IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2010 001306

FINDING INTO DEATH WITH INQUEST

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

Inquest into the death of David Allan D'ANGELO

Delivered on:	8 July 2015
Delivered at:	Coroners Court of Victoria 65 Kavanagh Street Southbank Victoria 3006
Hearing dates:	8 & 9 July 2013 21 January 2014
Findings of:	Coroner Paresa Antoniadis SPANOS
Representation:	Ms J. TAYLOR appeared on behalf of Alfred Health Ms P. MURPHY appeared on behalf of relatives of the deceased Mr C. GRANT appeared on behalf of Ambulance Victoria
Assisting the Coroner:	Leading Senior Constable John KENNEDY, Police Coronial Support Unit.

I, PARESA ANTONIADIS SPANOS, Coroner,
having investigated the death of DAVID ALLAN D'ANGELO
and having held an inquest in relation to this death on 8 and 9 July 2013 and 21 January 2014
in the Coroners Court of Victoria at Melbourne

find that the identity of the deceased was DAVID ALLAN D'ANGELO
born on 7 December 1979
and that the death occurred on 8 April 2010
at 70 Nicholson Street, Fitzroy 3065

from:

I (a) HEROIN TOXICITY

in the following circumstances:

BACKGROUND AND PERSONAL CIRCUMSTANCES[1]

1. Mr D'Angelo was a 30-year old Yorta Yorta man, the eldest child and only son of his mother, Maria. He had no relationship with his biological father and characterised his step-father as 'abusive', reporting that this man would 'belt' him and cause him considerable injuries.[2] Mr D'Angelo was seemingly ambivalent about his relationship with his mother, trying to maintain a close relationship with her but at times experiencing feelings of rejection.[3]
2. Between the ages of five and 12 years, Mr D'Angelo and one of his three sisters were reportedly sexually abused by two male extended family members. When the abuse came to light, both children were removed from their mother's care and Mr D'Angelo was placed in state-operated children's homes, and later, foster placements, but apparently never received professional assistance to address the abuse he had suffered. Mr D'Angelo reported what he described as 'hundreds of episodes of sexual abuse' to the police and, though his alleged abusers were questioned, they were never charged.[4] Mr D'Angelo reportedly found it difficult to understand why no prosecution eventuated and this only served to compound his distress.

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[1] This section is a summary of facts that were uncontentious, and provide a context for those circumstances which were contentious and will be discussed in some detail below.

[2] Psychological assessment prepared by Ian Joblin in September 1999 [Joblin Report].

[3] Joblin Report.

[4] Joblin Report.

3. Mr D'Angelo's school attendance was poor, particularly in secondary school. He left school after Year Eight, having attained only very limited literacy. He gravitated to the streets of Melbourne as a teenager where he was exposed to drugs and alcohol, experimenting with a range of illicit substances, and using marijuana regularly as a means through which to 'remain calm' and deal with 'the psychological manifestations of his traumatic history'.[5] Unsurprisingly, Mr D'Angelo came to the attention of police and ultimately served periods in youth detention and adult prison.
4. At the age of 18 years, Mr D'Angelo formed a relationship with Charlotte and the couple had a daughter together. For Mr D'Angelo, this period was one of stability and support during which he managed to live a law-abiding and substance-free life. Unfortunately, the relationship ended when Mr D'Angelo returned to drug use, which Charlotte would not abide.
5. Given his limited ability to cope with the loss of this significant relationship, Mr D'Angelo resorted to familiar and maladaptive coping mechanisms – drug use, transience and the company of like-minded peers – and started to use heroin for the first time.[6] Typical of many, Mr D'Angelo believed he could control his heroin use, however, as his dependence increased, he committed criminal offences to finance his daily use of the drug, which culminated in a further period of imprisonment.

PSYCHIATRIC HISTORY

6. Mr D'Angelo had a long history of psychiatric illness. His first documented contact with mental health services occurred in 1999 and, since then, he was admitted for psychiatric treatment on 16 occasions.[7] Mr D'Angelo was diagnosed with an adjustment disorder by the St Vincent's Aboriginal Health Service in 2005 and, in the same year, was admitted to The Alfred Hospital [The Alfred] following his first episode of psychosis. In 2008, he was diagnosed with schizophrenia, poly-substance dependence and antisocial personality disorder.[8] Oral antipsychotic medications featured in Mr D'Angelo's treatment, both as an inpatient and when an involuntary patient in the community, however his long-term compliance with medication was poor.[9]
7. Many of Mr D'Angelo's admissions to psychiatric units involved psychotic relapse of schizophrenia, often in the context of poly-substance use and involving the exercise by police of

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[5] Joblin Report.

[6] Joblin Report.

[7] Exhibit C.

[8] The Alfred's medical records pertaining to David D'Angelo 2008-2010 [MRs].

[9] MRs.

their powers under the *Mental Health Act* [MH Act] 1986 to detain and transfer an apparently mentally ill person for psychiatric evaluation.[10]

8. When experiencing deteriorating mental health, Mr D'Angelo generally presented as agitated, disorganised, incoherent, paranoid and apparently responding to internal stimuli, with little insight into his illness and poor judgement.[11] Deliberate self-harm was not a feature of his presentation.[12] Following admission, Mr D'Angelo was often initially nursed in seclusion due to his lack of cooperation with clinicians (including a history of absconding)[13] and displays of aggression towards his treatment providers. However, his aggression and overt psychotic symptoms ordinarily subsided quickly with the reintroduction of antipsychotic medication.[14]
9. Mr D'Angelo was a challenging patient to treat especially when in the community. His itinerant lifestyle, poly-substance use, limited insight into his mental illness – particularly, the deleterious effect of substance use on his mental health – and poor compliance with treatment, made it difficult for mental health services to maintain continuity of care. For similar reasons, Mr D'Angelo did not have consistent treatment for poly-substance dependence.[15]

ADMISSION TO THE ALFRED PSYCHIATRIC UNIT ON 24 MARCH 2010

10. During March 2010, Mr D'Angelo lived in crisis accommodation in Southbank operated by Hanover, a community agency that provides assistance and support to individuals experiencing housing crisis or homelessness. Hanover staff were aware of Mr D'Angelo's diagnosis of schizophrenia and became concerned by his increasingly agitated demeanour and response to auditory hallucinations and so, on 24 March 2010, they contacted the Homeless Outreach Psychiatric Services [HOPS].[16]
11. Psychiatric Nurses from HOPS attended to assess Mr D'Angelo's mental state and found him to be extremely agitated, mumbling to himself and responding to auditory hallucinations. They were unable to perform a complete assessment of his mental state due to his presentation but formed the view that he posed a high risk of harm to others at the time.[17] HOPS staff noted Mr

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[10] MRs.

[11] MRs.

[12] Exhibit C.

[13] MRs, most notably in 2008 when, despite attending The Alfred voluntarily for mental health assistance, Mr D'Angelo absconded from the Emergency Department when he was told that his Community Treatment Order would be revoked and he would be admitted for involuntary treatment as an inpatient.

[14] MRs and Transcript page 133.

[15] Exhibit C and MRs.

[16] MRs (see, in particular, Intake Assessment form).

[17] MRs (see, in particular, Intake Assessment form).

