IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2010 1251

FINDING INTO DEATH WITH INQUEST

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

Inquest into the Death of: DOMENICO CHIODO

Delivered On:	22 February 2013
Delivered At:	MELBOURNE
Hearing Dates:	6, 10-14, and 17-18 September 2012
Findings of:	CORONER K.M.W. PARKINSON
Place of death:	Northern Hospital, Cooper Street, Epping. Victoria
Counsel Assisting:	Mr T Wraight of Counsel. Instructed by Ms J Hawkins, Principal Solicitor - Coroners Court of Victoria.
Appearances:	Dr P. Halley of Counsel for Northern Health Service. Mr J. Hannebery of Counsel for the Chief Commissioner of Police. Ms B. Knoester of Counsel for North Western Mental Health Service. Ms R. Sweet of Counsel for Ms Nicole Jacobson Mr S. Cash of Counsel for Mr Scott Davidson.

I, KIM M. W. PARKINSON, Coroner having investigated the death of DOMENICO CHIODO

AND having held an inquest in relation to this death on 6, 10, 11, 12, 13, 14, 17, 18 September 2012

AT MELBOURNE

FIND that the identity of the deceased was DOMENICO CHIODO

BORN on 6 November 1976

AND the death occurred on 2 April 2010

AT Northern Hospital, 185 Cooper St, Epping VIC 3076

From:

1 (a) CARDIORESPIRATORY ARREST IN THE SETTING OF PRONE RESISTANT OF AN AGITATED OBESE MALE WITH SCHIZOPHRENIA AND CORONARY ARTERY DISEASE WHO HAD BEEN SEDATED

In the following circumstances:

1. An inquest was conducted into the death of Mr Domenico Chiodo (Domenic) on 6, 10-14 and 17-18 September 2012 and the following witnesses gave evidence in the proceeding: Associate Professor David Ranson, Forensic Pathologist and Dr Dimitri Gerostamoulos, Forensic Toxicologist each of the Victorian Institute of Forensic Medicine; Mr Lee Kennedy, Registered Psychiatric Nurse, of the Northern Crisis Assessment & Treatment Team; Sergeant Mark Spriggs, Constable Brendan O'Meara and Constable Kristy Brown each of Craigieburn Police Station; Senior Constable Mark Franco, Constable Deborah Oakes, Constable Troy Farley, Constable Samantha Whiting, and Sergeant Graeme Tressider, each of Victoria Police, Broadmeadows Police Station; Security Guards Mr Scott Davidson, Mr Anton Thavarajah, and Mr Ishmaeel Owshana employees of Northern Hospital.

2. The following clinical employees of the Emergency Department at Northern Hospital also gave evidence: Nurse Jenelle Vandenhurk, Clinical Nurse Specialist; Nurse Nicole Jacobson, Registered Nurse; Dr James Hayes, Emergency Physician; Dr Shu Ooi, Emergency Physician; Dr Chris Parry, Emergency Physician; Dr Soon Yee Teoh, Junior Medical Resident; Associate

Professor Suresh Sundram, Director of Clinical Services & Psychiatrist Northern Area Health Services; Dr Claudia Kleeberg, Consultant Psychiatrist Melbourne Health and Senior Sergeant Andrew Miles of Victoria Police, Operational Safety Tactics Training (OSTT).

3. I have been assisted by the submissions of the parties in this matter and in particular, by the submissions of counsel assisting, Mr Wraight and I have drawn from those submissions during the course of this finding where appropriate.

BACKGROUND AND MENTAL HEALTH HISTORY

4. Domenic was born on 6 November 1976 and he was 33 years old at the time of his death. He was born in Melbourne and grew up in the Lalor area. He was an average student and growing up had no mental health issues. His father reports that he began to experience difficulties when he was in year 10. He completed year 12 at Thomastown High School. Following school Domenic had several part time jobs but for most of his life he was not employed.[1]

5. From the age of 17 until his death, Domenic smoked marijuana. His father noticed he changed over the years after he commenced smoking, becoming more aggressive and getting into trouble with the police. Domenic lived with his father who supported and cared for him until the time of his death.

6. Domenic first presented to psychiatric services in 2000. Following his initial admission Domenic had 14 subsequent psychiatric inpatient admissions including the admission that led to the Restricted Community Treatment Order (RCTO) in 2009.[2] Most admissions were in the context of poor compliance with medications and complication of his psychiatric illness by cannabis use and dependence.

