IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: 2013 / 1891

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)
Section 67 of the ***Coroners Act 2008***

Inquest into the Death of: CRAIG RONALD MCMILLAN

Delivered On:	23 April 2015
Delivered At:	Coroners Court of Victoria Level 11, 222 Exhibition Street, Melbourne
Hearing Dates:	10 and 11 March 2015
Findings of:	PHILLIP BYRNE
Representation:	Mr P Laurie for the Chief Commissioner of Police Ms M Samaan for Ambulance Victoria Mr J Snowdon for Monash Health
Counsel Assisting the Coroner	Ms Sarah Gebert

I, PHILLIP BYRNE, Coroner, having investigated the death of CRAIG RONALD MCMILLAN

AND having held an inquest in relation to this death on 10 and 11 March 2015
at the Coroners Court of Victoria, 65 Kavanagh Street, Southbank, Victoria
find that the identity of the deceased was CRAIG RONALD MCMILLAN
born on 14 May 1975
and the death occurred on 1 May 2013
at Casey Hospital, Berwick, Victoria
from:

1 (a) UNASCERTAINED (DEATH IN CUSTODY).

in the following circumstances:

1. Mr Craig Ronald McMillan, 37 years of age at the time of his death, resided with his parents Mr Ronald and Mrs Rosetta McMillan and his sister Fiona at 28 Robin Drive, Carrum Downs.
2. At the commencement of the formal inquest Mr Ronald McMillan consented to myself and other parties referring to his son as "Craig" for the purposes of the hearing and the subsequent finding. I thank him for that indulgence.
3. Craig suffered from a long standing mental illness having been diagnosed with schizophrenia in 1998. Over a period of time Craig received treatment and was managed by Southern Health Mental Health Services initially at Dandenong Hospital and subsequently at Casey Hospital. Craig would have periods of relative wellness, but from time to time would "relapse" requiring intervention.
4. Craig's impending psychotic episodes/relapses could be predicted by his parents as he would display well known observed symptoms including heightened anxiety, paranoia, delusional behaviour, loss of appetite and sometimes aggressive behaviours.
5. Craig had been admitted to Casey Hospital on some five occasions since 2006. Although police were in attendance in some instances, on all occasions Craig was conveyed to hospital by ambulance.
6. Mr and Mrs McMillan advised the coronial investigator that Craig became increasingly unhappy about the prospect of further hospitalisation.

7. Craig was due for his fortnightly Respiridone injection on Thursday 2 May 2013, however due to concerns about his deteriorating mental state the treatment was brought forward to Monday 29 April 2013.

8. In the early hours of Wednesday 1 May 2013 his parents concerns were heightened when Craig appeared at their bedroom door declaring he was God. Later that morning Craig entered the kitchen with his overalls on claiming he was going to work; he had not been engaged in employment for some years.

9. About 9am Mr Ronald McMillan rang the Casey Crisis Assessment & Treatment (CAT) team seeking their urgent assistance. The CAT team call taker asked to speak to Craig; he gave them short shrift. As a result of that initial contact that day Craig was given a mobilisation category CAT 3, to be seen and assessed within 24 hours.

10. At 11am the family made a second call to the Casey CAT team. Mrs McMillan spoke with Ms Karen Brewer. Ms Brewer advised the CAT team would attend. She arranged for Ambulance Victoria and Victoria Police to attend due to the previous history of violence and aggression when floridly psychotic.

11. At 11.15am Ms Brewer signed an Authority to Transport without Recommendation. At the same time another member of the Casey CAT team, Mr Shane Szwaja signed a Request for a Person to Receive Involuntary Treatment for an Approved Mental Health Service.[1]

12. The CAT team arrived in Robin Drive and awaited the arrival of police and ambulance paramedics. At 11.24am ambulance paramedics Ms Jade Condie and Mr Pieter Bouman attended near the address and conferred with the CAT team. A decision was taken to await the arrival of police before attending at the premises.

