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Judge Sara Hinchey
State Coroner
Coroners Court of Victoria
65 Kavanagh Street
SOUTHBANK VIC 3006
via email: cpuresponses@coronerscourt.vic.gov.au

Dear Judge Hinchey

Re: COR 2009 005915 – Odisseas Vekiaris

I refer to the inquest into the death of Odisseas Vekiaris.

As a result of the inquest, three of the four recommendations made related to Ambulance Victoria. The first recommendation related specifically to Victoria Police. Recommendations two three and four, together with AV's responses are as follows:

Recommendation 1 (for Victoria Police)

> *That Victoria Police remove from its training material/literature reference to "Excited Delirium" and/or "Excited Delirium Syndrome" until such time that it is recognised by Australian medical professional bodies as a discreet medical condition/entity…*

Ambulance Victoria's comment:

AV's training material does not contain any reference to either *"Excited Delirium" or "Excited Delirium Syndrome".*

Recommendation 2

> *With the view to developing a collaborative and coordinated approach to the management of people presenting with delirium, agitation or acute behavioural disturbance by first responders, I recommend that Victoria Police and Ambulance Victoria convene a working group in consultation with the Australasian College for Emergency Medicine with the aim of developing a working protocol/clinical practice guidelines or operational work instructions between the organisations including but not limited to, exploring the development of a readily accessible reference tool such as, but not necessarily limited to, a pocket card such as developed by the NIJ's Technology Working Group on Less-Lethal Devices. The development of such a readily accessible reference tool (which could take the form of an application for telecommunication devices) should be consistent with Recommendation 1 and should instead adopt nomenclature for 'delirium' as it is referenced in the DSM-5.*

Ambulance Victoria's response:

From recent meetings with senior staff from Victoria Police's Centre for Operational Safety, AV is aware Victoria Police has already developed and introduced a pocket card for its operational officers. The card, entitled "Mental Disorder Reference Card", provides an overview of the mental disorders, their symptoms and behaviour that police may encounter. It also provides strategies to assist officers in resolving situations by using communication skills, minimal force and maintaining safety to all.

AV has reviewed the information contained in the pocket card (in particular, the material relating to "Delirium") and is of the view the information is both relevant and appropriate.

Ambulance Victoria has also recently revised the membership of its Medical Advisory Committee. This includes three members who are Fellows of the Australasian College for Emergency Medicine. We would therefore submit that Ambulance Victoria has sufficient input into future treatment strategies from the Australasian College for Emergency Medicine.

On that basis, AV submits Victoria Police has already implemented this Recommendation.

Recommendation 3

> *With the view to developing a collaborative and coordinated approach to the management of people presenting with delirium, agitation or acute behavioural disturbance by first responders, I recommend that Victoria Police and Ambulance Victoria develop a joint training package including but not limited to, scenario based training which is focussed on the implementation of any newly developed joint protocol, and the use of the readily accessible reference tool.*

Ambulance Victoria's response:

Ambulance Victoria does not support the introduction of a specific joint training package between AV and Victoria Police focussing on the implementation of the recently introduced reference card.

It is submitted police officers are not (and should not be) trained to diagnose a person's condition, but to recognise when a person needs medical attention – and take steps to ensure medical attention is obtained. This view is consistent with the material contained in the Victoria Police pocket card referred to in Recommendation 2.

Nevertheless, AV has worked collaboratively with Victoria Police in relation to a range of issues which arise in the emergency environment. AV has also been consulted by Victoria Police in the past on a number of operational issues.

Following discussions with senior staff from Victoria Police's Centre for Operational Safety, it is agreed that in future, AV and Victoria Police will work more collaboratively on the clinical aspects contained in the Victoria Police training material. In addition, AV will be appointing a senior clinician who will act as a liaison between AV and Victoria Police. By doing this, AV can ensure the clinical material being taught to police officers is consistent with AV training.

Recommendation 4

> *In anticipation that it may take some time for recommendations 2 & 3 to be considered, commenced, completed and implemented and with a view to supporting first responders and in particular, paramedics with enhancing understanding and knowledge of the constellation of presenting symptoms of persons experiencing the range of manifestations of delirium, I recommend that Ambulance Victoria, if they have not already done so, not only review the Police training material as referred to in paragraph 49 of AV's written submissions, but implement training and/or continuing professional development to its paramedics in this regard.*

Ambulance Victoria's response:

Ambulance Victoria accepts and has implemented this Recommendation.

