THE PARLIAMENTARY JOINT STANDING COMMITTEE OF COMMUNITY DEVELOPMENT IN COMMITTEE ROOM 3, PARLIAMENT HOUSE, HOBART ON 18 OCTOBER 2005

INQUIRY INTO STRATEGIES FOR THE PREVENTION OF SUICIDE

MR SCOTT TILYARD, ASSISTANT COMMISSIONER, TASMANIA POLICE WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED.

CHAIR (Ms Thorp) - Thank you for making yourself available to the committee.

Mr TILYARD - It's my pleasure.

CHAIR - This is our most recent reference looking into the causes of suicide in Tasmania specifically, brought up by yourself and the member for Nelson, Jim Wilkinson and we thought we needed to find out from the point of view of both the media and the police how we should be dealing with this issue and what protocols the police have in place. That was the way we were thinking, wasn't it, the protocols that were all in place, and setting up sensible sensitivities. So we will just give you an opportunity to tell us how it is really from the police's point of view.

Mr TILYARD - The responsibility of the police with regard to suicides primarily is to assist the Coroner in the investigation to establish the manner and cause of death. We provide all our police officers with the necessary training to allow them to do that from a response investigation capacity. As well, we provide additional training to our criminal investigation people in particular to allow them to conduct more thorough investigations at particular scenes. Our general approach is that every death is treated suspiciously until otherwise determined. For obvious reasons that is the way we have to approach these things. With a lot of the cases of apparent suicide that we attend it is relatively obvious from the onset that it is exactly that, most likely a suicide, but we never make that assumption until we have conducted an investigation. There are others where it is less clear and on those occasions we involve our detectives in the early stage to provide an additional level of oversight investigation until such time that we are satisfied that suicide is the cause of death. There are those cases that ultimately, whilst they initially appear to be suicide, turn out to be criminal acts that require further investigation.

So that is our basic response arrangement. We do have protocols in relation to how we investigate all deaths but suicides as well. There are issues associated with suicide investigations such as suicide notes which are quite often found left by people who have taken their own life. Not only are they an important aspect of the investigation but in certain circumstances they can be regarded as a legally binding will. So there are certainly processes that we need to follow to ensure that that is available for that process as well.

In addition to the numerous suicides that we attend around the State in any given year - and I think, and correct me if I am wrong, you already have before you some material provided through the crimes office regarding the actual number of suicides, causes and gender

breakdown and all that sort of thing - for the 2005 the year to date it is around the 64 to 65 mark statewide. We attend a lot of other incidents that are attempted suicides or threatened suicides - people who may really have no intention of actually taking their own life but will threaten to do so in certain situations and we have the responsibility to respond to and manage those types of incidents.

Mr WHITELEY - How many of those would be in the context of the current debate on domestic violence?

Mr TILYARD - I could not give you a precise figure but certainly there have been a number that I have personally been involved in, responding to quite a number of those over the years, that would fall within the category of a domestic violence-type situation where emotions run so high that all sorts of things can happen. You can end up with sieges and on occasions people being held hostage and threats being made.

Certainly there is a link. A few years ago we actually commenced an intelligence operation to collate those occasions where we were going to incidents that were attempts and threats so that we would have a database of information which previously we did not have. Primarily we did this for our own purposes because, as you can imagine, if you get a person who attempts or threatens suicide, quite often they will come again and in six months' time or 12 months' time we are dealing with the same individual.

It is handy for us to have ready access to information about what happened last time - how it was resolved, what sorts of things they were doing and claiming and so on. We have a database that provides that information for us and what that tells us at the moment in terms of the actual number of those that we have dealt with since January 2004 is approximately 400 cases of attempts and threats. I cannot really give you a breakdown of the types of situations and incidents. Whilst that information would be available, the database is not set up specifically to provide it. It is just really a 24-hour-a-day, seven-day-a-week quick access for us anywhere in the State to previous incidents.

CHAIR - To find a name.

Mr TILYARD - Yes. Search for a name, search for an address, that sort of thing, and very quickly we have that information to help us deal with the current situation, whatever that might be.

Mr WHITELEY - So those 400-odd instances are not necessarily 400 different people. How many different people would that represent?

Mr TILYARD - The majority of them would be different people but there would certainly be some duplication there. Some people might have come through three or four times, and with some individuals maybe even more over that period.

Mr FINCH - Did you say that is what you have on the database?

Mr TILYARD - Yes.

Mr FINCH - Over what period?