13. Shortly prior to midday a police unit, Carrum Downs 307 crewed by Constables Mark Aitken and Cameron Mitchell, arrived in Robin Drive. The police members were briefed by the personnel from the Casey CAT team. They were advised that Craig was apparently having a psychotic episode. They were further advised that previously there had been instances of aggression, that there was a prospect/risk of flight, and that Craig was a big man; hence the request for their attendance.

14. The two constables attended at number 28 Robin Drive and were admitted by Mrs Rosetta McMillan. Shortly after entering Craig appeared. Constable Aitken stated, when first observed,

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[1] Documents contained within the Coronial Brief of Evidence at pages 216 – 217.

Craig had a "confused look on his face". Craig, in no uncertain terms, told Constables Aitken and Mitchell, the attending CAT team and Ambulance Victoria personnel to get out of the premises, advising them he did not want to go to hospital.

15. After the initial confrontation, Constable Aitken said he "shepherded" Craig into the lougeroom where he endeavoured to reason with him. He claimed Craig was relatively calm at that time enquiring why police were there.

16. At 12.09pm Acting Sergeant Kelly Nisbet (at the time Ms Henderson) arrived in Robin Drive. Her role that day was Carrum Downs 251, a supervisory role over the Frankston Police Service Area. Ms Nisbet did not immediately enter the premises but after hearing a commotion inside, including much yelling and shouting, decided to enter. She approached Craig also endeavouring to calm him, advising Craig he needed to go to hospital for treatment.

17. CAT team member Mr Shane Szwaja advised Craig that the family were concerned for his wellbeing and believed he needed to go to hospital. Craig again advised he did not agree to go to hospital.

18. At this stage Craig's resistance (to use a neutral term) escalated. He demonstrated heightened aggression. It was patently clear he did not want to go to hospital voluntarily. It became necessary to handcuff Craig. By this time attending police were advised by the CAT team that they were not going to transport Craig to hospital. Ambulance paramedics also advised the CAT team and police that they would not transport Craig to hospital. The remaining option, the option of last resort, was settled upon.

19. In evidence Acting Sergeant Nisbet (Henderson as she was then) accepted she was "effectively in charge". She rightly stated she could not direct the CAT team or Ambulance Victoria personnel who had already advised her they did not propose to transport Craig to hospital. She was advised and satisfied an <u>Authority to Transport without Recommendation</u> and a <u>Request for a Person to Receive Involuntary Treatment from an Approved Mental Health Service</u> had been formalised. Ms Nisbet said she considered the hierarchy of transport options and formed the clear view that the option of last resort was the only available option.

20. Importantly Ms Nisbet maintained she turned her mind to the matters contained in the relevant <u>Victoria Police Manual – Procedures and Guidelines</u>[2] in relation to police involvement with people under the <u>Mental Health Act</u>, together with the matters contained in the <u>Victoria Police</u>

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[2] Exhibit "C".

Manual – Guidelines – Safe Management of Persons in Police Care or Custody, particularly paragraph 3.2 relating to transportation of a person with mental illness. [3]

21. Ms Nisbet also advised she had regard to paragraph 3.3 of the Victoria Police Manual – Policy Rules – Persons in Police Care or Custody. [4] Ms Nisbet described the considerations she undertook as going through "thought processes".

22. The Victoria Police Manual – Guidelines – Safe Management of a Person in Police Care or Custody provides a medical checklist, a flowchart under which a police member assessing a person in his/her care or custody is guided. Ms Nisbet stated she assessed Craig as 5 on the checklist "scale"[5]. She maintained Craig was conscious, alert and knew what was going on, being acutely aware he was being transported to hospital albeit against his wishes. Ms Nisbet maintained, and I accept her claim, that the assessment she made, although rudimentary and not a medical assessment as generally understood was reasonable in the prevailing circumstances. In evidence Acting Sergeant Nisbet said she considered directing one of her officers to travel in the back of the ambulance, but discounted that as "not safe". For a variety of reasons that, in my view, was a reasonable call. She conceded she did not consider the option of the divisional van following the ambulance. In any event, that option was somewhat academic as the ambulance paramedics made it clear they did not propose to transport Craig in any event.