D'Angelo's psychiatric history, poor compliance with treatment (he had not been treated since his last involuntary psychiatric admission to The Alfred in February 2009), and the potential that he would abscond from mental health services based on prior history. Accordingly, Mr D'Angelo was escorted by HOPS and police to The Alfred's Psychiatric Unit [TAPU].[18]

12. At TAPU, Psychiatric Registrar Dr Moncur reviewed Mr D'Angelo, finding him to be irritable, volatile and threatening, posing a high risk of injury to himself or others, thought disordered, largely incoherent and openly responding to auditory hallucinations. He lacked insight into his mental illness and was unable to provide informed consent to psychiatric treatment. In light of this presentation, Mr D'Angelo was recommended for involuntary treatment pursuant to section 9 of the MH Act and, given that he was assessed as posing a high risk of aggression, absconding and non-compliance, was initially nursed in seclusion.[19] Urinalysis conducted at the time of admission detected opiates, benzodiazepines and cannabinoids.[20]
13. Mr D'Angelo remained in seclusion between 5.30pm on 24 March and 12.30am on 25 March 2010. Category 2 observations, or observations every 15 minutes, were recorded throughout this period. Mr D'Angelo was administered 'once only' and 'as required' doses of diazepam and olanzapine which initially had no effect on his level of agitation.[21] His progress in seclusion was reviewed at 9.30pm by Dr Moncur who observed minimal aggression and greater compliance with treatment though Mr D'Angelo continued to mumble incoherently and 'shadow box' in seclusion.[22] Seclusion ceased when Mr D'Angelo was transferred to the High Dependency Unit [HDU] of TAPU after he was observed to be more settled for a continuous period of more than one hour.[23]
14. At 10.55am on 25 March 2010, Consultant Psychiatrist Dr Jianyi Zhang reviewed Mr D'Angelo and his status under the MH Act. He presented as dismissive, guarded and evasive and denied recent psychotic symptoms and drug or alcohol use. Dr Zhang noted that underlying agitation and disordered thought were evident and that Mr D'Angelo's presentation was similar to that recorded in February 2009. Dr Zhang's impression was that Mr D'Angelo suffered from inadequately treated schizophrenia and, when in his current state, presented a heightened risk of aggression towards others. Dr Zhang confirmed Mr D'Angelo's status as an involuntary patient

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[18] MRs.

[19] MRs, in particular, the "Recommendation for person to receive involuntary treatment from an approved mental health service' form and the initial "Risk Assessment" completed by Dr Moncur.

[20] MRs. Mr D'Angelo had reported recent heroin use and to drinking two cans of premixed vodka after collecting his Disability Support Pension.

[21] MRs.

[22] MRs, see Nursing/Progress Notes (especially that dated 24/3/10 at 9.30pm)

[23] MRs, see Nursing/Progress Notes.

pursuant to section 12AA of the MH Act, prescribed regular doses of diazepam and olanzepine and ordered that he continue to be nursed in the HDU.[24]

15. Over the following 24 hours, Mr D'Angelo was observed to be disorganised and 'wandering aimlessly' in the ward talking to himself, though he denied experiencing perceptual disturbance.[25] He remained aloof, suspicious of staff and irritable but showed no signs of aggression. Mr D'Angelo was visited by HOPS staff who brought with them a refund of accommodation expenses from Hanover, which TAPU held in safekeeping for him.[26] Hanover were to be informed of the likely length of Mr D'Angelo's admission, and offered to arrange storage of his possessions in the event his admission was more than a few days, but said they could not hold his accommodation.[27]

16. On 26 March 2010, Psychiatry Registrar, Dr William Soo, reviewed Mr D'Angelo for the first time. Mr D'Angelo presented as alert and euthymic. While no psychotic symptoms, perceptual disturbances or thought disorder was evident, he was dismissive and demonstrated limited insight into his mental illness. He could not recall the events that led to his admission to TAPU and did not appreciate that he had been mentally unwell beforehand. He was adamant that he only used substances, predominantly heroin, fortnightly and was unable to correlate his drug use with deterioration in his mental health. He indicated that he was not interested in referral for drug detoxification or rehabilitation because he did not perceive his drug use to be problematic. Mr D'Angelo reported a transient lifestyle in which he preferred to spend his time alone or with a select group of acquaintances; and said that he had no contact with his family.[28] He wanted to be discharged so that he could 'get on with [his] life'.[29] Dr Soo formed the view that Mr D'Angelo's admission had likely been precipitated by drug-induced psychosis and noted his previous history of poor compliance with mental health treatment.[30]

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[24] MRs, see in particular Inpatient Progress Note (dated 25/03/10 at 10:55) and Medication Records (Regular Medication).

[25] MRs, see Inpatient Progress Notes (dated 25/3/10 at 1915, 26/3/10 at 1440 and 27.3.10).

[26] MRs; Refunds of Hanover-related expensed were brought to Mr D'Angelo on two occasions (26 and 28 March 2010) and records indicate that these amounts, totalling $300.60, were receipted as 'property taken into custody' (Receipts 67871 and 67874). Mr D'Angelo's personal effects (Centrelink and bank cards, a mobile telephone and charger, and a cap) were also recorded and taken into the safe-custody of TAPU upon his admission (Receipt 67868).

[27] MRs; see Inpatient Progress Note made by a social worker dated 25/3/10 at 1615.

[28] I note that Dr Soo contacted Mr D'Angelo's mother (prior to his review of him on 26 March 2010) and advised her of his condition and whereabouts. Ms Joyce reported that she had last seen her son approximately two months earlier when he was staying at her home. She had observed deterioration in his mental health and commented that Mr D'Angelo had 'shot through' when she had contacted the Crisis Assessment and Treatment Team for assistance [see MRs Inpatient Progress Note made by Dr Soo on 26/3/10].

[29] MRs; see Inpatient Progress Note made by Dr Soo on 26/3/10.

[30] MRs; see Inpatient Progress Note made by Dr Soo on 26/3/10.

17. Over subsequent days, Mr D'Angelo continued to be nursed in the HDU, with Category 2 observations. He was generally more settled with only occasional irritability but remained isolative and responsive to internal stimuli. On 28 March 2010, when he considered that his mental state had improved since his admission and expressed a desire to be transferred to the Low Dependency Unit [LDU] of TAPU, Mr D'Angelo and was told that this was a decision to be made by his doctors in due course.[31]
18. During a review with Dr Soo on 29 March 2010, Mr D'Angelo was settled and cooperative but suspicious at times. He exhibited no signs of psychosis, disordered thought or perceptual disturbance. Dr Soo noted that Mr D'Angelo 'appeared to accept that he suffered from intermittent psychotic episodes' and that he had 'some ability' to relate them to his use of drugs.[32] Although Mr D'Angelo expressed a view that antipsychotic medications did little to assist him, Dr Soo noted that he appeared to accept – perhaps as these were expressed as prerequisites to discharge – both that his previous compliance with treatment had been poor, and that he needed to take antipsychotic medication regularly.[33] Dr Soo told Mr D'Angelo that he would be considered for transfer to the LDU when reviewed by Dr Zhang the following day.
19. On 30 March 2010, Dr Zhang reviewed Mr D'Angelo who presented as 'vague and perplexed', denying any psychotic symptoms, including nurses' observations of him posturing and talking to himself. The Consultant Psychiatrist discussed his ongoing treatment plan with Mr D'Angelo, including the likelihood that monthly haloperidol depot (a slow-release antipsychotic administered by intramuscular injection) would be introduced. Dr Zhang ordered that Mr D'Angelo remain in the HDU, ceased olanzapine and commenced him on haloperidol to be taken orally twice daily.[34]
20. Two days later, on 1 April 2010, Dr Zhang's impression was that Mr D'Angelo was improving. He was more settled, with few reports of disturbed behaviour or agitation from nurses, and no adverse reaction to haloperidol. A 'test dose' of monthly haloperidol depot was ordered and administered that afternoon.[35]
21. Dr Zhang authorised Mr D'Angelo's transfer to the LDU, with no entitlement to leave from the unit and continuation of Category 2 observations.[36] On arrival at the LDU, nurses noted that Mr

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[31] MRs; see generally Inpatient Progress Notes.

[32] MRs; see Inpatient Progress Note of Dr Soo (dated 29/3/10).

[33] MRs; see Inpatient Progress Note of Dr Soo (dated 29/3/10).

[34] MRs; see Medication Records (Regular Medication), where haloperidol is charted on 30/3/10.

[35] MRs; see Medication Records (As Required "PRN" Medications), where haloperidol decanoate is charted and administered on 1/4/10.

[36] MRs; see Inpatient Progress Note (dated 1/4/10, after Mr D'Angelo's transfer to the LDU at 1615). I note that ACN Layne transcribed Dr Zhang's orders in relation to transfer and leave by updating the Revised Risk Assessment form.