Mr TILYARD - Since the beginning of January last year, the first of January. So less than two years' data on that. The other thing on that too is that the process that sits behind that is a direction to our constables who are attending this sort of thing on a fairly regular basis, to put in one of these reports each time. It is possible that some of those particularly minor incidents where someone might have said something that might be construed as a threat to harm themselves might not have made it into that database. So that is the stuff that has made it into the database. The picture is probably slightly worse than that.

Mr FINCH - How strong an attempt does it have to be?

Mr TILYARD - There is no criteria. They could just say, 'Well, I am going to do myself in' more or less whilst they are being arrested over something else and that information should be put into the database. I should say too, to clarify, there is a totally separate database in relation to people that charge and if they make threats or they are assessed at being at risk of self-harm whilst they are in custody that is recorded in our online charging system. So it is a separate process to what I am talking about.

CHAIR - It is just useful to you, isn't it, if you have someone ringing up and making a threat, to be able to say that it is Tom Bloggs who regularly does this.

Mr TILYARD - It just helps us manage whatever the current situation is that we are dealing with because the police officers who dealt with the previous incident or incidents might not be around and available at the time, so it is handy to have a record of what happened last time. This is available 24 hours a day, seven days a week to police statewide.

Mr FINCH - I would like to come back to training of police officers and how strong that training is and how it focuses on suicide prevention and also dealing with the families of people when you have to present that news to the family. Can you go into a bit of detail about that situation and the process of the training?

Mr TILYARD - The basic training that we provide to all police officers is part of our normal trainee package through the academy because they need to know the processes and procedures, what the legislation is when it comes to dealing with all deaths, including suicide. That is the fairly general basic training that all police officers need. As I said, we give the additional training to our detectives because they need to be able to make an assessment regarding the scene and the body and whether or not there is a possibility that a crime has been committed. We also involve our forensic services people who do what essentially is a crime scene examination of these scenes whenever it is considered necessary as well.

In addition to that there are different ways that we deal with different types of deaths. Usually uniformed police will deal with it or the CIB if it is more serious. On occasions our coroner's associates who are seconded to the Justice department working for the coroners will take a more proactive role themselves to investigate and put the file together, That is particularly the case in suicides, obviously, but for sudden infant death syndrome we normally have specialist police come in because of the special sensitivities around that, dealing with the family in particular. So we do approach that in a slightly different way.

In addition to that, in more recent years we have implemented a program delivered through our staff support unit that focuses more on the preventative side of suicide, and I can take you through some of the key elements. This is delivered to all of our training courses now and it

is also delivered to our in-service police out amongst the districts. Basically, the things that are covered are some of the statistical information; some of the key definitions involved; perceptions of suicide; the risk factors of suicide; models of behaviour and how police officers can recognise that perhaps when they are going about their day-to-day duties; some of the different factors involved, including same-sex relationships, rural versus urban, migrant communities, Aboriginal communities, young males and older people and what the breakdown there is in relation to the statistics. Some sessions that they call linking and listening to people to try to pick up on those key indicators, that a person might be depressed or whatever. There are also other aspects including how we interface with other service providers and hospitals and what positive interactions police can make with individuals in certain circumstances that might steer people away from self-harm. So this is a more comprehensive package, I guess, leaning more towards raising awareness amongst our police officers but also trying to do something in terms of suicide prevention.

Mr FINCH - Who puts that package together for you? Is that psychologists or -

Mr TILYARD - It is the Federal Government Gatekeeper Program. I do not know a lot of the detail behind who put it together but it is a structured package that has been put together and it is delivered within police services right around the country, as I understand it. It is only a fairly recent initiative. In the past, very much the police response and our role has been the investigation of suicides for the Coroner, as I said. We acknowledge now that we have, because of the sheer number of contacts that we have with individual community members on a day-to-day basis -

Mr FINCH - First port of call.

Mr TILYARD - Exactly. We are talking to a lot of people we are going into a lot of homes and we are dealing with a lot of situations where sometimes if you know what the risk factors are you can pick up on that and try to take either some sort of positive action yourself or at least make appropriate referrals or talk to the family and try to get the family involved. Whatever the appropriate action is we want our people to take it at the appropriate time. In terms of notifications, you asked about passing on notifications to families, we do that all the time of course. Whenever there is a suicide here or elsewhere if there are next of kin or relatives in the State then it is the police who have the job of knocking on the door and telling people about it. And what sits behind that of course is the support processes that we have in place for our own staff.

Ms HAY - Counselling?

Mr TILYARD - Counselling. I do not know whether you would like one of these brochures -

Mr WHITELEY - CISD?