23. After Craig had been secured in the pod of the divisional van, the driver Constable Mitchell, activated the pod camera. Due to the position of Craig in the pod facing the front of the vehicle with his back against the back door of the van, the camera, fixed above the back door facing the cabin provided a partial view only of Craig; his upper torso and head were not displayed only the lower part of his torso and legs were able to be observed. That footage was reviewed and is in evidence. Constable Aitken conceded the fixed camera "most definitely" compromised his ability to adequately monitor Craig during the journey to Casey Hospital.

After the divisional van left Robin Drive for Casey Hospital, Constable Aitken activated the intercom and tried on a number of occasions to communicate with Craig asking if he was ok. Craig made no response. His failure to respond apparently did not "ring alarm bells" because Craig had been non-communicative after being handcuffed, taken from the house and placed in

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[3] Exhibit "D".

[4] Exhibit "E".

[5] Exhibit "G".

the van. In spite of there being no verbal communication between the police members and Craig he was visually monitored en route.

24. Constable Aitken said in evidence that some 5 – 10 minutes into the journey, just west of the Berwick/Cranbourne Road, Constable Mitchell activated lights and siren and engaged in urgent duty driving, for the remainder of the trip. Constable Aitken said he had a "gut feeling something was wrong." He added that he could not recall if there was a discussion with his colleague about the decision to proceed under lights and siren. In his statement, Constable Mitchell said he did not feel comfortable transporting a psychiatric patient in the divisional van and activated lights and siren to get to the hospital as soon as possible. I add, Constable Aitken stated it did not enter his mind to pull up and check Craig's condition; although he did say that if he could have observed Craig's face and noticed he was unconscious he would have pulled up and checked him.

25. How the decision that police, not the CAT team nor the ambulance, were to transport Craig to hospital was reached was an issue at inquest. Whilst it is true there was no formal inter-agency discussion regarding this decision, the CAT team indicated to the attending ambulance paramedics they did not propose to transport Craig. Ambulance paramedics also advised police members present they did not propose to transport Craig. The fact remains that members of all three agencies knew or were made aware that Craig had previously been violent and aggressive. Once it became clear that Craig did not agree to go to hospital voluntarily and was actively resisting being transported, it was understood by all that that the option of last resort was the only option available. In my view a formal discussion and "handover" was not required, however it could be argued the transparency of the decision making process would have been enhanced if a more formalised discussion had occurred. Even if such a formal discussion had occurred the ultimate decision would have remained the same.

26. When the divisional van arrived at Casey Hospital Constable Mitchell backed it up to the Emergency Department ambulance dock. Constable Aitken went into the Emergency Department to arrange for security. A decision was taken not to open the rear door of the van until hospital security staff were in attendance to escort Craig into the Department. Upon their arrival the door was opened and it was then recognised Craig was unresponsive. He was hurriedly attended to by a doctor and nurses, placed on a trolley and wheeled into the Emergency Department. The handcuffs were removed and advanced cardiac care measures commenced. After approximately 50 minutes of attempted cardio-pulmonary resuscitation

Craig could not be revived and he was formally pronounced deceased. I am entirely satisfied all reasonable steps were taken to endeavour to resuscitate Craig.

27. At one point in time, concerns were expressed about the period of time that elapsed between the divisional van arriving at the Emergency Department at Casey Hospital and when the van rear door was opened to get Craig out of the van. CCTV footage of that period was made available to the Coroner's Investigator. Submissions were invited in relation to the issue; no submissions were received. That matter was also not pursued at inquest. I do not propose to address the issue at length in this finding save to say that the lapsed period was not in the circumstances, inordinate and, in my view, had no bearing on the final tragic outcome.

28. In the last paragraph of his impact statement Mr Ronald McMillan stated:

> *"It is therefore my belief that no mentally ill patient should ever be transported in a divisional van".*

That very issue was, from the outset, a principal focus of my investigation. At the Mention/Directions Hearing on 28 May 2014 I determined to seek an additional statement from a senior clinician from Ambulance Victoria addressing two issues:

- Whether Craig should have been physically checked by attending Ambulance Victoria paramedics prior to transport to Casey hospital;
- Whether Craig should have been transported to Casey Hospital by ambulance rather than by police.