D'Angelo was 'polite and pleasant – good mood', he was socialising appropriately with co-patients and exhibited no psychotic symptoms.[37]

22. On 2 April 2010, Mr D'Angelo reported to nurses that his mood was 'OK' but nurses noted blunt affect, superficial engagement with staff and guardedness concerning his mental state.[38] He demonstrated 'some irritability' in response to his perception of a 'delay' to the review of his suitability for leave.[39] Mr D'Angelo informed LDU staff that he had a pending Magistrates' Court hearing on 7 April 2010 and the Associate Charge Nurse [ACN] was duly notified.
23. Between 3 and 5 April 2010, Mr D'Angelo remained in the LDU, spending much of his time alone in his bedroom and rarely using common areas other than during mealtimes.[40] Nurses observed him gesturing and talking to himself and that Mr D'Angelo had explained this behaviour as 'prayers'.[41] He remained difficult to engage and when he did engage, he was guarded. On the evening of 5 April 2010, Mr D'Angelo told LDU staff that he wanted to attend his court hearing on 7 April 2010.[42]
24. Dr Soo reviewed Mr D'Angelo again in the afternoon of 6 April 2010 and found him to be settled and cooperative but guarded. His mood was euthymic, his affect restricted, he showed partial insight into his mental illness and no psychotic symptoms.[43] Dr Soo discussed the treating team's discharge timeline and plan, inclusive of depot antipsychotic medication, a community treatment order,[44] HOPS follow-up and provision of accommodation assistance.[45] Dr Soo conducted a risk assessment and concluded that Mr D'Angelo's overall level of risk had reduced from 'moderate' to 'low' (the only indices still assessed moderate being the risks of absconding, non-compliance with treatment and substance abuse).[46] Mr D'Angelo was authorised to have staff-escorted leave for 20 minutes, three times per day and the frequency of nursing observations was reduced to Category 1 or 'General Observations'.[47]

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[37] MRs; see Inpatient Progress Note of Dr Zhang (dated 1/4/10).

[38] MRs; see, in particular, Inpatient Progress Note (dated 2/4/10 at 1320).

[39] MRs; see, in particular, Inpatient Progress Note (dated 2/4/10 at 1320).

[40] MRs; see generally, Inpatient Progress Notes dated 3-5/4/10.

[41] MRs; see, in particular, Inpatient Progress Note (dated 3/4/10 at 1830).

[42] MRs; see, in particular, Inpatient Progress Note (dated 5/4/10 at 2025).

[43] MRs; see, in particular, Inpatient Progress Note of Dr Soo dated 6/4/10.

[44] A community treatment order, pursuant to section 12 of the MH Act, allows individuals with psychiatric illness to be treated involuntarily in the community.

[45] MRs; see, in particular, Inpatient Progress Note of Dr Soo dated 6/4/10.

[46] MRs; see, in particular, the Revised Risk Assessment form completed by Dr Soo on 6/4/10 at 1350.

[47] MRs; see, in particular, Inpatient Progress Note of Dr Soo dated 6/4/10. General/Category 1 Observations commenced at 1345 on 6/4/10 (see Inpatient Visual Observation Worksheet). I note that 'General Observations' are noted to be those occurring at the frequency of 'shift changeover, mealtime, 1 hourly at night' though there was some

25. Staff-escorted leave occurred 'without incident' on the afternoon of 6 April 2010.[48] Mr D'Angelo was settled and appeared to sleep well overnight, although he did express some concern to nurses about his pending court hearing in the course of the evening.

CIRCUMSTANCES PROXIMATE TO DEATH

26. Early on the morning of 7 April 2010, Nurse Tony Aiuta, who was Mr D'Angelo's primary nurse that day, accompanied Mr D'Angelo to a nearby petrol station. During this short period of escorted leave, Mr D'Angelo's behaviour presented 'no issues' and Nurse Aiuta described his presentation that morning as settled and euthymic.[49]

27. Back at the LDU, at about 10am,[50] Mr D'Angelo was reviewed by Dr Soo. The Psychiatry Registrar noted that Mr D'Angelo was settled and cooperative but guarded, and that he appeared to be very mildly sedated.[51] Mr D'Angelo denied psychotic symptoms, displayed no signs of disordered thought, perceptual disturbance or delusional content in speech, and reported that he had been eating and sleeping well. He wanted to know when he would be allowed unescorted leave but when questioned about his reasons, was evasive, saying that he wanted to go 'shopping'.[52] Mr D'Angelo denied that he sought unescorted leave in order to obtain drugs and commented that had he wanted to abscond from treatment, he would have done so during escorted leave.[53] Dr Soo made no change to Mr D'Angelo's leave entitlement and advised him of the treating team's decision to seek an adjournment of his Magistrates' Court hearing that day as he was receiving involuntary psychiatric inpatient treatment at TAPU.[54] Dr Soo noted that Mr D'Angelo 'understood the rationale' for these decisions.[55]

28. At about 11:30am, the morning shift's ACN Megan Layne, agreed to take Mr D'Angelo on escorted leave so that he could smoke a cigarette, given that his primary nurse had already taken

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evidence that during his evidence at inquest that Dr Soo believed visual observations to occur more frequently than that, namely, once each hour (see Transcript pages 79, 92-93). Mr D'Angelo's dosage of diazepam was reduced and the medication was to be ceased within the next couple of days.

[48] MRs; see, Inpatient Progress Note (dated 6/4/10 at 'Nursing PM')

[49] Coronial Brief of Evidence (Statement of Tony Aiuta).

[50] The precise time at which Dr Soo's assessment of Mr D'Angelo occurred on 7/4/10 was not recorded in the MRs. However, during his evidence at inquest, Dr Soo provided information about the daily schedule in TAPU – commencing work at 8.30am, a handover meeting of 45 minutes to one hour's duration, a doctors' meeting of approximately 15 minutes' duration in which the day's workload is distributed before attending on patients – making it unlikely that the assessment occurred prior to 9.30am and more likely around 10am [see Transcript pages 66-68].

[51] MRs, see Inpatient Progress Note made by Dr Soo (dated 7/4/10).

[52] MRs, see Inpatient Progress Note made by Dr Soo (dated 7/4/10).

[53] MRs, see Inpatient Progress Note made by Dr Soo (dated 7/4/10).

[54] MRs, see Inpatient Progress Note made by Dr Soo (dated 7/4/10) and the letter, signed by Dr Zhang and dated 7/4/10, confirming Mr D'Angelo's inability to attend Court that day due to his involuntary admission at TAPU.

[55] MRs, see Inpatient Progress Note made by Dr Soo (dated 7/4/10).

him on leave earlier that day.[56] ACN Layne unlocked the LDU entrance and then realised that she did not have a cigarette lighter with her.[57] She asked Mr D'Angelo to wait while she retrieved a lighter from the 'Smokers' Drawer' in the office, situated about three metres away. ACN Layne observed that Mr D'Angelo remained at the LDU entrance when she entered the office but when she returned to the door no more than 10 seconds later, he was gone.[58] She assumed that Mr D'Angelo had walked downstairs to wait for her at the building entrance and so went downstairs. When she reached TAPU's ground floor entrance, there was no sign of Mr D'Angelo.[59] There were no further sightings of Mr D'Angelo in the vicinity of TAPU.

29. At 12.47pm, an ambulance was dispatched after a report that a man had collapsed following a suspected drug overdose and was lying unresponsive and in respiratory distress in the foyer of an address in Elizabeth Street, Richmond.[60] Ambulance paramedics Gideon Smit and Lauren Boxsell, arrived at the scene at 12.52pm and found the man in a supine position with an altered consciousness state (Glasgow Coma Scale of 7), respiratory depression, pinpoint pupils and evidence of recent injection marks. He was unable to open his eyes or speak.[61] A full set of vital signs was taken and manual ventilation commenced. Paramedics diagnosed an opiate overdose and so administered 2mg of Naloxone (an opioid antagonist, marketed as Narcan) intramuscularly.

30. The man responded to treatment, regained consciousness and his respiration returned to normal. Vital sign observations were repeated at 1.15pm, and these were unremarkable.[62] He identified himself as David D'Angelo and produced a health care card in that name.[63] He denied pain, injury, nausea and headache and declined to be transported to hospital. The paramedics advised him not to take drugs again that day, to have 'someone keep and eye on him' and to call for an ambulance if his condition deteriorated.[64] Mr D'Angelo left the scene and paramedics left shortly after.[65]

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[56] Coronial Brief of Evidence (Statement of Tony Aiuta).

[57] Exhibit N.