Mr TILYARD - Yes. It fits under the Critical Incident Stress Debriefing program that we have run for a number of years. All the emergency services use a combined program here in Tasmania and there are certain circumstances in which Critical Incident Stress Debriefing is a considered appropriate for suicides. There are criteria, and I have those here if you are interested in them, when that sort of process is virtually always implemented but suicide is not one of them. It really depends on the nature of the incident that you are dealing with and the personal circumstances of the officer involved.

CHAIR - When it is particularly shocking?

Mr TILYARD - Yes. Particularly serious injuries. When I say 'serious injuries' I mean particularly graphic, nasty situations or if children or young people in particular are involved. I know that we had one here, just off the top of my head, a couple of years ago where I think a 12-year-old hung himself. Anything to do with a child would be something where we would then look at implementing that program.

It is obviously traumatic for anybody who is involved in responding to this type of situation and the police are just one of the agencies that have to respond to every one that happens.

Mr FINCH - What practices do you have in place for attempted suicide in a call-out? What are your practices for referral or for keeping an eye on them?

Mr TILYARD - The most normally-invoked practice is trying to take some action under the Mental Health Act. We have authority under the Mental Health Act if we are concerned about the mental state of a person to take them into custody and to a place of safety for assessment. That is normally one of the main hospitals, the emergency management section of the hospital, where they are assessed by a psychiatric registrar and either admitted for observation or treatment or allowed to leave.

CHAIR - You would have to be pretty confident that it was a serious threat to do that, I would imagine.

Mr TILYARD - We would. There are other incidences that we deal with where someone might be depressed or they might be saying things and we can simply deal with it by taking them to a friend's house or a family member's house or getting someone to come round and look after them, just as long as we are satisfied that they are going to be okay when we leave. In other cases we will make referrals to a health department to try to address the problem so that they can take over the case management and look at issues such as counselling. In extreme cases most of the time the police action is that we need to put that person in a situation where they will be safe and where their needs can be assessed. Normally that is done by taking them to a hospital.

It would be fair to say that there is occasionally some frustration that we feel as a police service when we are dealing with a person in what can be pretty extreme circumstances. We take them yelling and screaming to a hospital and wait around a number of hours for them to be assessed and basically they end up leaving about the same time as we do after someone has had a look at them. I am not being critical of the people involved in that process because they are more experienced and trained than we are to make that sort of assessment but there is the odd occasion when we feel that it might have been more appropriate to admit them than let them go. I am mindful of the fact also that there are a whole range of issues that might have influenced that decision.

CHAIR - That is a matter of alternative places to take them.

Mr TILYARD - Well, that might be something that needs to be looked at.

Mr FINCH - That might be a recommendation that we put forward in respect of cooperation between the police and the

Mr TILYARD -There is certainly a lot of cooperation and we have managed to work our way through a lot of these issues at the local level. I do want to emphasise I am not being critical of the hospitals or the personnel who are involved. Certainly the hospitals have put in place protocols to try to get to our people sooner to do the assessments once we are there waiting, particularly if the person is violent, trying to assess them sooner and hopefully admitting them to one of the wards at the hospital for assessment.

Mr FINCH - You would not know what the prevailing issues are in the community; the number of staff that you have available might be needed for other work and could be sitting there twiddling their thumbs.

Mr TILYARD - Yes. There is a requirement under the Mental Health Act that the assessment is to occur within four hours. We have done a lot of work with hospitals, we have liaison groups established around the State with the main hospitals in particular and I think it is fair to say there has been a bit of an improvement in relation to the waiting time. It usually tends to be closer to four hours than four minutes.

Mr FINCH - Is there a time when you are more called on to go through that process? I am thinking of nights, weekends, Christmas.

Mr TILYARD - Yes, it is usually of an evening when the hospitals happen to be fairly busy anyway. You cannot really put an actual time on it but there is something to be said for the old full moon idea because we do seem to get a few extra when there is a full moon. Unfortunately, I think it is Murphy's Law a bit, but it is always -

CHAIR - It's a full moon tonight isn't it?

Mr TILYARD - It is pretty full at the moment. It is Murphy's Law that when they are flat out at the hospital it seems to be when we get all the cases. Normally it is of an evening though and not so much of a morning and afternoon, although we do have admissions that we try to make under the Mental Health Act during the day as well. For these people often it is not just their mental state, it might be drugs and alcohol they have taken as well and we will put them in of an evening.

Mr FINCH - What is the delay; getting someone in out of hours?

Mr TILYARD - No, in the major hospitals they have people there but they are obviously pretty busy and it is a case of when they can leave the psychiatric ward and come down to Accident and Emergency and do the assessment.

Ms HAY - How long does the assessment take?