7. During the course of his illness, Domenic was prescribed various antipsychotic medications including olanzapine, respiridone, fluxenthixol and zuclopenthixol. At the time of his death, he was prescribed quetiapine 1000mg daily.[3]

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[1] Inquest Brief page 114-115 M. Chiodo

[2] Medical records page 94 Psychiatric history

[3] Exhibit 23 –Statement of Dr Claudia Kleeberg dated 22 July 2010

8. Domenic had an extensive forensic history. In 2002, he was admitted to the Thomas Embling Hospital, a secure forensic unit, in relation to a number of assault and weapons charges. In 2008, he was admitted to the Wilfred Lopes Centre in Tasmania, which is also a secure forensic unit. He was placed on a Community Treatment Order but later absconded. In August 2008, he was remanded at the Melbourne Assessment Prison in relation to charges of attempted armed robbery, theft, assault and possession of cannabis. He later transferred to the Thomas Embling Hospital.[4]

9. On 22 March 2010, following discussions with treating teams, Associate Professor Suresh Sundram, the Authorised Psychiatrist for the Northern Area Mental Health Service, revoked Domenic's RCTO.[5] As a result of the revocation, Domenic was required to be taken to an approved mental health service for continued treatment. In the evening of 22 March 2010, Domenic was admitted to the emergency department of the Northern Hospital.

10. At approximately 12.45 hours on 23 March 2010, Domenic broke free from mechanical restraints. Hospital security guards, police and medical staff wrestled with Domenic in order to gain control of him on the floor. After a period of time wrestling with him, Domenic ceased resisting. With the assistance of further police, he was lifted back onto the hospital trolley where he was observed to be cyanotic. Moments later, he was observed to be in cardiac arrest.

11. A number of medical staff performed CPR and Domenic was revived. He was intubated and placed on life support. On 1 April 2012, following consultation with the family, life support was removed. Domenic died on the morning of 2 April 2010.

CIRCUMSTANCES LEADING TO REVOCATION OF RCTO

12. On 18 June 2009, as a result of the 2008 charges that led to incarceration at the Thomas Embling Hospital, the County Court ordered that Domenic be placed on a Restricted Involuntary Treatment Order for two years pursuant to s.93 of the *Sentencing Act* 1991.[6]

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[4] Exhibit 23 –Statement of Dr Claudia Kleeberg dated 22 July 2010 and Medical Records page 95 IB.

[5] Exhibit 1 –Statement of Associate Professor Sundram dated 28 July 2010

[6] Medical Records page 47 - Order of Judge McInerney

13. On 27 June 2012, Domenic's order was modified to a RCTO pursuant to s 15A of the *Mental Health Act* 1986 (Mental Health Act).[7] He was placed in the care of the Northern Mobile Support and Treatment Service (NMSTS). The four conditions of the RCTO were that he: reside at his father's house; attend punctually at his mental health clinic appointments at Whittlesea Community Health Service in Epping; adhere to his medication regime and undertake random urine drug screens.

14. The NMSTS supervised Domenic's medication on a daily basis, either at home or at the NMSTS offices. He had four weekly appointments with the Consultant Psychiatrist however, his attendance was irregular and his insight into his illness and need for treatment remained poor. Urine screens continued to be positive for cannabis.[8]

15. In late January 2010, NMSTS became increasingly concerned about Domenic's hostility towards clinicians. He failed to attend his medical review on 16 March 2010 and clinicians were unable to contact him. On 20 March 2010, Domenic's father Mario contacted the NMSTS expressing concern about his son's mental state. His father advised clinicians that Domenic had not been violent or threatened violence and that he was not concerned about any physical threat to himself or family members.

16. On 21 March 2010, NMSTS clinicians consulted with the Northern Crisis Assessment Treating Team (NCATT) and Epping Police.

17. On the morning of 22 March 2010, after discussions with NCATT clinicians, Associate Professor Suresh Sundram, the Authorised Psychiatrist for the Northern Area Mental Health Service formed the view that it was no longer possible to treat Domenic safely in the community and that his ongoing treatment required an immediate period as an in-patient in a mental health facility. Dr Sundram revoked Domenic's RCTO.[9] It was decided that Domenic would be transported to the Northern Hospital.[10]

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[7] Exhibit 30 – Inquest Brief RCTO, Medical Records page 45

[8] Exhibit 23 –Statement of Dr Claudia Kleeberg dated 22 July 2010

[9] Inquest Brief page 748 Revocation Order

[10] Exhibit 1 –Statement of Associate Professor Sundram dated 28 July 2011

18. Pursuant to s 15D(2)(b) of the Mental Health Act 1986, when a patient subject to a RCTO has their order revoked, they are deemed to remain as an involuntary patient under the original Restricted Involuntary Treatment Order 'who is taken to be absent without leave from an approved mental health service'.