[58] Exhibit N.

[59] Exhibit N.

[60] Coronial Brief of Evidence (VACIS Electronic Patient Care Report [EPCR] #1419).

[61] Coronial Brief of Evidence (EPCR and Statement of Gideon Smit).

[62] Coronial Brief of Evidence (EPCR and Statement of Gideon Smit).

[63] Coronial Brief of Evidence (Statement of Gideon Smit).

[64] Coronial Brief of Evidence (Statement of Gideon Smit).

[65] The EPCR indicates that paramedics were 'clear' at 2.12pm notwithstanding that the final observations of Mr D'Angelo occurred at 1.15pm and, for all intents and purposes, the episode of treatment concluded shortly thereafter. Paul Burke, Clinical Review Specialist at Ambulance Victoria, gave evidence at inquest in which he explained that the likely reason for the delay between the completion of paramedic treatment of Mr D'Angelo and their departure from the

31. Later, at about 4pm, Mr D'Angelo paid for accommodation in a shared occupancy room at The Hub Backpackers [The Hub] in Fitzroy, and received a swipe card with which to gain entry to the building.[66] He met his room mate, Mr Simpson, in Room 15 and they talked for a while over a cigarette, Mr D'Angelo apparently confiding the events of the day, including his flight from the LDU, heroin overdose and treatment with Narcan.[67] Mr Simpson observed that Mr D'Angelo appeared to be 'heavily drug affected' that afternoon.[68]

32. Mr D'Angelo and Mr Simpson left The Hub, separately, in the evening and the latter did not return until the following morning. At about 7.55pm, Mr D'Angelo used his swipe card to enter The Hub's main entrance where he appeared to the afternoon shift manager, Mr McDonald, to be significantly affected by drugs.[69] Mr McDonald assisted Mr D'Angelo by 'carrying' him to Room 15 and left him there.[70]

33. At about 5.25am on 8 April 2010, Mr Simpson returned to his room at The Hub. Once inside, he observed Mr D'Angelo lying flat on his back on the top bunk bed, with his legs dangling over the edge.[71] He appeared to be deceased and so Mr Simpson summoned assistance. Ambulance Victoria paramedics attended and confirmed that Mr D'Angelo was deceased.[72]

34. Victoria Police members Constables Elliott and Eames-Meyer also attended and commenced the investigation into Mr D'Angelo's death. Constable Elliott photographed the scene and conducted a search of the room during which he found a cigarette packet containing a small amount of green vegetable matter, a spoon, cigarette lighter and 'deal bag', health care and bank cards in the name of David D'Angelo, a mobile telephone and some loose change. Constable Elliott conducted a LEAP check via Police Communications and ascertained that Mr D'Angelo was the subject of an active missing person notification, initiated by The Alfred Hospital.[73]

INVESTIGATION – SOURCES OF EVIDENCE

35. This finding is based on the totality of the material the product of the coronial investigation of Mr D'Angelo's death. That is, the brief of evidence compiled by Detective Senior Constable

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scene was that they used the time to clean up their equipment, restock medicines and complete paperwork. See Transcript pages 28-29.

[66] Coronial Brief of Evidence (Statement of C/ Sean Elliott).

[67] Coronial Brief of Evidence (Statement of Paul Simpson).

[68] Coronial Brief of Evidence (Statement of Paul Simpson).

[69] Coronial Brief of Evidence (Statement of D/S/C Matthew Rizun).

[70] Coronial Brief of Evidence (Statement of D/S/C M. Rizun).

[71] Coronial Brief of Evidence (Statement of Paul Simpson).

[72] Coronial Brief of Evidence (Statement of C/ S. Elliott).

[73] Coronial Brief of Evidence (Statement of C/ S. Elliott).

Matthew Rizun of the Yarra Crime Investigation Unit, the statements, reports and testimony of those witnesses who testified at inquest and any documents tendered through them, and the final submissions of Counsel. All of this material, together with the inquest transcript, will remain on the coronial file.[74] In writing this finding, I do not purport to summarise all the material and evidence, but will refer to it only in such detail as is warranted by its forensic significance and in the interests of narrative clarity.

PURPOSE OF A CORONIAL INVESTIGATION

36. The purpose of a coronial investigation of a *reportable death*[75] is to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.[76] The *cause* of death refers to the *medical* cause of death, incorporating where possible the *mode* or *mechanism* of death. For coronial purposes, the *circumstances* in which death occurred refers to the context or background and surrounding circumstances, but is confined to those circumstances sufficiently proximate and causally relevant to the death, and not merely all circumstances which might form part of a narrative culminating in death.[77]

37. The broader purpose of any coronial investigations is to contribute to the reduction of the number of preventable deaths through the findings of the investigation and the making of recommendations by coroners, generally referred to as the *prevention* role.[78] Coroners are also empowered to report to the Attorney-General in relation to a death; to comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice; and to make recommendations to any Minister or public statutory authority on any matter connected with the death, including public health or safety or the

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[74] From the commencement of the *Coroners Act 2008* [the Act], that is 1 November 2009, access to documents held by the Coroners Court of Victoria is governed by section 115 of the Act.

[75] The *Coroners Act 2008,* like its predecessor the *Coroners Act 1985*, requires certain deaths to be reported to the Coroner for investigation. Apart from a jurisdictional nexus with the State of Victoria, the definition of a reportable death in section 4 includes deaths that appear *to have been unexpected, unnatural or violent or to have resulted, directly or indirectly, from accident or injury* and the *death of a person who immediately before death was a patient within the meaning of the Mental Health Act 1986".*

[76] Section 67(1) of the *Coroners Act 2008.* All references which follow are to the provisions of this Act, unless otherwise stipulated.

[77] This is the effect of the authorities – see for example *Harmsworth v The State Coroner* [1989] VR 989; *Clancy* v *West* (Unreported 17/08/1994, Supreme Court of Victoria, Harper J.)

[78] The 'prevention' role is now explicitly articulated in the Preamble and purposes of the Act, cf: the *Coroners Act 1985* where this role was generally accepted as 'implicit'.

administration of justice.[79] These are effectively the vehicles by which the prevention role may be advanced.[80]

FINDINGS AS TO UNCONTENTIOUS MATTERS

38. In relation to Mr D'Angelo's death, most of the matters I am required to ascertain, if possible, were uncontentious from the outset. His identity and the date and place of death were not at issue. I find, as a matter of formality, that David Allan D'Angelo born on 7 December 1979, aged 30, of no fixed abode, died at The Hub Backpackers situated at 70 Nicholson Street, Fitzroy, on 8 April 2010.

39. I find that at the time of his death, Mr D'Angelo was a "person placed in custody or care" as defined in section 3[81] of the *Coroners Act* 2008 because he was an involuntary patient at The Alfred Psychiatric Unit.

40. The medical cause of Mr D'Angelo's death was similarly uncontentious. On 13 April 2010, Dr Shelley Robertson from the Victorian Institute of Forensic Medicine [VIFM] performed an autopsy and reviewed the circumstances of the death as reported by the police to the coroner. Dr Robertson found no signs of significant injury or significant natural disease, although she did note that changes to the lungs consistent with bronchopneumonia were evident.

41. Dr Robertson also noted the results of toxicological analysis of post-mortem samples that showed levels of benzodiazepines (diazepam and its metabolite) and haloperidol consistent with their therapeutic use, and 6-monoacetylmorphine (6-MAM, a specific heroin metabolite), morphine, and codeine. Dr Robertson attributed the cause of Mr D'Angelo death to heroin toxicity.[82]

42. Based on Dr Robertson's advice and a a matter of formality, I find that Mr D'Angelo's death was caused by heroin toxicity.

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[79] See sections 72(1), 67(3) and 72(2) regarding reports, comments and recommendations respectively.

[80] See also sections 73(1) and 72(5) which requires publication of coronial findings, comments and recommendations and responses respectively; section 72(3) and (4) which oblige the recipient of a coronial recommendation to respond within three months, specifying a statement of action which has or will be taken in relation to the recommendation.

[81] See section 3 of the Act, and in particular, subsection (i) of the definition relating to persons placed in custody or care.

[82] Coronial Brief of Evidence (Report of Dr Shelley Robertson).