I wanted to understand what practices/procedures/guidelines/protocols were in place in determining when paramedics would not be responsible for transportation of a mental health patient to hospital.

29. Mr Russell Nelson, a Clinical Support Officer with Ambulance Victoria, a vastly experienced paramedic, provided a statement in a timely manner. That statement is in evidence and can speak for itself.

30. I subsequently decided I would like to hear viva voce evidence from Mr Nelson so that he could respond directly to the principal issue of concern of the family. Mr Nelson was unavailable but Ambulance Victoria indicated that another senior clinician, Mr Tony Armour, would provide a statement[6] and would be available to give evidence at the formal inquest. At paragraph 4 of his

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[6] Exhibit "H".

statement Mr Armour, also a vastly experienced paramedic described the various roles undertaken by Clinical Support Officers. I note one of those important roles is to conduct reviews of clinical performance. Annexed to Exhibit "H" are policy documents:

- Ambulance Victoria Clinical Practice Guideline – A0101;
- Department of Health - Information Sheet;
- Ambulance Victoria Operational Work Instruction – Service Improvement System.

31. Mr Armour also addressed the two issues I had raised, which are noted in paragraph 28.

32. Mr Armour gave evidence on the first day of the inquest. He gave evidence about "assessment steps" (referred to as surveys in Ambulance Victoria guidelines).

    a) Primary Survey
    b) Vital signs Survey
    c) Secondary Survey

    Mr Armour maintained that any form of "hands on" medical assessment was not feasible. The attending ambulance paramedics had been advised of Craig's previous history of aggression and violence towards family and clinicians. He conceded the paramedics undertook a visual assessment only. In her statement (in evidence as part of the balance of the Coronial Brief of Evidence – Exhibit "O") Ambulance Victoria paramedic Ms Jade Condie stated:

    > *"Examination of the patient was not possible due to him being aggressive, erratic and uncooperative".*

    In his statement, her colleague ambulance paramedic Mr Pieter Bouman said he held the same view.

33. In his review of the incident Mr Armour concluded that the decision by the attending paramedics was a "reasonable response in the circumstances". <u>I agree with that conclusion.</u>

34. In November 2012 Craig was reviewed by interventional cardiologist Dr Robert Lew. I have examined the medical records of the Southern Cardiology Group pertaining to Craig. In a letter to Dr Caroline Hardy, Craig's general practitioner, Dr Lew confirmed Craig had a resting tachycardia which he suspected may be related to the Risperidone Craig was taking. In his letter, Dr Lew says he organised for Craig to wear a Holster Monitor and proposed to review him when that test was concluded. I have raised the issue of tachycardia because it would appear that neither the ambulance paramedics in attendance at Robin Street, nor the attending police were made aware of that condition. In his impact statement, which was in effect his final

submission to the Court, Mr Robert McMillan maintained that the tachycardic condition coupled with the circumstances in which Craig was restrained, cuffed and placed in the rear of the divisional van, led to a lethal arrhythmia and death. The question is, should those involved have been advised of the tachycardic condition by family members present, or should they have proactively enquired as to whether Craig suffered from any condition which may compromise his wellbeing. I have wondered if attending paramedics and police had been aware would things have been different or would the outcome have been the same? After earnest consideration, those are matters I just can't answer. I will however consider whether that issue is one upon which I should make a formal recommendation.