ATTENDANCE AT THE HOME TO APPREHEND DOMENIC

19. Following the decision to revoke Domenic's RCTO, clinicians with the NCATT communicated with Domenic's father Mario and the police to arrange a time to meet at Domenic's home and transport him to the Northern Hospital.[11]

20. The order was revoked by Associate Professor Sundram on the morning of 22 March 2010, and arrangements to apprehend Domenic were made in the context of the availability of clinicians and police. It appears from this and other evidence, clinicians did not consider there was any immediate urgency about the timing of the apprehension and it did not occur until after 20.30 hours that evening.

21. In the meantime, and in the planning of the revocation or the apprehension, the issue of immediate availability of an in-patient mental health bed had not been addressed. Inquiry in this regard took place after the apprehension and it appears from the emergency department. The evidence is that a medical clinician documented in the emergency department notes that there were 'no high dependency psychiatric beds in state' that evening and noted 'refer to emergency department'.[12]

22. At approximately 20.30 hours, psychiatric nurse Mr Lee Kennedy and social worker Ms Suzanne Stuart of NCATT met with members of Victoria Police for a briefing before approaching the house.[13] The NCATT workers and the police approached the front door and were met by Mario who led them to Domenic's bedroom. Ms Stewart and police officers Delle-Virgini, Morrison and Hall went to the bedroom. Police officers Davis and Down remained in the hallway while officers Spriggs and Evans remained outside at the rear of the

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[11] Exhibit 7 –Statement of Mr Lee Kennedy dated 20 May 2011

[12] Exhibit 35 - Inquest Brief page 548 and Transcript 122.23

[13] Morrison, Davis, Spriggs, Delle-Virgini, Down, Hall, Evans

premises.[14] Although Domenic was verbally abusive toward police when they approached him, he was not physically aggressive. He was handcuffed and complied with police instructions to enter the divisional van, in which he was transported to the Northern Hospital emergency department.

23. Mr Kennedy's evidence was that it was not within his authority to arrange or to make inquiries regarding the availability of in-patient psychiatric beds or to revisit the issue of apprehension and that once the order had been revoked the responsibility was to apprehend and transport to the designated location, in this case the emergency department.

ADMITTANCE TO THE EMERGENCY DEPARTMENT OF THE NORTHERN HOSPITAL

24. On arrival at the Northern Hospital emergency department at approximately 21.08 hours, Domenic was placed in resuscitation room 2 (R2). Nurse Jenelle Vandenhurk was the emergency department clinical nurse specialist and nurse in charge of the unit on the evening. Nurse Vandenhurk spoke with NCATT staff members and was informed that Domenic would be staying in the emergency department at least throughout the night as no mental health beds were available. She was also told to keep him physically and chemically restrained due to his violent history.[15] The mental health clinicians then left the hospital to attend to other patients in the community.

25. Dr James Hayes, the doctor in charge of the emergency department that night, decided that shackling and chemical sedation was warranted.[16] Nurse Vandenhurk signed the 'Approval/Authority for Mechanical Restraint' form.[17]

26. Police members Spriggs, Delle-Virgini, Morrison and Davis assisted hospital staff in securing Domenic to the bed. As Domenic was being rolled onto his left side he spat twice in the face

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[14] Exhibit 35 - Inquest Brief page 130 - Statement of Constable Davis

[15] Exhibit 25 - Statement of Ms Janelle Vandenhurk dated 8 July 2010

[16] Exhibit 18 - Statement of Dr Hayes dated 20 June 2012

[17] Exhibit 27 - Inquest Brief page 755 Approval Authority for Mechanical Restraint form

of Sergeant Delle-Virgini. Sergeant Delle-Virgini stated that his immediate reaction to this was to strike Domenic to the right side of his face with an open left hand.[18]

27. Sergeant Delle-Virgini then pressed his left forearm down on the right side of Domenic's face while Constable Morrison placed a pillow on Domenic's face to prevent him spitting.[19] Davis states that she also placed a pillow above Domenic's face.[20] Domenic was shackled to the bed and given sedative medication of olanzapine and midazolam.[21] Police involved in transporting Domenic to the hospital and in the initial restraint had all left the hospital by 23.20 hours.