FOCUS OF THE CORONIAL INVESTIGATION AND INQUEST

43. In common with many other coronial investigations, the primary focus of the coronial investigation and inquest into Mr D'Angelo's death was on the circumstances in which he died. Specifically, the investigation and inquest examined the following issues and whether or not any or each of them had caused or contributed to Mr D'Angelo's death:
    a. The adequacy of arrangements in place at TAPU/LDU for escorted leave at at April 2010;
    b. The adequacy of the LDU staffs' response to Mr D'Angelo's flight from the ward; and
    c. The absence of a 'flagging system' that would facilitate identification/location of an individual reported to police as 'missing' if s/he is treated by Ambulance Victoria.

    It is convenient to deal with the evidence in relation to each of these issues in turn.

ESCORTED LEAVE ARRANGEMENTS AT TAPU IN APRIL 2010

44. Although in the first instance, the decision to allow an involuntary inpatient leave from a mental health institution is a clinical one, it of course implicates policy and practical matters as well. At inquest, I had the benefit of the testimony of a number of witnesses who clarified how leave arrangements functioned during Mr D'Angelo's TAPU admission in March-April 2010, and alterations made to them subsequently.

Clinical Considerations

45. Drs Soo and Zhang and Associate Professor Stafrace each emphasised the 'balancing act'[83] undertaken when making clinical decisions throughout an episode of psychiatric care given the MH Act requirement that psychiatric treatment be provided in the least restrictive manner possible in the circumstances. Thus, the treating team seeks to strike an appropriate balance between competing objectives by evaluating a range of clinical considerations including the patient's psychiatric history, and mental state examinations and risk assessments conducted over the course of an admission, when making treatment decisions including decisions about leave. That said, it was acknowledged that there are 'no absolutes' in clinical decision-making in psychiatry, given that it is contingent, in part, on the frankness of the patient's self-report of symptoms and not only the clinician's interrogation, observation and judgement.[84]
46. After reviewing him on 6 April 2010, Psychiatry Registrar, Dr Soo, granted Mr D'Angelo short periods of staff-escorted leave that same day. At inquest, Dr Soo provided a detailed account of

[83] Transcript pages 40, 47 & 50 [Dr Soo], 137 [Dr Zhang] and 229 [A/Prof Stafrace].

[84] Transcript page 75.

the clinical considerations that informed this decision.[85] He observed that Mr D'Angelo's presentation had improved markedly since his admission almost a fortnight earlier and that over the course of the previous week he had adjusted well to the LDU.[86] Mr D'Angelo's agitation and psychotic symptoms had subsided, though he remained guarded, and he no longer posed a risk to others.[87] He was far more cooperative with clinicians and acknowledged the need for ongoing psychiatric treatment. Antipsychotic medications had been introduced with positive effect and, clinically, he was only days away from being ready for discharge.[88] Mr D'Angelo's past behaviour – his history of poor compliance with treatment, absconding and illicit drug use – was considered a potential indicator of future conduct and so remained current risks, though ones considered to have moderated during the admission.[89]

47. Mr D'Angelo participated in two uneventful staff-escorted leave periods before being reviewed again by Dr Soo on 7 April 2010.[90] At inquest, much was made of Dr Soo's notes of this review, especially Mr D'Angelo's enquiry about unescorted leave and his 'evasive' responses to questions concerning his reasons for seeking such leave, in light of his continued 'guarded' presentation.[91] Dr Soo conceded that psychiatrists cannot read a patient's mind to discover concealed symptoms or motivations[92] and that the sequence of the notes he made on 7 April 2010 suggest he had assumed Mr D'Angelo asked about unescorted leave in order to obtain illicit drugs.[93] He also conceded that Mr D'Angelo was at 'long-term'[94] risk of substance use and drug use posed a 'significant problem' for his physical and mental wellbeing.[95]

48. Dr Soo indicated that discussions with patients about their drug and alcohol use invariably occur during the course of treatment (once acute mental ill health had passed). He conducted discussions of this type with Mr D'Angelo several times, particularly in the context of granting leave, and included information aimed at assisting Mr D'Angelo to relate his drug use to deteriorating mental health and about decreased tolerance to drugs following a period of

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[85] See Transcript pages 73-76 inclusive.

[86] Transcript page 47.

[87] Transcript pages 73-76.

[88] Transcript pages 73-76; see also Dr Zhang's comments at Transcript pages 135 and 142.

[89] Transcript page 76 and MRs, in particular, the Revised Risk Assessment form completed by Dr Soo on 6/4/10 at 1350.

[90] Se MRs.

[91] MRs, in particular Inpatient Progress Note made by Dr Soo on 7/4/10.

[92] Transcript page 47.

[93] Transcript page 104.

[94] Transcript page 104.

[95] Transcript page 103.

abstinence, and offering referral to allied health services for treatment.[96] Dr Soo rejected as 'coercive' any approach to treatment and substance use management whereby Mr D'Angelo would be kept 'on the psychiatric ward without any leave until the point where he agrees to change his ways and undertake drug and alcohol treatment'.[97] Such an approach would be contrary to the MH Act.

49. Dr Soo explained that there are therapeutic benefits to the incremental removal of restrictions on a patient's liberty over the course of treatment. In particular, he observed that the grant of leave often encouraged patients to engage in a way that is necessary for treatment over the long term.[98] Moreover, staff-escorted leave is a mechanism through which inpatients can be supported (in the event they experience distressing symptoms) when they leave the relative safety of the controlled environment of the psychiatric ward.[99] Short staff-escorted leave, of necessity, ensures that patients remain close to the hospital, usually within its grounds or the nearby park or shops.[100] In Mr D'Angelo's case, the grant of staff escorted leave also provided a means through which the risk that he may use drugs while on leave could be minimised.[101]
50. I note that Dr Soo's decision to grant leave, and the conditions of that leave, was supported by a colleague[102] with whom he discussed matters contemporaneously, and was explicitly endorsed by Consultant Psychiatrist, Dr Zhang, [103] and The Alfred's Director of Psychiatry, A/Prof Stafrace.[104]

Staff Escorted Leave in practice

51. TAPU is situated in a standalone two-storey building. The HDU is situated on the ground floor and the LDU on the first floor.[105] Each ward has a separate fenced courtyard, the LDU's accessible via an exterior staircase, and each ward has a single main entrance/exit.[106] Once outside the main entrance of either the HDU or LDU, no other locked door impedes exit from TAPU, or indeed, The Alfred's grounds during the day. Neither ward's entrance is patrolled by

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[96] Transcript pages 77-78 and MRs.

[97] Transcript page 103.

[98] Transcript page 47.

[99] Transcript page 48.

[100] Transcript page 99.

[101] Transcript page 142.

[102] Dr Jeanes was consulted; see MRs, in particular Inpatient Progress Note made by Dr Soo on 6/4/10.

[103] Transcript page 156.

[104] Exhibit D.

[105] Transcript page 188; a combined clinical and administrative area is situated on the second floor.

[106] Transcript page 188. There are other points of access and egress, however, such as emergency doors/fire exits.

security staff, nor surveilled by CCTV cameras.[107] The Alfred adopted a campus-wide "Totally Smokefree Policy" in June 2008 such that after that date, smoking was no longer permitted on its property, including in the courtyards.[108]

52. The HDU is a 'permanently locked' ward, that is, one in which entry/exit is controlled by a lock operated by a member of staff.[109] The LDU is an 'open' ward and so the main door need not remain locked. The shift leader of each shift, usually the ACN, determines whether the main door of the LDU is to be locked based on a clinical risk assessment of the patient group. No written protocol guided the locking of doors in open wards at TAPU until December 2010.[110] However, on the day Mr D'Angelo absconded, the LDU door was locked.[111] I note A/Prof Stafrace's comments that it is not uncommon for patients to abscond from TAPU and whether the ward door is open or locked, mitigates the risk 'not a jot'.[112]
53. In April 2010, the LDU had capacity to accommodate 22 patients,[113] who were a mixture of voluntary and involuntary patients,[114] nursed by five nurses[115] per shift. Nurses maintain progress notes (usually made at the end of their shift), perform visual observations and dispense medications. So there may be as few as three nurses 'out on the floor', available to engage with patients at any one time.[116] The responsibility of escorting patients during staff-escorted leave also falls to the nursing staff. Although it is considered preferable that a patient be escorted on leave by his/her primary nurse, for obvious reasons, this is not always possible.[117]
54. During his evidence, Dr Soo described the "Locker" system used at TAPU to manage patients' belongings. Each patient is assigned a locker in which their possessions are stored, unless they

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[107] Exhibit D. A CCTV camera is situated at the TAPU building entrance.