Mr TILYARD - It varies. From personal experience, and I am going back a few years now since I did my last one, it can be anything from about 15 to 20 minutes through to well over an hour depending on the person and the Registrar. What we have done to try to speed the process up is to fill in a form that is basically an overview of the incident that we have taken from the person. The Registrar can get the forms in advance and have a bit of a flick through

so that they can start thinking about it before they talk to the individual and there is a permanent record for the hospital as well as to what happened on that occasion. We have tried everything we can to speed up the process but it really comes down to the Registrar being available to do it as soon as he or she can. The police officers of course want to get back out on the road and get on to the next incident or whatever.

Ms HAY - Does the act state that the Registrar is the only person who can make the assessment?

Mr TILYARD - Yes, pretty much. Obviously it is people with appropriate qualifications and it is usually the psychiatric registrar of the hospital that does it.

Mr MORRIS - I would like to follow on in the sense that we go back a little. With individuals with mental health illnesses many of them would have a case manager of some degree or another. Do you have access to records to the point where you could identify who the person's case manager is or do you ask them as a routine matter whether they have a case manager, and can you contact the case manager because presumably that is the person who knows most about them within the community at least?

Mr TILYARD - We can usually find that out pretty quickly even after hours just through the after-hours contacts for the Health department, Mental Health Services. This is normally not a major issue, and we will talk to their doctors as well, their normal doctor, and we can normally find out fairly quickly who their case worker is and who their doctor is. Occasionally you have difficulty getting that person on the other end of the phone or whatever but that doesn't tend to be a major issue.

One of the things that we have done in more recent years is identify an emerging problem in relation to people with mental health conditions out in the community who are off their medication. Unfortunately, what was most commonly occurring was that it got to the point where they had been off their medication for a while and it was known, or suspected to some extent, that they were probably not taking their medication but it had escalated to a point where they more or less barricaded themselves in somewhere before the police got involved. There have been plenty of occasions when we have been stuck there overnight or whatever trying to sort it out once it has reached that point. We have put in place some better liaison arrangements with Mental Health Services so that we get a bit of a heads up, even if it is just a phone call at the local level, if there is someone who is not taking their medication and who they think might be a bit of a problem so that we can try to work through with Mental Health Services some strategies to do something about that situation before it gets to the point where we are dealing with someone barricaded in and threatening to hurt themselves and not wanting to come out. That has worked relatively well.

Mr MORRIS - We have made some amendments to the legislation to put a new process in place for those who are refusing to comply with community treatment orders, hopefully short-circuiting them having to deteriorate to the point of police getting involved before they can get treatment. I am interested in particular in terms of access to records because we know that, in particular in relation to the Royal Hobart Hospital, the records for in-patients at the hospital are not shared with the community mental health services. There is no communication and even as recently as this last month I have asked again whether that issue has been resolved, and the answer is no, it has not. I wonder how much of an extra work load is on you fellows.

Mr TILYARD - The flow of information has improved to some extent. I think the difficulty we have is that because of privacy concerns et cetera often there is confusion about what information can and can't be provided. People tend to err on the side of caution - the local unions are in trouble if they say something they are not supposed to say or provide a document they are not supposed to provide. Because of the uncertainty around it, which can be quite confusing, there is a bit of an understandable reservation to share information sometimes. We have a memorandum of understanding with the Health department that provides for information sharing, particularly in urgent situations where someone's life might be at risk, that we can get access pretty much to whatever we need to safely resolve the situation and look after the welfare of the individual concerned. That has improved in recent years.

Mr FINCH - Do you do that after hours?

Mr TILYARD - Yes, provided there is someone at the other end who can access the information after hours.

Mr MORRIS - Could we as a committee have a copy of that.

Mr TILYARD - I don't see any reason why not.

Mr MORRIS - Great. That would be really useful.

Mr TILYARD - We have had it for quite a number of years and it is in the process of being reviewed at the moment. Off the top of my head, I think it has almost got to the point where it will be reassigned by the commissioner and the secretary of the Department of Health and Human Services. Probably the current one is the one I can give you. I have been involved in the discussions and I know there have been some enhancements to the information-sharing aspects of the draft that is about to be signed off.

Mr MORRIS - It does seem that in all these cases what we need is a whole-of-government approach. There should not be a demarcation between the police and the hospital, for example, because one would have thought there is another angle on treating things cautiously and that is that what is in the best interests of the patient really needs to be dealt with as a priority. If they have information that is relevant to how you handle a person or understand a person, then surely that can be shared. Okay, there are privacy issues but I think we have to learn to be a little less precious to some extent for everyone's benefit.