THE INCIDENT

28. Division 1 Nurse Nicole Jacobson took over the care of Domenic at approximately 21.50 hours. Her role was to provide 'one on one' nursing care and to keep the patient under direct observation at all times. At that stage, he was still very agitated. She states that she built a rapport with him and he calmed down.[22] Nurse Jacobson described him as being slightly anxious but showing no aggression towards her and was co-operative, willingly taking medication and obeying her commands.

29. Whilst not a trained mental health nurse, Nurse Jacobson was familiar with mental health patient nursing having experienced many mental health emergency department admissions since completing her Bachelor of Nursing in 2005 and commencing work at the Northern Hospital.

30. In the period from admission on 23 March 2010 until the time of the identified collapse the following medication was identified by the pathologist as having been administered:[23]

    21.12pm olanzapine 10mg IM, midazolam 10mg IM

    21.15pm 20g IVC inserted midazolam 10mg IV

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[18] Exhibit 35 - Inquest Brief page 139 Statement of Constable Delle-Virgini

[19] Exhibit 35 - Inquest Brief page 127 Statement of Constable Morrison

[20] Exhibit 35 - Inquest Brief page 131 Statement of Constable Davis dated

[21] Exhibit 35 - Inquest Brief page 644 Nursing notes Emergency Department

[22] Exhibit 26 - Statement of Nurse Nicole Jacobson dated 24 May 2010

[23] Exhibit 2 - Autopsy Report of Associate Professor David Ranson dated 10 March 2011

21.26pm midazolam 5mg IV

21.35pm midazolam 5mg IV

21.51pm pt reported to be clam and co-operative

23.30pm delusional symptoms, calling out, temazepam 20mg PO

00.05am temazepam 10mg PO

00.43am ? midazolam 10mg IM – likely to be the same as 0.47am dose. Appears to be a timing discrepancy between the emergency department nursing notes, and the emergency department medication chart.

00.47am midazolam 10mg IM - ? same as 00.43am dose

00.50am haloperidol 2.5mg IM

31. At approximately 23.38 hours, Constables O'Meara and Brown arrived at the hospital with another patient who had been detained pursuant to s10 of the Mental Health Act. The patient was placed in the cubical next to Domenic. The evidence is that the patient was violent and aggressive and that the presence of this patient resulted in an increase in Domenic's level of agitation. Nurse Jacobson also commented that the resuscitation cubicle R2 was a high traffic area and that Domenic was becoming agitated by all the people walking past and yelling comments which was consistent with his psychosis.

32. Dr Parry also stated that Domenic's agitation was evidenced by his deluded commentary. Nurse Jacobson's evidence was that when the patient in the next cubicle calmed down so also did Domenic. He described in detail a number of his delusional thoughts which were documented by Nurse Jacobson. Nurse Jacobson attempted to minimise the level of activity outside his cubicle and to reduce the stimulation to which he was exposed as it was increasing his agitation and keeping him awake. It did not appear to either clinician that the sedative medication was effective.

33. Protocol required that the restraints be removed every four hours to check for pressure areas and to allow for hydration and toileting. Nurse Jacobson upon doing so at 00.15 hours, noticed that he was co-operative and not attempting to escape so after her observations she left the chest and ankle restraints off.

34. At approximately 00.30 hours on 23 March 2012, Domenic asked to go to the toilet. Nurse Jacobson considered that as he had calmed somewhat, appeared to be co-operative and there were police and security in the department, that it was appropriate to allow him to be escorted to the toilet rather than use a pan.[24]

35. Police members O'Meara and Brown assisted security guards Mr Scott Davidson, Mr Anton Thavaragah and Mr Ishmaeel Oshawa to escort Domenic to the toilet with no incident. Upon his return only the wrist restraints were re-applied, the feet restraints being left off as Nurse Jacobsen considered that they were unnecessary due to his co-operative behaviour.[25]

36. A few minutes after he returned, at approximately 00.42 hours Nurse Jacobson heard the tear of velcro and observed Domenic break free from his wrist restraints. Domenic confronted security guard Scott Davidson who was standing near the cubical. Mr Davidson asked him to go back to bed. Domenic replied, "I'm leaving". He then ran towards Mr Davidson and attempted to punch him in the face.[26] Constable O'Meara stepped in and from about five metres away, deployed a burst of OC spray to Domenic's face.[27]

37. Mr Davidson grabbed Domenic and with the assistance of Constable Brown they took Domenic to the ground. He continued to struggle violently. Constable O'Meara together with security guards, Mr Owshana and Mr Thavarajah, then assisted in restraining Domenic while he remained on the ground.