[108] Transcript page 189. I note that A/Prof conceded that the hospital's no smoking policy meant that pressure was brought to bear on psychiatrists to grant leave so that patients could smoke [Transcript page 190] and, similarly, that ACN Layne reported that nurses experienced a similar pressure to facilitate staff-escorted leave.

[109] Exhibit D and Transcript page 192.

[110] Exhibit D and Exhibit J [Alfred Health policy "Locking Doors to Open Wards in Mental Health Settings"]. I note that although several witnesses indicated that in April 2010 the ACN determined whether or not the LDU door was locked, the policy adopted subsequent to Mr D'Angelo's flight from the LDU refers to this decision being a "collaborative" one. However, the ACN retains the authority to unilaterally lock doors in response to an imminent increased risk to patient safety.

[111] See, for instance, Exhibits D & N and Transcript page 290.

[112] Transcript page 222 and Exhibit D.

[113] It's not clear from the evidence before me whether the LDU was fully occupied at the time Mr D'Angelo absconded.

[114] Transcript page 138. The relative proportion of voluntary-involuntary patients is not clarified by the evidence at inquest.

[115] Transcript page 211.

[116] Transcript page 211.

[117] Transcript page 52.

are items of high intrinsic value and stored in the safe.[118] ACN Layne gave evidence that HDU patients 'never' had access to personal items, but that LDU patients' access to personal items was determined on a 'case-by-case basis' by staff, usually the patient's primary nurse.[119] Both witnesses acknowledged the need to withhold possessions from patients in clinically appropriate circumstances.[120] Although the receipt of a patient's personal effects and cash is documented in the Medical Records, it is not clear that return of items to a patient is documented at all.

55. There is no evidence before me to suggest that Mr D'Angelo gained unauthorised access to his belongings and I note ACN Layne's evidence that Mr D'Angelo's primary nurse, Nurse Aiuta, would have determined the items to which access was granted.[121] Notwithstanding the benefits of incremental removal of restrictions on a patient's liberty identified by clinicians, it is surprising that, while detained as an involuntary patient, Mr D'Angelo left the LDU (ostensibly to smoke a cigarette during staff-escorted leave of up to 20 minutes duration) with all of those items later found with him at The Hub (bank and health care cards, and a mobile phone).
56. In April 2010, TAPU did not maintain a designated leave register, or use any process to document patient leave beyond a notation made in the Progress Notes.[122] As is the case with all such notes, they provide a summary of significant events, not a moment-by-moment account of an interaction or nursing shift, and as such tend not to record details like who accompanied a patient on leave, what was done or specific feedback about the patient's response to leave.[123] Nurse Aiuta's note about Mr D'Angelo's uneventful leave on the morning he absconded is illustrative: 'SEL to petrol station w/out reported incident'.[124]
57. A Risk Assessment Folder containing each patient's Risk Assessment form, including details of any leave permitted, is kept on the ward. A patient's entitlement to leave continues until it is changed by the treating psychiatrist.[125] However, nurses may restrict leave if they have clinical concerns about the patient, pending review by a psychiatrist.[126] ACN Layne testified that she

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[118] Transcript page 82.

[119] Transcript page 320.

[120] Transcript pages 82 and 320. I note a slight discrepancy between the witnesses such that Dr Soo casts staff as 'facilitators' of patient access to belongings (and that access to wallets and phones was 'normal' in LDU), and ACN Layne sees staff as gatekeepers.

[121] Transcript page 321. Though it is not clear whether an relevant primary nurse makes such decisions each day or whether once a primary nurse has returned an item to a patient, that item remains in the patient's possession thereafter.

[122] Transcript page 164.

[123] Transcript page 51.

[124] MRs Inpatient Progress Note made by Nurse Tony Aiuta on 7/4/10 at 1435. "Staff-escorted leave to petrol station without reported incident".

[125] Transcript page 53.

[126] Transcript page 54.

could not remember checking the Risk Assessment Folder before agreeing to take Mr D'Angelo on leave, but she was aware that Nurse Aiuta had escorted him earlier in the shift and so she felt 'comfortable'[127] doing so herself. She recalled that Mr D'Angelo reminded her that she had agreed to take him out on leave but 'he wasn't pushy about it'[128] and that he had wanted to attend his court hearing.[129] However, ACN Layne stated emphatically that there was nothing in Mr D'Angelo's presentation that indicated to her that he might abscond; if there had been, she would not have agreed to escort him on leave.[130]

58. ACN Layne gave evidence that she 'did not anticipate' that Mr D'Angelo would abscond when she momentarily left him at the unlocked LDU entrance to retrieve a cigarette lighter from the office.[131] Indeed, her first thought was that he had gone downstairs ahead of her and would be waiting for her at the front of the TAPU building.[132] When ACN Layne did not see Mr D'Angelo at the front of the building or in its immediate vicinity, she returned to the ward and notified his primary nurse, Nurse Aiuta, whose responsibility it was to determine what to do next.[133]

RESPONSES TO MR D'ANGELO'S FLIGHT FROM THE WARD

59. At the time Mr D'Angelo absconded from the LDU, the procedure governing the TAPU staff response was the "Missing/Absconded Patient Psychiatry" [The Policy], a policy approved in 2000 and most recently reviewed in 2008.[134] The Policy outlined practices aimed at minimising the risk that a patient will abscond or go missing (primarily through regular risk assessment and visual observation of patients). The Policy also provided 'general guidelines' about the actions to be taken "promptly" when a patient is missing or has absconded. [135] Missing/absconded involuntary patients were to be reported missing to the police.[136] While "missing" and

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[127] Transcript page 287.

[128] Transcript page 302 and Exhibit N.

[129] Transcript page 290.

[130] Transcript page 302.

[131] Transcript page 290.

[132] Exhibit N.

[133] Transcript page 291.

[134] A fresh policy – "Missing and Absconded Patients Guideline" – was formulated following in internal review and a clinical literature review, and was in place at the time of the inquest in 2013.

[135] Exhibit E. The Policy specifies the class of staff member responsible for particular actions in response to a missing/absconded patient. I note that The Policy designated a coordinating role to the "Shift Leader" which is a term apparently used interchangeably with "ACN" by employees of TAPU providing evidence in this investigation. I note too ACN Layne's evidence [see Transcript 291 and 293] that Nurse Aiuta was the one responsible for 'making calls and completing forms' from which it appears implicit that she did not play an actively coordinating role.

[136] Exhibit E, page 2.

"absconded" patients were defined as those believed to have left without agreement or who had not been sighted within 15 minutes of their specified observation period, no timeline for "prompt" action was defined in the document.[137] I note A/Prof Stafrace's evidence that the term "prompt" had been interpreted with some 'flexibility' and through the 'lens of clinical judgment'.[138]

60. ACN Layne told Nurse Aiuta 'immediately' that Mr D'Angelo had absconded.[139] The two then had a discussion and it was decided, by Nurse Aiuta, that Mr D'Angelo should be given '+/- a couple hours' to return to the ward voluntarily.[140] ACN Layne explained that this was a 'judgement call' made in light of the available information. This information included Mr D'Angelo's settled presentation that day, his risk assessment rating (in particular, that he was a low risk of causing harm to others or deliberately to himself), and the fact that it was not unusual for patients to leave the ward, to attend to mundane matters and return.[141]
61. ACN Layne expressed the view that Nurse Aiuta's judgement was not unreasonable in the circumstances.[142] She acknowledged that there is a general reluctance to immediately notify police that a patient is absent without leave, as this may prove to be precipitous and so place an unnecessary burden on police.[143] It is apparent from the Inpatient Progress Notes,[144] and ACN Layne's evidence at inquest,[145] that the nurses believed that Mr D'Angelo may have left to attend his court hearing (despite being told that correspondence had been sent to the court to adjourn the matter).[146]
62. In accordance with The Policy, it appears that a search of The Alfred's grounds occurred[147] and that Dr Zhang was notified that Mr D'Angelo had left the ward in contravention of his leave

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[137] Exhibit E, page 1.

