPS for escalation. QPS officers rang the supplied Mental Health phone number and were not answered. Further calls were placed with no response from Mental Health. The matter was set for re-attendance and requests were made to attempt to contact Mental Health. An email was forwarded but remained unsighted by the COMCO and CAD job card was subsequently closed.*

f. At 3.18pm, the Police were contacted by a clinician from Mental Health querying the status of the previous request (which had been closed). Shift availabilities were provided for mental health staff for a collaborative attendance. Mental health was available till 4.30pm. A new CAD job was opened.

g. At 3.31pm, the Police contacted a mental health clinician and confirmed the RFPA had been approved. Contact details were provided to mental health of the Police so they could coordinate attendance times and teams.

h. At 4.02pm, Police rang to advise they were going to terminate the RFPA without attendance to Mr T's address. The mental health services advised they had after hours staff available to attend at 6pm.

i. At 5.48pm, the mental health service advised Police they were delayed. Police attended Mr T's address and climbed over to the first-floor veranda. Mr T was not located. The unit was in darkness and remained locked. The Police conducted neighbourhood enquiries with a resident of another unit. He advised he had not seen Mr T since the day before and that usually Mr T was away from his unit until late.

j. The mental health service requested the on scene Police officer reattend Mr T's address. Police received an email from a clinician from mental health asking if Police could also attend Mr T's residence on 31 July 2021. Mobile phone contact details were supplied, and the CAD job was reopened and rescheduled for 8.30am.

k. At 9.05pm, the Nambour Police reattended on Mr T's unit. There were no mental health clinicians present despite Police expecting their presence.

Police contacted the mental health service and were advised they could not attend as had been arranged. Officers were advised that mental health would submit a new RFPA in the coming days. The CAD job was closed at 9.06pm.

l. On 31 July 2021 at 3.48am, patrolling Police from Coolum located Mr T's vehicle at Wilkinson Park Lookout. It was empty. A street check was entered by the Police.

m. At 9am, Police reattended Wilkinson Park and confirmed Mr T's vehicle was in place. At 10.21am, a Sergeant requested a crew attend Wilkinson Park to confirm Mr T's vehicle was still on scene. A crew attended at 11.11am and the vehicle was not located at the park.

n. At 10.21am, a new ATAP reflecting Mr T's absence and escalated concerns was completed and approved at 10.33am in draft form. The approved ATAP was forwarded through to the warrant bureau and a flag placed against Mr T identifying a MHA transportation warrant.

o. At 3.38pm, the mental health service requested a check be conducted at Mr T's home address. Police patrolled known parks in the area.

p. At 6.11pm, police attended Mr T's residence. The place was in darkness, and nobody was home. Police contacted the mental health service to advise them of the attendance on Mr T's home. It was agreed the Police would attend at 7.30pm and if Mr T was not there, Police would re-attend the following day.

q. At 9.45pm, the station was advised to patrol throughout the night at know spots and Mr T's residence.

r. On 1 August 2021 at 7.26am Police reattended Mr T's residence entering the unit complex to the front door. Mr T was not located; the vehicle was absent. The neighbour advised he had not seen Mr T for a while. The job was left open and a request for reattendance was made and recorded.

s. At 6.40pm, the Nambour Police advised they had suspended reattendance for the day shift due to more urgent matters and workload.

t. On 2 August 2021 at 9.28am, with all locations checked and rechecked, the CAD job card was closed. Mr T had been flagged with the approved ATAP warrant. In the absence of articulation of self-harm, the threshold for mobile phone triangulation was not permitted until Mr T was listed as a missing person.