Review of Police training material

AV has now reviewed the Victoria Police training material relating to delirium, including their recently introduced pocket card and the online training module. AV is satisfied with the content of the training material.

AV training and continuing professional development for paramedics

As part of AV's continuing professional development (CPD), changes and any new guidelines are notified to paramedics as follows:

(a) complex changes/new guidelines may form part of CPD training sessions; and

(b) less complex changes may be the subject of an information bulletin or an on-line training program.

AV uses Clinical Practice Guidelines (CPGs), a set of medically endorsed guidelines for assessment and treatment by paramedics. The CPGs consist of systematically developed statements to assist decisions about appropriate emergency health care for specific clinical circumstances.

While AV does not have a specific CPG in relation to delirium, it does have specific guidelines for a range of common medical presentations which arise in the emergency context, for example, hypoglycaemia, anaphylaxis, management of overdose, the agitated patient and suspected stroke.

Since this case occurred, there have been a number of changes to CPGs relevant to this case, including but not limited to the following:

- CPG A0106 – Mental Health Assessment;
- CPG A0107 – Mental Health Conditions; and
- CPG A0708 – The Agitated Patient.

While CPG A0106 has been in existence for some time, it has recently been altered to contain more information. CPG A0107 is a new guideline. Both were developed in consultation with a number of mental health (CATT) teams around Melbourne during 2014. These CPGs will be rolled out to paramedics in the 2016 CPE program.

CPG A0708 – The Agitated Patient – was introduced in 2004 and recommended the administration of Midazolam. In 2015, AV's Medical Advisory Committee approved a change to this CPG, to include an "Extreme Agitation" pathway. This now provides for the administration of Ketamine as a more effective pharmacological approach for patients with extreme agitation. The Extreme Agitation pathway is intended to provide protection for patients and staff in circumstances where there is a high risk of extreme violence and the priority is to sedate the patient quickly and effectively. The patient demonstrating extreme agitation will preferentially be treated with IM Ketamine.

I have attached copies of the above mentioned CPGs.

Other matters

In July 2015, Ambulance Victoria amended its operating procedures whereby in circumstances where a patient requires transport to a medical facility and it is necessary for the transport to be carried out by Victoria Police, then the attending ambulance will follow the police vehicle in close proximity to the medical facility.

These changes were implemented by AV following a Coroner's Court inquest regarding a death in custody. The 2013 case involved a 37 year old male mental health patient who required transport from his home to hospital. Given his aggressive nature, police transported the patient in the rear of a police van. On arrival at hospital a short time later, the patient was found deceased in the rear of the van.

Ambulance Victoria consulted with Victoria Police about this change. We also communicated the changes and provided Victoria Police with a copy of the revised policy.

I trust the responses satisfactorily address Her Honour's Recommendations. I acknowledge the comments were made to assist Ambulance Victoria perform at the highest level in its service to the community.

Yours sincerely

Tony Walker

Assoc Prof TONY WALKER ASM
Acting Chief Executive Officer

cc: I.Patrick, General Manager Clinical & Community Services
C.Grant, Manager Professional Standards
Professional Standards

enc. Ambulance Victoria CPG A0708 – The Agitated Patient
Ambulance Victoria CPG A0106 – Mental Health Assessment
Ambulance Victoria CPG A0107 – Mental Health Conditions

The Agitated Patient

CPG A0708

Special Notes

- This CPG applies to patients who present with agitation or aggressive/violent behaviour. It may be used for those who are designated as Compulsory Patients under the Mental Health Act 2014; and also those who are in Police custody under section 351 of the Mental Health Act 2014
- Patients initially managed under the **Mild/Moderate Agitation** section can be escalated to the **Extreme Agitation** section if their behaviour deteriorates and they present more at risk than when first assessed, with the maximum doses of medications in that section then applying.
- Under the **Extreme Agitation** section of the CPG, it is preferable to manage the patient with **Ketamine** as the first option if available.
- Rousable drowsiness is defined as the patient being asleep but rousing if their name is called.

Hyperthermic psychostimulant overdose

- Sedation should be initiated early in hyperthermic patients who have been using psychostimulants to assist with cooling and avoid further increases in temperature secondary to agitation.