[138] Transcript page 187-8.

[139] Exhibit N.

[140] Coronial Brief of Evidence (Statement of Tony Aiuta).

[141] Transcript page 297 [ACN Layne] and page 196 [A/Prof Stafrace].

[142] Transcript page 318.

[143] Transcript page 297.

[144] MRs, see Inpatient Progress Note made by Nurse Aiuta on 7/4/10 at 1435.

[145] Transcript page 309.

[146] I note that Nurse Aiuta does not appear to have made any inquiries to determine whether or not Mr D'Angelo had attended court.

[147] ACN Layne 'assumed' Nurse Aiuta conducted the grounds search [Transcript page 293] and Nurse Aiuta notes on the Absconder Notification form that a search of 'ward, grounds, surroundings' had been conducted [see MRs].

conditions.[148] The timing of these actions is unclear. However, ACN Layne observed that the Consultant Psychiatrist is ordinarily informed shortly after a patient is noted to be missing.[149]

63. The purpose of timely notification of the treating psychiatrist is to include them in a discussion about risk which will inform decision-making about the most appropriate response to a patient's absence from the ward.[150] Although Dr Zhang did not appear to have any independent recollection of his involvement in such a discussion about Mr D'Angelo, he confirmed that he is 'usually' involved in decision-making about the notification of police and that it was 'common practice to wait and see' whether a patient returns voluntarily, unless the patient poses a risk to themselves or others.[151] Dr Zhang observed that Mr D'Angelo was not a risk to himself or others at the time he absconded, although he conceded that it was always a risk that he would use drugs, and that was part of the reason he was to be escorted while on leave.[152]

64. It appears that the only other actions taken in relation Mr D'Angelo's flight from the LDU between 11.30am and 2.30pm were telephone calls to Mr D'Angelo, his mother, sister and Hanover. It is not known at what time Nurse Aiuta endeavoured to contact Mr D'Angelo and his mother by telephone and was unable to reach them. However, Mr D'Angelo's sister's telephone records establish that a telephone message from TAPU was received at 2.25pm on 7 April 2010 advising her that Mr D'Angelo had absconded.[153]

65. Not long before the afternoon shift change, at about 2.30pm, VicPol were notified that Mr D'Angelo had absconded from TAPU. The "Requirements Prior to Reporting Missing Persons", "Absconder Notification" and "Personal Physical Description" forms were faxed to VicPol and Nurse Aiuta followed up with a telephone call to St Kilda Road police station, speaking to Constable Holt.[154]

66. These documents contained a physical description of Mr D'Angelo, his status under the MH Act, the time and location in which he was last seen and the efforts already made to locate him. In the remarks section of these forms, Nurse Aiuta noted that Mr D'Angelo was a Koori man who currently appeared settled though guarded and was a poly-substances user who could be

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[148] Transcript page 140.

[149] Transcript page 295.

[150] Transcript page 195.

[151] Transcript page 142.

[152] Transcript page 142.

[153] Transcript page 227. Nurse Aiuta also contacted Hanover, Mr D'Angelo's last know address at an unknown time.

[154] MRs.

aggressive when under the influence of illicit drugs.[155] It was suggested that Mr D'Angelo may have left the LDU in order to appear at court in relation to 'possession charges'.[156]

67. Significantly, both Dr Zhang[157] and A/Prof Stafrace[158] opined that the delay of three hours between Mr D'Angelo's departure from the LDU and when he was reported to VicPol as a missing person was too long.[159] Implicit in their comments is an acknowledgment that the actions of TAPU staff did not comply with The Policy's exhortation that "prompt" action be taken in relation to missing or absconded patients.[160] That said, these witnesses volunteered that The Policy was inadequate, particularly in so far as it failed to provide staff with useful guidance about timeframes for action.[161]

68. A/Prof Stafrace provided evidence about the review undertaken of The Policy following Mr D'Angelo's death and the development of a new policy, "Missing and Absconded Patients Guideline" [the New Policy].[162] In addition to introducing new measures aimed at reducing the likelihood that patients will abscond or go missing, key features of the New Policy are specific instructions about escalation to senior staff, particularly in the first hour after a patient's absence is noted. Also, the introduction of reporting timelines for all absconding patients, including requirements that VicPol be notified within 30 minutes if the patient is deemed "high risk" and otherwise, after an immediate search of the hospital grounds proves unsuccessful.[163] According to A/Prof Stafrace, under the New Policy, VicPol would have been notified that Mr D'Angelo had absconded within an hour, that is, by 12.30pm.[164]

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[155] MRs, see Personal Physical Description, Missing Person or Escapee and Requirements Prior to Reporting Missing Persons Forms.

[156] MRs, see Personal Physical Description Form.

[157] Transcript page 144.

[158] Transcript page 206.

[159] I note that ACN Layne would not concede that the delay was 'unreasonable' [Transcript page 318] but did acknowledge that three hours' delay was 'at the longer end' of a reasonable timeframe [Transcript page 293]. Dr Soo stated that he was not involved in any discussion about how long staff should wait for Mr D'Angelo to return before notifying police, but he would under the new protocol [Transcript page 112].

[160] I note, however, A/Prof Stafrace's evidence [Transcript pages 185-6] that an internal review concluded that The Policy had been 'broadly followed'.

[161] Transcript page 144 [Dr Zhang] and page 214 [A/Prof Stafrace], see also Exhibit D.

[162] Exhibit D and Transcript pages 215-6. The New Policy is Exhibit F.

[163] Exhibit F.

[164] Transcript page 215. A/Prof Stafrace conceded that TAPU 'still [has] some work to do' to ensure that staff comply with the timelines stipulated in the New Policy rather than continuing to rely on clinical judgments. He observed that, as at the date of the inquest, in one-in-three cases where patients go missing or abscond, the timelines are not followed [Transcript page 216].

69. Once VicPol receive a notification that a person is missing, the details received from the reporting party are recorded on a Missing Person Report[165] and faxed to the Central Data Entry Bureau where they are entered into the Law Enforcement Assistance Program [LEAP].[166] Once an individual is recorded as missing on LEAP, the investigation will remain 'active' until s/he is located. In addition, and any police member who conducts a "name check" via LEAP would be notified that the person is listed as missing.[167]

70. On the basis of the information provided by the reporting party, the police member to whom the missing person notification is made, in consultation with her/his sergeant, will conduct a risk assessment that will shape VicPol's operational response, including the identification of appropriate avenues of inquiry. Common avenues of inquiry include contacting family members or friends of the missing person, notifying VicPol units in the relevant area to 'Keep A Look Out For' the individual, and dispatching VicPol units to an address or location at which the missing person may attend.[168]

71. At inquest, Senior Sergeant Steve Bills testified that the best chance of finding an absconded psychiatric patient is if there is a quick notification that s/he has gone missing and the reporting party is able to provide a last known location.[169] In this case and in his opinion generally, psychiatric units are 'slow to report' absconders.[170] Nonetheless, he acknowledged that while the types of inquiries mentioned above would be conducted, VicPol operational priorities are such that it would be unusual for an 'active search' to be undertaken for an absconded psychiatric patient unless s/he presented a 'very high risk' to themselves or others.[171]

72. S/Sgt Bills observed that TAPU had provided all of the information VicPol required to initiate a missing person investigation.[172] Although notification was delayed, it was 'highly unlikely' that Mr D'Angelo would have come to the attention of VicPol[173] given that he was "minding his own business" and had no usual address that could be searched.[174] S/Sgt Bills stated that

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[165] The Missing Person is assigned an 'incident number' and is essentially an active investigation from this point onwards [Transcript page 206].

[166] Exhibit L and Transcript page 206. A 'sub-incident' number is assigned at this stage.

[167] Exhibit L.

[168] Exhibit L. After this task is completed, response and divisional supervisors are notified; section sergeants oversee all active missing person investigations and provide direction and instruction as required and station commanders received monthly reports, via the portfolio holder, on all active investigations.