Mr TILYARD - I would agree with that. Obviously we are very careful about what we do with the information - and that is the key.

The other thing I haven't really touched on, but I will mention, is the response arrangements we have for a particular situation: if it is high risk then we will bring in our specialist groups to help resolve the situation.

Mr FINCH - What is high risk?

Mr TILYARD - If there is a serious risk to life or serious damage to property, basically. It could be like a siege situation where someone has a firearm or they are threatening with a knife to kill themselves or whatever. We will bring in our specially trained police to deal with it or

assist in dealing with it. For example, our negotiators get special training to deal with suicide intervention so they will actually talk with the person. They will communicate with the person, yelling over the fence, talking on the telephone, whatever it takes to resolve the situation - and we resolve a lot.

In the vast majority of those situations, where it gets to the point the negotiators will generally resolve it. There have not been too many when we have not been able to sort it out. I was personally involved in one that wasn't resolved, quite a few years ago now, but most of the time we will manage to talk to the person and resolve it that way. So that specialist group does receive special in training in relation to suicide intervention.

Mr WILKINSON - What type of training does that involve, Scott?

Mr TILYARD - For the negotiators?

Mr WILKINSON - Yes. It worked up at New Norfolk with that bomb threat, didn't it?

Mr TILYARD - Yes, that is right. I used to be State commander for the negotiation unit so I have some expertise in this area. There are basically two levels of training that the negotiators get. There is the basic course that we put them through here, which is a standard course that all police jurisdictions put their negotiators through. Then there is also a national-level course focused more at counter-terrorism type situations, but it does cover the same principles that the negotiators are using to deal with suicide intervention cases.

The other thing that we do regularly in our response to these things, particularly in relation to suicides, is to use our psychologist. On some occasions we will engage the services of a psychiatrist. For example, Ian Sale has done a lot of work with us over the years to provide advice to our negotiation team, listen to the tapes, listen to the person, get involved in the strategic planning meetings that the negotiator is having about what to say to the person - which roads to go down and that sort of thing - and they will assist us in resolving a situation. So a lot of resources get thrown at these things and I guess New Norfolk is a classic example of that.

During that particular incident there were threats being made that they were going to harm themselves and, at one point, the male offender alleged that the female had actually taken her own life, that she had overdosed. We did not know whether that was right. We did not think that was right and it turned out not to be right. It is quite common in that type of situation - a barricaded person or hostage siege situation - that the offender will either make direct threats of self-harm or at least allude to that possibility. So it is something we need to manage.

Mr WHITELEY - No amount of money and training would be a waste.

Mr TILYARD - No, not at all.

Mr FINCH - What happens, Scott, after these incidents? How far does the police interest in the clients or the people go; how far does your concern go? Do you have practices and protocols in place?

Mr TILYARD - Not as such because once the situation is dealt with at the scene and the investigation is under way, obviously t a lot that goes on with the family during the

preparation of the coroner's file. At the local level quite often there is direct police/family contact but in some cases it can go on for many years, even after the situation. But the formal aspect of the police role is more or less finished and then it goes on maybe to counselling services delivered by other agencies or what-not.

Mr FINCH - I was thinking more of after an incident of attempted suicide.

Mr TILYARD - The situation is monitored so far as the individual is concerned.

Mr FINCH - Is that part of your process?

Mr TILYARD - It is part of the process in terms of the intelligence operation that we have as to where they are living and that sort of thing and what sort of contact they might be having with police. It is not as formal as a requirement that -

Mr WHITELEY - You could action in five days time or something.

Mr TILYARD - Yes, that's right. It is a case where, at the local level, we try to keep tabs on what the person is up to, where they are and that sort of thing. In terms of the attempted suicides cases it is not close monitoring, no.

Mr WHITELEY - So it becomes more the intellectual property of the local constabulary?

Mr TILYARD - Basically, yes. Up until a few years ago we were recording the fact that we had dealt with an attempted suicide or threatened suicide situation, because we do have records of everything that our people get dispatched to, but we did not have it in an intelligence database that we could readily access and search. That is the benefit of our starting this intelligence operation. It is a little intelligence operation in amongst our huge intelligence database. But it does give us that 24 hours a day, seven days a week capacity.

Mr WHITELEY - Do you have to search for it separately? Do you have to literally go in and say, 'Kathryn Hay - I want to search this part of the database that may include a threatened suicide', or does it come us as part of a whole range of her speeding fines et cetera?