Response from the Mental Health Service

31. I provided a copy of the statement from the Police, requesting a response from the Health Service. I have been advised,

    a. Information obtained from a key person in Mr T's life supported the clinician's risk assessment, confirming the need for QPS assistance to locate and transport Mr T for an inpatient admission.

    b. Mental Heal and Specialised Services (MHSS) acknowledges that QPS risk and threshold assessment is conducted using a different methodology than

the clinical risk assessment performed by Authorised Mental Health Practitioners.

c. The health services do not have a copy of the ATAP as an ATAP can only be saved in the Consumer Integrated Mental Heal and Addition (CIMHA) application once approved with a QCAD Police ID number.

d. MHSS apologises for any shortcomings that may have occurred during the initial drafting of this document.

e. On 30 July 2021, a mental health clinician did attend Mr T's residence at 6.20pm. The health service acknowledges there was a slight delay in attendance due to other demands.

f. The health service advised they could not attend at 9pm and a request was made for a repeat visit to the residence on 31 July 2021 and that occurred at 8.30am.

g. On 31 July 2021, as least restrictive options had been explored and the risk remained high, an ATAP was completed by an Authorised Mental Health Practitioner and accepted by QPS.

h. The representative from the health services states,

> *CIMHA records document MHSS communications, actions and escalations regarding this case. They confirm that Mental Health Clinicians followed the legislative requirements of the Mental Health Act 2016, in accordance with the Chief Psychiatrist policies 'Managing Involuntary Patient Absences' and 'Transfers and Transport'. The Clinicians employed the least restrictive process appropriate to the level of risk for this person.*

32. The Health Service has acknowledged there is an opportunity to improve the clarity and effectiveness of communications regarding ATAPS and 'Request for Police Assistance' to ensure QPS and MHSS have a comprehensive understanding of the information shared.

Location of Mr T's Remains

33. On 19 May 2022, a witness attended the Mossman police station to advise that approximately two weeks earlier, he had located a bone at Emmagen Creek, North of Cape Tribulation.

34. Police took possession of the bone, it was photographed and taken to Scientific Services in Cairns.

35. The witness described the area where the bone was located which was about 7 kilometres north of Cape Tribulation. It was located on the side of a creek bed. The witness with two other persons searched the area to see if they could locate any other bones or remains.

36. The witness had not been able to attend the police station earlier than he did due to inclement weather.

37. On 22 June 2022, Police attended the Emmagen Creek area with the witness and

another person. Police inspected the side of the creek bed where the bone had been located. A further search of the south creek bed for approximately 500 metres was conducted through the mangrove and back toward Cape Tribulation Bloomfield Road. No other human remains were located.

38. The witness who was a local tour guide and very familiar with the area believed due to the location of the bone (at the high water mark at full tide in the middle of debris, branches etc.) it was more than likely to have been washed in from the sea as opposed coming downstream, based solely on the geography and shape of the creek and the unusually wet weather and high tides at the time.

39. The left human femur bone located at Emmagen Creek was sent for DNA testing. On 19 September 2022, Forensic Scientific Services have confirmed there was a match for Mr T.

40. The Police spoke with Mr T's brother. He advised Mr T was a concreter and had worked in various locations, he believes that Mr T had visited Far North Queensland in the past and recalled that Mr T may have spent time in Cape Tribulation. He was unable to provide any details of who and where he would have stayed.

41. Police made enquiries in the Cape Tribulation area. On 21 September 2022, a representative from the Douglas Shire Council advised the Council had located Mr T's vehicle on the Cape Tribulation Bloomfield Road north of Cape Tribulation. The vehicle had been towed to the Killaloe Refuse Facility.

42. The vehicle was located by the Police. It had been in the open area for approximately one year with both windows down. The roof was caved in, and the windscreen smashed. Police have advised it appears the vehicle had been damaged in an accident, with damage to the front passenger side and smashed drivers side headlight.

43. The vehicle had been first reported to the Council on 5 August 2021 as an abandoned vehicle causing a hazard.

44. On 6 August 2021, road maintenance workers from the Council attended the vehicle which was about 2.2 kilometres north of the Beach House, Cape Tribulation and 2 kilometres south on Emmagen Creek. The front passenger side was partially in a ditch and the back was protruding into the north bound side of the road. It looked like it had crashed into the banking at the side of the road. From the state of the car, the Council workers thought someone must have been living in the vehicle.

45. The vehicle was towed off the road that day and further into the ditch to remove the hazard. They placed a Douglas Shire Council notice to remove the abandoned vehicle from the road. During the following month the workers travelled past the vehicle and noticed the swag had been removed from the back of the vehicle. They did not notice any further damage.