[169] Transcript page 241.

[170] Transcript page 240.

[171] Transcript page 256.

[172] Transcript page 262.

[173] Transcript page 258.

[174] Transcript page 258.

unfortunately, earlier notification that Mr D'Angelo was missing was not likely to have made much practical difference to VicPol's ability to locate him sooner than they did.[175]

"TREAT AND RELEASE" AND THE "FLAGGING" OF MISSING PERSONS

73. Mr Paul Burke, Clinical Review Specialist at Ambulance Victoria, gave evidence about AV's guidelines in relation to the treatment of individuals suffering from an apparent opioid overdose. He stated that since the late 1990s, in response to an apparent reluctance to seek ambulance assistance for associates believed to have overdosed, lest this result in VicPol involvement, AV adopted a "treat and release" approach in such situations when clinically safe to do so.[176] As a result of this policy, AV call-outs to overdose incidents will not result in VicPol attendance unless paramedics require assistance in fear for their own safety or apprehend that the patient is mentally ill and may required the use of police coercive powers under section 10 of the MH Act.[177]

74. Clinical literature demonstrates that when patients treated with naloxone to reverse the effects of opioid overdose can mobilise as usual, and their vital sign observations[178] are normal, it is safe not to transport them to hospital for observation.[179] Moreover, according to Mr Burke, the 'usual pattern' is for patients like Mr D'Angelo who have recovered from overdose/naloxone administration, to refuse transportation to hospital.[180] As nothing in Mr D'Angelo's presentation indicated mental illness or a lack of capacity, once he declined further treatment or transport, paramedics could not lawfully compel him to do otherwise.[181]

75. AV treated Mr D'Angelo nearly two hours before he was reported missing and there was an active VicPol investigation underway. However, even if Mr D'Angelo's missing person notification had occurred before his contact with AV, paramedics would not have known (and could not have been informed) that he had absconded from TAPU. This is because although Victoria's emergency communications are co-ordinated by the same entity, the Emergency Services Telecommunications Authority [ESTA], the systems used by AV and VicPol are separate and configured to the specific requirements of each. Thus, ESTA's emergency

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[175] Transcript page 241.

[176] Transcript page 17 and Exhibit A.

[177] Exhibit A. Section 10 of the MH Act empowers police members to apprehend individuals believed to be mentally ill and who present as a threat to the safety of themselves or others.

[178] That is, oxygen saturation, respiration rate, temperature, heart rate and level of consciousness.

[179] See generally the two clinical articles appended to Mr Burke's statement, Exhibit A.

[180] Transcript page 17.

[181] Exhibit A and Coronial Brief of Evidence (Ambulance Victoria Electronic Patient Care Record and Statement of Gideon Smit).

dispatch system is location-based, not person-specific. ESTA advised that it would be 'too difficult', inefficient and potentially lead to delayed dispatch if the system were related to an individual's identity.[182] Moreover, legislation limits access to VicPol's law enforcement databases (including LEAP) to VicPol personnel or ESTA Police Dispatchers who are explicitly authorised by a VicPol member to conduct a specific inquiry for 'legitimate operational purposes'.[183]

76. Nonetheless, I note the evidence of S/Sgt Bills and Mr Burke who, although cognisant of the particular relevance of privacy issues, both acknowledged that a system of inter-agency data sharing that would facilitate identification and return of absconders who have had contact with emergency services such as AV would be a 'huge benefit'.[184]

CONCLUSIONS

77. The standard of proof for coronial findings of fact is the civil standard of proof, on the balance of probabilities, with the *Briginshaw* gloss or explication.[185] The effect of the authorities is that Coroners should not make adverse findings against or comments about individuals, unless the evidence provides a comfortable level of satisfaction that they caused or contributed to the death.

78. Having applied the applicable standard to the available evidence, I find that:

    a. Mr D'Angelo suffered a psychotic relapse of schizophrenia and was admitted to The Alfred Psychiatric unit for involuntary treatment on 24 March 2010. His psychotic symptoms subsided with the reintroduction of antipsychotic medication and his mental health had improved considerably over the course of the admission.
    b. It was reasonable and appropriate for Mr D'Angelo to be granted escorted leave in the terms stipulated by Psychiatry Registrar, Dr Soo, on 6 April 2010.
    c. Mr D'Angelo's presentation on 7 April 2010 was such that The Alfred Psychiatric Unit staff could not reasonably have been expected to predict that he might abscond from the Low Dependency Unit on that day.

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[182] Coronial Brief of Evidence (Statement of Craig Fechner).

[183] Coronial Brief of Evidence (Statement of Craig Fechner).

[184] Transcript pages 243 [S/Sgt Bills] and 23 [Mr Burke].

[185] *Briginshaw v Briginshaw (1938) 60 C.L.R. 336 esp at 362-363.* "The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding, are considerations which must affect the answer to the question whether the issues had been proved to the reasonable satisfaction of the tribunal. In such matters "reasonable satisfaction" should not be produced by inexact proofs, indefinite testimony, or indirect inferences..."

d. In the circumstances, it was not unreasonable that ACN Layne agreed to escort Mr D'Angelo for a short period of leave.
e. The available evidence does not enable me to determine whether Mr D'Angelo's flight from the Low Dependency Unit was premeditated, and if so from what point in time, or was an impulsive and opportunistic reaction to the circumstances in which he found himself.
f. Notwithstanding that at the time he absconded Mr D'Angelo did not clinically present any imminent or high risks of harm to others or himself, a three hour delay before reporting him to police as a missing person was unreasonable, particularly in light of his status under the *Mental Health Act*.
g. As at April 2010, The Alfred Psychiatric Unit's Missing/Absconded Patient Psychiatry policy was inadequate and provided insufficient guidance to staff to ensure timely reporting of Mr D'Angelo as a missing person.
h. I am unable to conclude that had The Alfred Psychiatric Unit staff made an earlier report to police that Mr D'Angelo's death could have been prevented or that the delayed report caused or contributed to his death.
i. Ambulance Victoria paramedics' treatment of Mr D'Angelo's overdose prior to 1pm on 7 April 2010 was appropriate and was delivered in accordance with clinical literature and relevant practice guidelines.
j. The search efforts of Victoria Police, once alerted, were reasonable and appropriate.
k. Mr D'Angelo died as a result of heroin toxicity in circumstances of an accidental or inadvertent overdose.

COMMENTS

Pursuant to section 67(3) of the Coroners Act 2008, I make the following comments connected to the death:

1. When a missing person report is made to Victoria Police, in respect of an involuntary patient who has absconded from a psychiatric facility, the prospects of locating the patient would be enhanced by the provision of a photograph taken during their current episode of care. This is not current practice and a number of concerns were raised by or on behalf of Alfred Health about such a practice. Nevertheless, with appropriate safeguards around access, retention and use of such photographs, it is likely that provision of photographs in conjunction with missing person reports would enhance efforts by Victoria Police to locate patients and return them to care.

2. Even in the current paradigm of the least intrusive, least restrictive care, Mr D'Angelo's access to his personal belongings was problematic in this case, in that it facilitated his ability not only to abscond, but to travel to the Richmond area, to access and use heroin and to obtain overnight accommodation. Conversely, this also enabled him to be identified by Ambulance Victoria personnel so that his movements in the period between leaving the TAPU and his death could be elucidated at least to some extent during this investigation. That said, Alfred Health could improve their records as to the personal items returned to involuntary patients who are still inpatients, and the rationale for doing so.

3. In the case of absconding involuntary psychiatric patients, there is scope for improvement in information sharing data between key agencies, such as Ambulance Victoria and Victoria Police, to improve the prospects and timeliness of locating and returning involuntary patients to care. This should involve a relatively small number of patients and should not compromise the gains of the "treat and release" approach taken by Ambulance Victoria to overdose patients.

I direct that a copy of this finding be provided to the following:
Mr D'Angelo's family
Director of Psychiatry, Alfred Health
Chief Psychiatrist
Ambulance Victoria
Victoria Police
ESTA, c/o Craig Fechner
D/S/C Matthew Rizun of Yarra Crime Investigation Unit

Signature:

PARESA ANTONIADIS SPANOS
CORONER
Date: 8 July 2015