Mr TILYARD - It is separate but we now have an integrated system so that if we put in a name of an individual it will pretty much tell you the vast majority of information we have on an individual, whether it is an intelligence report, a traffic infringement notice or if they have something before the court. It is linked. It might mean that at the moment, because of our current set-up, we might have to go to that database and have a look, but at least we know it is there.

Mr WHITELEY - Oh, it's flagged.

Mr TILYARD - Some of it is available with the click of a button but some of it says, 'In this system there are six reports that relate to these people'.

Mr WHITELEY - If you're going to get a call out you're not going to want to be spending half an hour doing a search at a small community policing station.

Mr TILYARD - That's exactly right.

Mr WHITELEY - You want to be able to take the report off the printer and take it with you.

Mr TILYARD - The benefit of it is that all those systems I have spoken about are available from any of our computers statewide, in all of our police stations, 24 hours a day.

Ms HAY - So someone in Hobart could look up Brett's illegal campaigning last election?

Laughter.

CHAIR - He wasn't charged.

Mr WHITELEY - That's right. Thank you. You are the only one speaking any truth.

Laughter.

Mr FINCH - I am just curious about the level of concern for a person's welfare after you have dealt with an incident in a referral situation for that person; is that part of your consideration?

Mr TILYARD - Yes. That does happen all the time. As I mentioned previously, with each situation we always assess what is the best course of action to take. Some of that is as simple as ringing mum or dad and getting them to come around, sit down and have a talk with the person and they will take over looking after the person. At other times we make referrals to the Health department for some sort of counselling or other formal follow-up. It is only in the more extreme cases that we take more of a police intervention role and take them off by force if necessary to hospitals and things like that. It really comes down to a case-by-case assessment of what is in the best interests of the individual.

Mr FINCH - Is an assessment needed every time?

Mr TILYARD - An assessment is made every time, not a formal documented assessment but we train our police officers who attend as to what should happen. It gets reported, as I say, on our database; it is also gets reported to their supervisors and to their inspector. Their activities are reviewed on a daily basis and if there is a need for one of those people to intervene to make sure that something gets done that doesn't seem to have been done then that happens.

Mr FINCH - What is the police record on that sort of action? Is it good, getting better?

Mr TILYARD - It is getting better all the time, particularly since we have started this new training program to make police officers more aware of some of the risk factors involved and some of the different types of referrals that you can make as well. I think in the past, as I said before, the traditional approach and the police role is to go in, deal with the situation at the time. If it has been an actual suicide, you have responsibilities to the coroner in terms of the investigation and the reporting. There probably hadn't been sufficient thought given to how we case-manage these people who are making threats or attempting to, other than the normal referrals that we make. But that has been formalised in more recent times so that we ensure that we are referring when we need to.

Ms RITCHIE - My question is in relation to people who have perhaps attempted suicide or displayed certain sorts of behaviour, and then taking them, say, to the Royal Hobart Hospital. You did mention that on occasions the patient is leaving at the same time as you are. I know you have levels of frustration at times where perhaps certain people are allowed back out, as you indicated, but are there any instances where police officers will take it upon themselves to put someone in a police lockup, for lack of a better word, because they feel that they need to be secured? Do the police ever take it upon themselves, if they have been released but they are still worried about them, to put them in a police scenario?

Mr TILYARD - That has happened. Often these people have actually committed offences, often arrestable offences. In a normal scheme of things we could probably just take them back to the police station and if they were considerably affected by alcohol we could detain them for a number of hours until they sobered up or whatever. But if there is a question about their mental health then it may well be that it is not necessarily appropriate to charge them with anything anyway.

Ms RITCHIE - That is what I am wondering. I can understand that when there is a capacity to charge and hold, but I am really interested whether or not you just hold. They have committed no crime and they have been released from the Royal after you have taken them for an assessment. You perhaps cannot understand why, and I understand those cases, so do you just hold them for that reason?

Mr TILYARD - Not normally. Sometimes the only thing that they may have done is to assault police. I am not saying that is a minor matter, but technically they could be arrested, taken back to the police station and in certain circumstances remanded in custody for a while. But if we have been called to deal with a person with a mental issue and it is quite clear that they certainly seem to have a mental issue -

Ms RITCHIE - And they are heading back towards the bridge or something.

Mr TILYARD - Well, yes, and the chances of convicting them in a court are questionable anyway. There is nothing to be gained by charging them with anything; we just want to make sure that they are okay. We take them to a hospital and there is an assessment made, and that assessment basically is they are fine - they just very angry or whatever. Then, if we are still concerned about them or other people that they might be a threat to at 3 o'clock in the morning, we might make the decision that, if they are fine, we will revisit the charge and we will take them to the police station and give them a bed for a few hours. In the cold light of day hopefully they would have calmed down a bit and might not be such a threat.