Methamphetamine affected patients

- Patients affected by methamphetamine ("Ice") may present with extreme agitation and violence. Doses of **Midazolam** that would usually be effective in other scenarios may be ineffective. These patients may be managed as per the **Extreme Agitation** section of this CPG using **Ketamine**. Target therapeutic doses of **Ketamine** are **4 mg/kg IM** or **1 mg/kg IV**.

Traumatic head injury

- In patients with mild to moderate acute traumatic head injury (GCS 10 – 14), sedation can only be given after consultation with the duty AV Clinician.

Elderly / Frail Patients

- Elderly and/or frail patients are particularly sensitive to the effects of benzodiazepines including **Midazolam**. Aim to use the lowest dose possible and carefully monitor for side effects.
- Elderly patients can present with delirium, which is an acute and reversible change in cognitive function and distinct from dementia. Consider and exclude clinical causes as per CPG.

Paediatric Patients

- Paramedics must consult with RCH via the Clinician before sedating paediatric patients under this guideline.

General Care

- Paramedic safety is paramount at all times. Do not attempt any element of this CPG unless all necessary assistance is available. Prior to administering sedation, clear communication with all parties involved in restraining the patient is a key factor in reducing the risk of needlestick or other injuries.
- Bodily restraint using restraint devices may be used without the use of sedation in circumstances where the patient will not sustain further harm by fighting against the restraints.
- The anterolateral mid-thigh is the preferred site for IM injection. Access to this will likely be dictated by the position the patient is restrained in.
- Restraint devices should be removed if there is any evidence of compromised patient care, however Paramedic safety is paramount.
- The indications for the use of restraints, type of restraint and the time of application and removal must be documented on the PCR.
- In all cases where sedation is administered, supportive care should be provided as required including:
  - airway management
  - supplementary O_2 as per **CPG A0001 Oxygen Therapy** if sedated with **Midazolam** or as routine if sedated with **Ketamine**
  - perfusion management as per **CPG A0705 Inadequate Perfusion (Non-cardiogenic / Non-hypovolaemic)**
  - temperature management as per **CPG A0901 Hypothermia / Cold Exposure or CPG A902 Environmental Hyperthermia / Heat Stress**
  - reassessment and management of clinical causes of agitation.
- The indications for the use of sedation must be clearly documented on the PCR.
- The **Mild / Moderate Agitation** pathway is intended for patients who do not present a high risk of extreme violence or for whom the risk is expected to be controlled with **Midazolam** alone, e.g. a combative dementia patient or a hyperthermic psychostimulant patient presenting with agitation/restlessness rather than violence.
- The **Extreme Agitation** pathway is intended to provide protection for patients and staff in circumstances where there is a high risk of extreme violence and the priority is to sedate the patient quickly. It should be applied judiciously and exercising clinical judgement.

The Agitated Patient

CPG A0708

Status

- Agitated patient

Stop

- **Paramedic safety is paramount**
  - Hazards
  - Violence
  - Clear egress
  - Body fluids
  - Sharps
  - Reduce stimuli

Agitated Pt

Action

- Communicate with patient
  - Avoid confrontational behaviour
  - Gain patients co-operation for assessment
  - Utilise verbal de-escalation strategies

Assess / consider

- Assess and Mx clinical causes (as far as possible)
  - A Alcohol / drug intoxication
  - E Epilepsy (post-ictal)
  - I Insulin or other metabolic cause – hypo / hyperglycaemia, renal / liver failure
  - O Overdose / oxygen (hypoxia)
  - U Underdose (including alcohol / drug withdrawal)
  - T Trauma (head trauma) – consult with Clinician if (after pain relief) patient requires sedation
  - I Infection / sepsis
  - P Pain / psychiatric condition
  - S Stroke / TIA
- Also consider grief or extreme stress
- There may be a combination of factors
- Extreme agitation will be undifferentiated agitation as assessment will usually be impossible. Therefore, as soon as practicable after the patient is controlled, reversible causes should be managed and treatment of identified clinical issues commenced

Able to Mx without restraint / sedation

Action

- Manage causes as per appropriate CPG
- Beware patient condition may change and agitation increase requiring restraint / sedation
- Transport to appropriate destination, ensuring sufficient assistance in transit
- Provide early notification to receiving hospital as appropriate