38. Mr Davidson was at Domenic's head, with his head hyper-extended in a head lock. Constable O'Meara was further down his back and Constable Brown further down his body again trying to restrain his legs. Mr Thavaragah and Mr Owshawa also assisted by restraining his legs.[28] Mr Davidson's evidence was that he also placed his full body weight on Domenic's torso during the course of executing the headlock. These events occurred in the period 00.43 - 00.45 hours.

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[24] Exhibit 26 - Statement of Nicole Jacobson dated 24 May 2010

[25] Exhibit 26 - Statement of Nicole Jacobson dated 24 May 2010

[26] Exhibit 14 - Statement Mr Scott Davidson dated 23 March 2010

[27] Exhibit 11 - Statement Constable Brendan O'Meara dated 23 March 2010

[28] Exhibit 11 - Statement Constable Brendan O'Meara dated 23 March 2010

39. Domenic was continuing to struggle and Constable O'Meara drew his baton and began striking Domenic in the shoulder blade area. Constable Brown says she extended her baton and began striking on his legs.[29]

40. Nurse Jacobson states that while Mr Davidson had Domenic in a headlock Domenic began choking. She twice told Mr Davidson that Domenic was choking, the second time telling him to "ease off the windpipe".[30] Nurse Jacobsen's evidence was that after the second request, Mr Davidson appeared to ease pressure upon the windpipe and she had no further concern regarding this matter.[31]

41. Constable Brown called for further police assistance at 00.45 hours. At this point the struggle was continuing. Constable O'Meara asked a nurse to retrieve his OC spray that had fallen to the floor. He again deployed OC spray to Domenic's face which also hit Mr Davidson's face. Around this time, Nurse Jacobson administered Haliperidol 2.5mg IM as directed by Dr Parry.[32] She reports that after administering this drug she inquired of those restraining Domenic whether he was breathing ok and that they responded that he was. Dr Teoh's evidence was that he continued to make observation of Domenic in the period up to the administration of the Haliperadol and that he had been breathing to that point. He did not further observe respiration after that time. Domenic ceased struggling shortly after the administration of the Haliperadol at 00.50 hours.

42. Constables Franco and Oats are recorded on the police mobile data terminal as arriving at 00.51 hours. When Constable Franco arrived he noticed a male who was face down, his head on the side, restrained on the floor and was not resisting.[33] His evidence was that he entered the emergency department within seconds of arrival at the hospital and his observations were made immediately he arrived. Constables Farley and Whiting are recorded on the mobile data terminal as arriving at 00.53 hours. Constable Whiting states that she also observed that Domenic was not moving.

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[29] Exhibit 10 - Statement Constable Kristy Brown dated 23 March 2010

[30] Exhibit 26 – Nurse Nicole Jacobson dated 24 May 2010

[31] Transcript page 409 and 416

[32] Exhibit 20 - Statement Dr Chris Parry dated 6 May 2010

[33] Exhibit 15 - Statement Constable Mark Franco dated 23 March 2010

43. Constable Franco was aware of the risk of positional asphyxia and his evidence was that he recognised that Domenic was somebody at risk of positional asphyxia and this influenced his management of the situation. His evidence was:[34]

> *"the better plan was to restrain him on a bed. The plan was to bring the bed as close as possible, lift him up, put him straight onto the bed and then put the shackles on him".*

44. In order to implement this plan he required the assistance of the additional police members Farley and Whiting. Constable Farley relieved the security guard Davidson who had been affected by OC spray. Constable Franco's evidence was that Domenic was not resisting, that he 'wasn't moving around' at this time.[35] He and Constable Franco put on gloves and masks as did Constables Farley and Whiting when they arrived and before they intervened. This process was described by the officers as occurring quite quickly after their arrival.

45. Whilst Domenic was no longer resisting Constable Franco was concerned that he may become violent again when restraint was eased. For this reason, he considered it was necessary to replace the security guard with Constable Farley at Domenic's head.