Ms RITCHIE - Basically, what you are saying is that there are instances where you might see someone for a second or third time in an evening.

Mr TILYARD - It would be unfair to say a third time; that would be very rare. There are certainly occasions where we might take someone to hospital and someone has a look at them and says, 'No, we do not think that they need to admitted'. Then we get called back to deal with them.

Ms RITCHIE - Again.

Mr TILYARD - Again, yes. You might recall an incident - and do not quote me on it but I am pretty sure that I am right - a couple of months ago at Sandy Bay - a guy with a gas cylinder in a flat. It was over two consecutive nights. Well, at the end of the first night I think we took him to be assessed and he was released after an hour. And then exactly the same thing happened. Now, 20/20 hindsight is a wonderful thing but we would not have taken him in the first time unless we thought there was a bit of a problem there. I do not want to be critical because it is all right for me to sit here and say, 'Why can't these people be admitted every time?' Well, that is just not practical anyway. There are issues, including the number of patients that they can take at the hospital, that need to be taken into account.

Mr WILKINSON - You can say that they need to be admitted and the doctors say they cannot be admitted.

Ms HAY - Can you ask for another opinion? If a person is released and does not fulfil the assessment requirements, whatever those might be, they are released and you are called out again, do you often or ever take them back to the hospital for another assessment?

Mr TILYARD - Well, we would because we would normally not have any other option. A second opinion would not be practical because there is normally only one person available to do it anyway, particularly if it is the early hours of the morning and that sort of thing. I am not asking for a second opinion.

Mr WILKINSON - Is there anything that we can do as far as government is concerned to make it better for you in relation to the system that you have. I am not in government, but as recommendations for the committee.

Mr TILYARD - I guess there is the issue of what do we do with these people if we have got them in custody. It is not necessarily appropriate to charge them or anything; they just need help. What do we do with them at 3 o' clock in the morning if for whatever reason the hospital cannot take them, because we do not have the option of saying we cannot do anything about them because we get left with it? Someone has got to make sure that they are safe and we have to make sure that the community is safe. So it is not simple.

Mr WILKINSON - So what is your suggestion; how should we deal with it?

Mr TILYARD - I think that people have given this a lot of thought over the years and no-one has come up with any answers yet. I guess some sort of a facility where we can take them, where they can -

Ms HAY - What was the one in Launceston; what was that called? A weekend program.

CHAIR - I cannot remember.

Ms HAY - So some more facilities, like this house where two or three people go into to assist -

Mr FINCH - Time-Out.

Ms HAY - Time-Out; so more facilities like that around the state.

Mr TILYARD - For us it is often a temporary thing. If something happens in the early hours of the morning, as these things tend to, we have resources tied up with it. So we might have a car and a couple of police officers tied up on a busy night and they could certainly be better deployed doing other things. Now, if they are tied up for a number of hours, essentially babysitting, then any way that we can free that resource up to be out in the community is a benefit to us. Quite clearly it is not always appropriate to put these people in a police cell.

Mr WHITELEY - Exasperating.

Mr TILYARD - Yes. And there needs to be somewhere for them to go, even if it is a short-term thing. It is probably a little bit selfish from our perspective but we are looking to free up the resources for other reasons. Clearly a lot of them are going to need a more ongoing arrangement of care, and there are processes in place for that sort of thing, but the short-term accommodation, emergency accommodation aspect has been a bit of a problem for us.

Mr FINCH - The question that I was going to ask in respect of when you do have people in jail or in a holding situation, what are the protocols like now in regard to preservation of those people and just how you need to house them et cetera? What concern do you show for them - inspections and that sort of thing?

Mr TILYARD - The situation now has changed from what it used to be in the past where we had, and we still have, cells at many of our police stations. In the smaller stations they are not used as cells; they are used for all sorts of things, including storage, because people who are remanded in custody are detained now at our major remand centres. That means that in some cases we might have to drive them a considerable distance to put them where they have better designed facilities and better monitored facilities for these people. I mentioned before our assessment process. They might need to be put into a special cell - a sort of anti-suicide cell - in remand centres, where they have video monitoring and that sort of thing. It is very close monitoring, much better than it used to be in years gone by when they were in police stations. If there is any suggestion that they are injured or that they might need to seek some sort of medical treatment, we either take them to the hospital or we get somebody to come in and have a look at them. So we are very careful about that and it is very closely monitored.