35. The matter was reported to the coroner. An immediate autopsy was directed. A full autopsy and ancilliary tests were undertaken at the Victorian Institute of Forensic Medicine (VIFM). Doctor Malcolm Dodd, Senior Forensic Pathologist performed an autopsy, his Autopsy Report is in evidence[7]. In that report Doctor Dodd advised the cause of death:

1 (a) UNASCERTAINED (DEATH IN CUSTODY)

Although the cause of death was undetermined Doctor Dodd, in the comment part of his Autopsy Report, made several pertinent observations. So that nothing is lost in the translation I reproduce in this finding several excerpts from Doctor Dodd's report:

> *"It is documented that schizophrenics may die suddenly and unexpectedly, particularly when a state of agitation is evident.*
>
> *The mechanism of this relate to raised blood pressure and rapid and perhaps an irregular heart rate leading to a lethal arrhythmia.*
>
> *Excited delirium is a relatively common diagnosed cause of death in persons suffering from acute psychotic illness and in particular, in the context of a death in custody.*
>
> *Generally, these deceased persons are of a younger age group, have a documented psychiatric history, may or may not be on antipsychotic medication, and more often than not, have also taken illicit substances such as Cocaine or Amphetamine.*
>
> *In this context, the cause of death is likely to be a lethal arrhythmia triggered by the state of agitation".*

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[7] Exhibit "L"

He added:

> *"Given the above, I am disinclined to assign excited delirium as a leading cause of death in this case".*

36. Doctor Dodd also gave viva voce evidence at the inquest hearing. In answer to a question from Ms Gebert Doctor Dodd said he could not say definitively if earlier attempts at resuscitation would have made a difference, but conceded that if it had been known Craig had lost consciousness, and the van had been pulled over, and if ambulance paramedics could have intervened earlier in the journey, there may have been a "better chance" Craig could have been revived. Doctor Dodd in a very helpful explanation of a complex issue suggested death was precipitated by a combination of factors, including:

    - Schizophrenia;
    - Obesity;
    - Respiridone;
    - Tachycardia – high resting heart rate;
    - Irregular heart beats;
    - Anxiety;
    - Hypertension;
    - Agitation; and
    - Exhaustion from the struggle.

    All potentially contributing to a final mechanism; rhythm disturbance, a lethal arrhythmia resulting in death.

37. Following established protocol in cases of death in police custody, Victoria Police conducted a Critical Incident Management Review. A copy of the report of the review dated 27 February 2014, which was chaired by Superintendent Cindy Millen, was made available to the Court. Save for the front page and the two recommendations contained in paragraphs 79 and 80, I suppressed the contents of that report from publication or broadcast, being satisfied publication of the balance of the report would be contrary to the public interest (as required by s 18(2) of the Open Courts Act 2013).

38. The second of the recommendations of the Critical Incident Management Review suggested there be a "technical review of the pod camera's (sic) to enable a 360° view from the cabin." Before considering whether there was scope for a coronial recommendation, in furtherance of my preventative role under the *Coroners Act 2008*, I requested an additional statement from Victoria Police as to the status of the recommendation made by the Review.

39. A statement has been provided by Mr Frank Melilli, Manager of the Transport Branch, Operational Infrastructure Department, Victoria Police. The statement was made available to the interested parties and was entered into evidence at the inquest hearing.

40. Consideration is being given to installing a second camera in the pod of existing divisional vans, but to do so raises the issues of a significant cost and data management. Mr Melilli advises that the Transport Branch:

> *"is still in the process of working through the various issues identified to determine whether the installation of an additional pod camera in current vans is feasible".*

When that process is concluded, the matter will go before the Vehicle Policy Committee of Victoria Police who will make the ultimate decision.

41. I include a short, but important, excerpt from Mr Melilli's statement, he advised:

> *"Victoria Police intends that the next version of the divisional van will come with a 360° view digital recording system (DVR). Victoria Police have already commenced concept planning for the new vehicles. It is anticipated that these vehicles will be trialled in small numbers from late 2015 / early 2016 onwards and there will be a large-scale roll out to replace the current divisional vans in 2018".*

42. In those circumstances, with the stated intention of providing a 360° view digital recording system in the next generation of Victoria Police divisional vans, there is little scope for me making a recommendation; the enhanced provision of equipment is already planned, although it may well take some time.