46. On 14 September 2021, RACQ removed the vehicle to local refuse facility, and this is where it was located when Police inspected the vehicle. It was in the condition in which the vehicle was when inspected by Police. The two drivers side wheels were missing, and it had damage to the roof and windscreen. The workers believe the damage to the car when seen by Police may have happened when it was recovered by the Council. The car was inspected by the Police forensics team.

47. On 24 September 2022, a search and rescue exercise was undertaken over a two

day period. No skeletal remains or items of interest were located.

48. On 26 September 2022, flyers of Mr T were circulated to local businesses. No further information was obtained.

49. In response to a media release for information concerning Mr T, a witness contacted the Police. He advised,

    a. In August 2021, he was working north of Emmagen Creek concreting on the Donovan Range.

    b. He would travel maybe five times a day for phone reception.

    c. On 3 August 2021, he saw Mr T on multiple occasions just south of Emmagen Creek sitting next to his white Ute.

    d. On 4 August 2021, he is not sure of the exact time but saw Mr T standing on the side of the road. Mr T jumped out in front of him and started to shadow box. He had a few grazes on his head.

    e. Further along the road he came across the white Ute, it was on its roof partially blocking part of the road, facing north. There was no one around. He stopped and looked inside but did not notice any blood or items of interest.

    f. He returned later that day and noticed the white Ute had been righted and was back on its four wheels. He photographed the vehicle. He did not contact the Police or report the vehicle.

    g. He did not see Mr T after this day.

50. Police searched the area where the car had been located. The SES vertical rescue team searched the downside of the hill on the ocean side. No human remains or items of interest were located.

Police Investigation

51. Police have advised there was no recognised system in place where a local Council is to contact the QPS or the Department of Main Roads and Transport if they seize an abandoned vehicle.

52. The Police have since asked that the Douglas Shire Council inform the Police if they are removing a vehicle so a Q Prime street check can be undertaken. While it is a local arrangement, it was advised it would be beneficial in the future if there was a system in place for all Councils to inform the Police.

Forensic Pathologist Examination

53. An examination of Mr T's left femur bone was completed by a forensic pathologist. There was no ballistic debris or discernible significant natural pathology.

54. A portion of the bone was sent to Forensic Biology, Brisbane for DNA analysis. The analysis identified the tissue as being from a missing person (Mr T) who had been reported missing approximately nine months before discovery of the bony tissue.

55. The forensic pathologist concluded the cause of Mr T's death was undetermined.

Abandoned Vehicles

56. I wrote to the Local Government Association of Queensland (LGAQ) to explore raising awareness with local councils on the processes associated with the relocation of abandoned vehicles, and in particular notification to the Police.

57. Ms Smith, the Chief Executive of LGAQ advised the LGAQ can assist by circulating relevant awareness information via their Local Government Governance Network, as well as updating relevant resource material.

58. I wrote to the local Douglas Shire Council. They advised their investigations of abandoned vehicles are conducted in accordance with the Transport Operations (Road use Management) Act 1995 and relevant local laws. They have confirmed there currently is no formal process to notify the Police about abandoned vehicles or any guideline to manage this aspect. They support the involvement of the LGAQ in this issue and believe a standardised approach across Councils would be highly beneficial, for example, the creation of an online portal for reporting and managing impounded vehicles could streamline efforts and improve coordination. They welcome the opportunity to collaborate with the Police to ensure the best outcomes for the community.

59. I approached the Police through the Coronial Support Unit. I have been advised that in NSW, Western Australia, Victoria, and Northern Territory that if a vehicle is towed then there is a website where vehicles can be checked to see where the car is. In Queensland, without a website or coordination by the Department of Transport and Main Roads (TMR), the Police are the default and are only told if a towing company reports it. As TMR has every vehicle registration on their system, the Police draw data from TMR to check vehicle registration. They have advised that if a person wants to check if a vehicle is encumbered by finance, then the TMR website can be checked, and it is possible to see if the vehicle is registered.

60. Police are of opinion the practical solution is for TMR to be the holder of information concerning towed vehicles. Police would then check the status of the vehicle on the TMR website as part of their missing person checks.

61. I wrote to TMR, and received a response from Ms Stannard, the Director General. She advised the management (including up to removal) of abandoned vehicles in Queensland depends on the type of road (state-controlled, local government, or private). She has confirmed currently there is no legislative requirement for abandoned vehicles to be reported to a central agency such as TMR or the Police.