Requires restraint / sedation

- Does not respond to verbal de-escalation
- Clinical causes have been excluded
- Patient risk to themselves or others
  - Combative, agitated or aggressive

Stop

- If patient severely agitated or violent, treat as per **Extreme Agitation**
- Ensure sufficient physical assistance
- Mild to moderate head injury GCS 10 – 14, manage pain and consult if sedation required
- All sedation under this CPG is aiming for rousable drowsiness
- Apply restraints as required – including to sedated patients

Mild / Moderate Agitation

Action

- **Midazolam 5 - 10 mg IM**

  - Administer lower doses **(2.5 – 5 mg IM)** for elderly, frail, weight < 60 kg, SBP < 100mmHg, or sedating drug / alcohol involvement
  - Repeat at 10 minute intervals if necessary, titrated to patient response
  - **Max. total dose 20 mg**. Consult for further if required

- **Midazolam 2.5 - 5 mg IV**

  - Administer lower doses **(1 – 2 mg IV)** for elderly, frail, weight < 60 kg, SBP < 100mmHg, or sedating drug / alcohol involvement
  - Repeat at 5 minute intervals if necessary, titrated to patient response
  - **Max. total dose 30 mg**. Consult for further if required
  - IM injections may be indicated until IV access can be established

Extreme Agitation

Action

- If **Ketamine** not available: **Midazolam up to 20 mg IM**
  - Repeat at 10 minute intervals if necessary, titrated to patient response
  - **Max. total dose 40 mg**. Consult for further if required
- **Administer Ketamine IM**
  - < 60 kg **200 mg** **OR** If an IV is in situ, **Ketamine 50 - 100 mg IV**
  - 60 – 90 kg **300 mg**
  - > 90 kg **400 mg**
- Once Pt is controlled and an IV in situ, maintain sedation **with Midazolam 2.5 - 5 mg IV** at 5 minute intervals if necessary. **Max. total dose of Midazolam 60 mg (IM+IV)**

Mental Status Assessment

CPG A0106

Special Notes

- Almost half of Australians aged 16-85 will experience a mental health disorder at some point in their life. Mental health related cases comprise approximately 10% of the AV caseload.
- The most effective way to ascertain if a patient is considering self-harm is to ask them directly. Questions such as "Are you thinking of killing yourself?" or "Have you thought about how you would do it?" helps to avoid misinterpretation and they do not encourage a person to engage in self-harm.

General Care

- The Mental Status Assessment is a systematic method used to evaluate a patient's mental function. In undertaking a mental status assessment, the main emphasis is on the person's behaviour. This assessment is designed to provide Paramedics with a guide to the patient's behaviour, not to label or diagnose a patient with a specific condition.
- The Mental Status Assessment is to be used to indicate some of the clinical triggers that determine the necessity of a patient being transported to hospital. Mental health encompasses a varied range of conditions and presentations and these guidelines are not prescriptive for all complaints or statuses. It is expected that Paramedics will continue to use their clinical judgement for the most appropriate treatment options for this patient cohort.
- Patients with a history of mental illness are over-represented in mortality rates in a number of areas and should not be underestimated due to their underlying mental health history. If the patient has a primary complaint other than a mental health crisis then this should be assessed appropriately as per any other patient, with a conscious acknowledgement that the patient is at higher risk of death from a variety of causes if they are not treated seriously.
- Patients demonstrating high-risk symptoms should not be considered for non-transport options. Consideration for police support should be made early if it is apparent that the patient is resistant to transport to an ED.
- Patients meeting the criteria for needing immediate support may be considered for non-transport if the available options for further care are in both the patient and Paramedic's judgement suitable to meet the needs of the patient and address the crisis. If the available care options are inadequate or unavailable then transport remains the default option.