COMMENTS

Pursuant to section 67(3) of the **Coroners Act 2008,** I make the following comment(s) connected with the death:

1. In her statement to the Court dated 4 June 2013, Craig's mother Mrs Rosetta McMillan levelled strident criticism of the police members who attended to facilitate Craig's transportation to Casey Hospital for treatment. Apparently reading from pre-prepared notes, Mrs McMillan alleged Craig was just thrown into the van on his stomach. This allegation was not pursued at inquest and in any event is not supported by the body of evidence. Although obviously some force was required to get Craig into the back of the divisional van, I do not accept he was thrown into the van on his stomach. Certainly, he was bodily carried to the rear of the van, and resisting, placed in feet first remaining in a sitting position with his back against the rear door of the pod all the way to Casey Hospital. I suspect Mrs McMillan's claim of excessive force was, in all likelihood a perception coloured by overwhelming grief and shock at the loss of her son). I am entirely satisfied the force used was not excessive in the prevailing circumstances, but only sufficient to achieve the task of securing Craig in the van to transport him for treatment. Those who advised Mrs McMillan that "police had stuffed up and got this case wrong" were ill informed.

2. I commend Detective Sergeant Mark Hatt for a comprehensive, thorough, timely and objective Coronial Brief of Evidence. Finally I commend Ms Sarah Gebert, counsel assisting, who not only did much of the preparatory work but also was able, within the restrictions of her role, to provide Craig's family with much appreciated assistance.

RECOMMENDATIONS

Pursuant to section 72(2) of the **Coroners Act 2008,** I make the following recommendation(s) connected with the death:

1. When, as a last resort, Victoria Police have the onerous responsibility of transporting a mental health patient to hospital under circumstances such as those seen here, then the police officer who makes the decision to transport, prior to endorsing that decision, proactively enquire of family members, and others present, whether the person about to be transported has any medical conditions which may potentially compromise the patients wellbeing.

2. Adopting an observation of Doctor Dodd, professionals (Victoria Police, Ambulance Victoria and CAT teams under the umbrella of Department of Health) dealing with patients suffering a mental health episode who are, or are about to be restrained, be provided with a special warning, by way of practice direction, of the increased risk of death the condition poses.

POST SCRIPT

After completing my finding, I received material from Mr Colin Grant, Manager Professional Standards Ambulance Victoria in relation to an amendment to an Ambulance Victoria Operational Work Instruction. Mr Grant advised that the refinement to their practices and procedures followed an internal review of the evidence given at the formal inquest. I include a short excerpt from Mr Grant's email which provides the rationale for the amendment; he said:

> *"..AV has since identified that in this instance it would have been prudent for the ambulance to follow the police van containing Mr McMillan to hospital as a precautionary measure."*

I include in this post script the promulgated amendment titled (WIN/OPS/015 – Responding to Events – Operation Staff). Mr Grant also stated that Victoria Police will be advised of the amended work practice. The additional direction in the existing Operational Work Instruction provides:

Paragraph 2.4.2

> *"...Where a patient requires transport to a medical facility and this transport can only be carried out safely by police, AV will follow police in close proximity. This decision needs to be considered in the context of using other options that may be available to facilitate transport by ambulance, and to manage the risks presented (e.g. de-escalation techniques; Police escort in ambulance; use of sedation and/or use of restraints as per guidelines).*
>
> *A plan to ensure the police and AV vehicle do not become separated should be developed in advance of the transport. Transport of a patient with medical needs to hospital by Police is only to be considered as a last resort."*

The idea of a further internal review post inquest, when all the evidence is in, is commendable as is the proactive approach to reviewing, and if thought appropriate, refining operational practices and procedures.

I direct that a copy of this finding be provided to the following:

The family of Craig McMillan

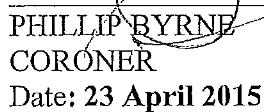
Victoria Police

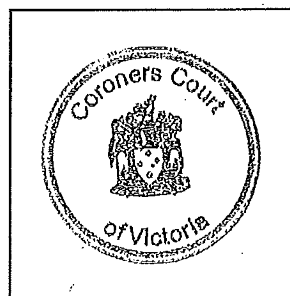
Mr Colin Grant, Ambulance Victoria

Monash Health

The Department of Health and Human Services

Signature:





PHILLIP BYRNE
CORONER
Date: **23 April 2015**