62. Further, there is no legislative definition for what constitutes an abandoned vehicle. For state-controlled roads where a vehicle poses a low-risk hazard and has not been removed within seven calendar days, it is generally considered abandoned. Before removing a vehicle, TMR checks the vehicle's details against the QPS database to determine if the vehicle is of interest. Once a vehicle is towed from a state-controlled road, TMR registers the tow via the QPS online 'tow notification' system. Ms Stannard says, "*this system was created by QPS for use when vehicles are towed, but it does not serve as a centralised register of abandoned vehicles across Queensland*".

63. Ms Stannard acknowledges the importance of improving abandoned vehicle reporting processes. She states,

> *While there is currently no statewide register for abandoned vehicles, TMR*

notes that QPS maintains a tow notification system, which could serve as a model for potential enhancements. ***TMR welcomes ongoing discussions with QPS and other stakeholders to explore opportunities for refining existing processes and ensuring better coordination.***

We remain open to engaging in further conversations on this matter and appreciate the opportunity to contribute to any future recommendations*.* (emphasis added)

Conclusion

64. After considering the material obtained during the coronial investigation, I consider I have sufficient information to make the necessary findings required by s45(2) of the *Coroners Act 2003*, in relation to Mr T's death.

65. Mr T had a long history of mental illness. He was a known schizophrenic who was on a community treatment order requiring him to regularly present to a mental health service for anti-psychotic medication. Mr T had recently returned from Cairns and had briefly re-engaged with a mental health service on the Sunshine Coast. Unfortunately, Mr T became non-compliant in presenting to the health service and with that, he experienced an escalation in his psychosis.

66. Various attempts were made by the clinicians to try and persuade Mr T to re-engage with the service. When he eventually presented to the clinic, he was clearly unwell and left prior to being assessed and being administered medication. The clinicians sought the assistance of the Police to return Mr T to the service. While there was some initial confusion concerning the ATAP, that is whether the initial circumstances warranted that level of Police involvement, Police agreed to assist and by the following day an amended ATAP was accepted by the Police.

67. Police attempted to locate Mr T with no success. The clinicians were kept advised of the attempts by the Police to locate Mr T. It seemed Mr T was actively trying to avoid the Police and clinicians. At this time, a missing person's report was not made as it was hoped Mr T would return.

68. It seems Mr T likely made the decision to quickly leave the area as evidence by his car being seen on the Bruce Highway on 1 August 2021. While the Police closed off the CAD job to locate Mr T, Mr T had been flagged with the approved ATAP warrant. That is, he was flagged on the Police system had Police been able to locate him.

69. Mr T travelled to Cairns. He was known to the local mental health service but there is no evidence Mr T attempted to contact that service. He was clearly unwell, and a witness observed him on the road near Emmagen Creek. The witness did not think to report Mr T at the time.

70. Mr T was not sighted again after 4 August 2021. There is no evidence as to what happened to Mr T after this last sighting. I accept the forensic pathologist's opinion that Mr T's cause of death cannot be determined.

71. While Mr T's vehicle was located by the local Council, the local Council did not make enquiries with the Police as to the whereabouts of the owner of the vehicle. This is unfortunate because had an enquiry have been made on 5 August 2021 when it was reported as an abandoned vehicle, Police would have been alerted to the potential whereabouts of Mr T and search efforts could have commenced at or around that time. It is not possible to say whether that would have made a difference to the

outcome, but it was a lost opportunity to undertake a search to locate Mr T.

72. I am not satisfied that it is in the public interest to hold an Inquest (formal court hearing) There is also no uncertainty or conflict of evidence as to justify the resources required for the use of the judicial forensic process and no suspicious circumstances that have not been resolved or resulted in criminal charges. On that basis I have determined that an Inquest is not required. I have though written to the various stakeholders encouraging them to review processes around abandoned vehicles and will provide each agency with a copy of these findings. I have also sought the consent of Mr T's family to publish these findings on the Coroner Court of Queensland website to raise awareness of this issue.

73. I again extend my condolences to Mr T's family and friends for their loss.

I close the investigations.

Melinda Zerner
Coroner

02 May 2025