Ms HAY - I was thinking about the recommendations that we might put in our report based on what we can do to, if it is taken up, to help what you do. But I think that you have already listed them, like short-term placements, so that at 3 a.m. on a Saturday morning your time is not taken up. There are also possibly better facilities and resources for the person involved and possibly the hospital assessment could take place without an unduly long wait. Is there anything else that you can see that would actually make it a better service for those people and assist your officers as well?

Mr TILYARD - I think those are the main things that I have covered. I guess that we have talked about the mental health issues, which are huge issue. Depression is another aspect, and it is a mental health issue as well. With a lot of the suicides that we deal with, depression is a major factor leading to that person taking their life. I think that operationally we are pretty well positioned in terms of our response protocols. The legislation is appropriate; the provisions of the Coroners Act are good. It is mainly the short-term emergency accommodation that is a problem for us. I am not being critical of the current service providers.

Mr WHITELEY - This might not be an appropriate question in view of the terms of reference, but I'll have a go. Taking a step back, we have been focusing on what happens after an event, after an incident has occurred, and how we are dealing with it. Obviously some excellent things are happening. Do the police generally have a view on what's feeding this? You are dealing with a whole raft of issues across the community. Your officers must pick up a sixth sense of the links between these things. Do you have any view that you are in a position to express here?

Mr TILYARD - I can't give you a definitive answer because a range of factors can influence somebody to take their own life. Depression in its various forms is a major factor. We could probably sit here all day and think of influences that might result in somebody being depressed. Certainly in the cases we deal with it seems to be the personal circumstances of people that lead a lot of them to do it. With some of them, neither the relatives nor we can fathom why it has happened. In other cases it is quite clear that there has been a breakdown in a relationship, which is a major factor. Again, this closely overlaps with domestic violence. The majority of murder-suicides that we have here are examples of that. We can all think of examples: Brighton, Launceston, Longford.

Mr WILKINSON - There was a family violence order in the Brighton example.

Mr TILYARD - There was, yes. Quite often that is the result of a breakdown in a relationship, as are a lot of the suicide attempts that we deal with. People just don't deal with them appropriately.

Mr WHITELEY - What about drugs and alcohol? Are they factors?

Mr TILYARD - Yes. Certainly drug overdose is one of the main factors in terms of a means of taking one's life. Alcohol is involved in about 80 per cent of the jobs that we receive of an evening. After dark, about 80 per cent of what we do is alcohol-related in some way, so it is definitely a factor. Quite often the people we deal with in these situations have been taking alcohol to excess or using drugs.

CHAIR - Are there any protocols in place in the force to assist officers with suicide prevention?

Mr TILYARD - Who have threatened themselves?

CHAIR - Just generally speaking, if there is awareness that it is something you need to keep an eye on.

Mr TILYARD - Yes. Critical incident stress debriefing is a part of our formal process, but we also have an employee assistance program for people who might need some assistance, whatever that might be. We will organise counselling for our own people, outside of things like CISD, if they have difficulties coping with situations. We also have our psychologist, who will see people and who periodically assesses some people anyway because of some of the work areas we have: the coroner's office; forensic services people who go to these scenes, take and develop photographs and do scene examinations; fatal accident investigation. People in these areas are more at risk of developing problems. Our psychologist has a program of regularly sitting down with these people, whether or not they have recently been involved in anything. He sorts through those issues and monitors them to see what, if anything, we need to do for the officers or for their families.

CHAIR - Including what to watch out for, if they are not sleeping etc?

Mr TILYARD - Yes, those indicators that there might be a problem. We have had that in place for a long time. In an emergency service like police - as with the fire service and ambulance - you must have that because your people are dealing with these things every day.

CHAIR - There would be an admission now, would there not, amongst the members of the force that there is nothing strange about talking to someone if you have a problem?

Mr TILYARD - Yes. When I started there was a reluctance from some people because they thought you might be seen as a bit weak or that you needed that sort of thing, but that is well and truly a thing of the past. People recognise now that this is part of the overall process, a step in the process of dealing with the incident. It is just as important to be there for other people as it is to be there for oneself. I have been involved in many of these things. Sometimes you forget just how much it means to other people to have you there as well. Even if you think you don't really need it, you still want to be there for your colleagues. The other thing is that you can go to 100 events, but there is something about just one that triggers something.

Mr WILKINSON - It's amazing, isn't it, that a couple of the officers who have been in strife were involved in a traumatic incident a month or two before and as result found it difficult to perform their duties. There always seems to be this underlying event, the recent traumatic incident. Would you agree with that?

Mr TILYARD - Certainly there have been occasions when people have been to things that have played on their mind.

CHAIR - Thank you very much, Scott; you've been of great assistance.

THE WITNESS WITHDREW.