Mental Status Assessment

CPG A0106

		LOOK FOR, LISTEN TO & ASK ABOUT ALL CATEGORIES BELOW *THE PATIENT MAY BE SUFFERING FROM SOME OF THE FOLLOWING EXAMPLES* **Remember verbal de-escalation strategies, active listening and calm/open body language**
OBSERVE	**Safety**	Paramedic, patient and bystander safety is the first priority. Assess the scene for dangers i.e. location, weapon. Obtain police support early if required. Maintain vigilant reassessment of scene safety.
	Appearance	Look for signs indicative of mental health issues or poor self-caring; uncleanliness, dishevelled, malnourished, signs of addiction (injection marks/nicotine stains), posture, pupil size, odour.
	Behaviour	Patient may display; odd mannerisms, impaired gait, avoidance or overuse of eye contact, threatening or violent behaviour, unusual motor activity or activity level (i.e. wired or buzzing), bizarre/inappropriate responses to stimuli, pacing.
	Affect	Observed to be; flat, depressed, agitated, excited, hostile, argumentative, violent, irritable, morose, reactive, unbalanced, bizarre, withdrawn etc.
LISTEN	**Speech**	Take note of: rate, volume, quantity, tone, content, overly talkative, difficult to engage, tangential, flat, inflections etc.
	Thought Process	May be altered, can be perceived by patient jumping irrationally between thoughts, sounding vague, unsteady thought flow when communicating verbally.
	Cognition	May be exhibiting signs of impairment such as; poor ability to organise thoughts, short attention span, poor memory, disorientation, impaired judgement, lack of insight.
DISCUSS	**Thought Content**	May be dominated by; delusions, obsessions, preoccupations, phobias, suicidal/depressed or homicidal thoughts, compulsions, superstitions.
	Self-Ham	Ask patient directly if they have attempted self-harm, suicide or are thinking/planning for these. Ask about previous attempts.
	Perceptions	Patient may be suffering from; hallucinations (ask specifically about auditory, visual and command hallucinations), disassociation i.e. 'I feel detached from my body', 'my surroundings aren't real', 'I am not in control of my actions'.
	Environment	Risk factors include; lack of familial and social support, addiction or substance abuse, low socio-economic status, life experiences, recent stressors, sleeping problems or comorbidities (either physical or mental health conditions).

Mental Health Conditions

CPG A0107

Status

High index of suspicion that patient is suffering from Mental Health Issue

Stop

- Assess scene for dangers
- Ensure safe environment for Paramedics, patient and bystanders
- Continually and dynamically reassess scene for changes in patient/bystander behaviour i.e. increasing aggression/ violence
- Consider application of CPG A0708 The Agitated Patient

If Danger Present

- Withdraw from scene to a safe distance
- Inform communications staff of situation, and request police assistance
- Only re-approach patient/scene once escorted or instructed by police.
- Any violent or extremely agitated behaviour is immediately considered 'High Risk', requiring patient transport.

No Apparent Mental Health Issue

Action

- Continue with patient assessment
- Apply relevant CPG as required

Mental Health Issue Present

Complete Mental Status Assessment CPG A0106

Assess/Consider

- Assess and Mx Clinical/organic causes (as far as possible). See AEIOU TIPS in **CPG A0708 – The Agitated Patient.**

Does the Pt have "High - Risk" symptoms?

Access

Patient is considered to be "high-risk" if any of the following are present:

- Suicidal ideation (attempt, thoughts, intent or plan)
- Self-harming behaviours or actions
- Intentional overdose/poisoning
- Cognitive impairment (except if normal for patient)
- Erroneous or altered perceptions e.g. delusions, hallucinations or evidence of other thought disorder(s)

Yes

Transport Pt to Hospital

Action

- Ascertain patient's home address and which mental health catchment they belong to (via AV clinician or VACIS).
- Transport patient to appropriate and/or nearest available hospital.

No

Are there signs that the Pt requires immediate support?

Access

- Patient lacks any readily available social/emotional support options
- Evidence of not coping. Can be visualised from environmental cues or verbalised by patient e.g. 'I'm at my wit's end'/ 'I can't do this anymore'.
- Patient is perceived to be in a dangerous social situation e.g. potential domestic abuse.

Yes

Create Support Action Plan for Pt

Action

- Contact patient's own mental health practitioner **OR**
- Contact patient's GP for appointment to discuss Mental Health Plan/Assessment **OR**
- Contact CAT team or 1300 crisis triage number relevant to patient's home address and mental health catchment **OR**
- Contact Pt's family member or friend to support Pt at this time. Wait on scene for their arrival.

If these options are not suitable or are unsuccessful, transport Pt to an appropriate hospital.

No