46. The police officers assisted in lifting Domenic back onto the bed. Constable Whiting observed that he was not breathing. Nurse Jacobson noticed he was cyanotic and unconscious and Constable Franco tried unsuccessfully to find a pulse.

47. Dr Chris Parry was notified and noted that he was cyanosed and in asystolic cardiac arrest.[36] Dr Parry's evidence was:

> *"Nicole requested that I review the patient at around 0100 because there was concern regarding his breathing. The patient was cyanosed in the face and not moving. The patient was immediately transferred to the bed and CPR was commenced because he was in asystolic cardiac arrest. Two boluses of adrenaline and one of atropine were administered. After securing an endotracheal tube the patient returned to spontaneous*

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[34] Transcript page 229.9

[35] Transcript page 231.10

[36] Exhibit 26 - Statement of Nurse Nicole Jacobson dated 24 May 2010

circulation after approximately 10 minutes and was transferred to intensive care after further stabilisation".

48. Dr Parry commenced CPR. Dr Shu Ooi, the senior doctor in charge of the night shift, took over as the team leader in the resuscitation and performed the intubation. At approximately 02.41 hours, a team of doctors from ICU assessed Domenic and organised CT scans. Domenic was transferred to the ICU at 04.30 hours.[37]

49. CT scans revealed global hypoxic brain injury. On 1 April 2012, following consultation with the family, treatment ceased. Domenic died on 2 April 2012 at 08.30 hours.

MECHANISM OF DEATH

50. Associate Professor David Ranson, forensic pathologist stated that the medical cause of death was *cardio-respiratory arrest in the setting of prone restraint of an agitated obese male with schizophrenia and coronary artery disease who had been sedated*[38]. However, he commented that the exact mechanism of death in the circumstances remains uncertain.

51. Dr Ranson reported upon his autopsy examination:[39]

> *"According to the information made available to me a number of individuals were involved in struggling with this person and at some point during the course of this event the person appeared to have suffered a cardiac or cardio-respiratory arrest. Such cardiac arrests can occur in a setting where individuals with a psychotic illness who are struggling violently are physically restrained in such a way that it impairs their chest movement and their ability to adequately breathe however evidence of asphyxia is usually not seen in this scenario."*

52. At the same time, the heightened physical activities in the setting of a psychological agitation may increase the individual's vulnerability to cardiac arrest as part of the development of a

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[37] Exhibit 19 - Statement of Dr Shu Haur Ooi dated 2010

[38] Exhibit 2 - Statement of Autopsy Report Associate Professor David Ranson dated 10 March 2011

[39] Ibid.

hyper-catacholinergic state and these scenarios may be compounded by the presence of sedating drugs.

53. Other possible mechanisms could include relative hypoxemia associated with the restraint environment and the obesity, physiological stress in a setting of coronary artery atherosclerosis and/or autonomic instability associated with schizophrenia.

54. Detailed dissection of the head and neck regions revealed no evidence of any superficial or deep bruising to the neck structures. There was no evidence of any damage to the thyroid cartilage or the hyoid bone and no evidence to indicate that the upper airway had been damaged or compromised as a result of direct external force to the neck.

55. Associate Professor Ranson commented that determination of an underlying medical cause of death in such a case is difficult from a pathologist's perspective. He stated that whilst it was clear that Domenic died of his cerebral ischaemic injury and bronco-pneumonia, this cause of death is generic and related to the time interval between the cardiac arrest (resuscitated) and his eventual death days later.

56. He commented that the key factors relating to the cause of the cardiac arrest and subsequent ischaemic cerebral injury included paranoid schizophrenia, agitation, physical activity (struggling with staff), sedating drugs, prone restraint, coronary artery atherosclerosis and obesity (BMI greater than 30).

57. He concluded that the exact mechanism of death in these circumstances remained uncertain and that he was unable to conclude on his examination that physical blows or use of capsicum spray directly caused the death although they could have been indirect factors contributing to agitation.

58. The autopsy revealed no evidence of indicia of asphyxia such as petechiae, however the pathologist stated that the period of time (10 days) which had elapsed between event and eventual death may have meant that resolved.[40]

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[40] Transcript page 48.10

ISSUES EXAMINED DURING THE COURSE OF THE INQUEST

59. The inquest examined the issue of the medical cause of Domenic's death in view of the forensic pathologist's advice that the mechanism was uncertain. Also examined were factors which may have contributed to the death of Domenic whilst he was in custody and care. Those matters were: the circumstances of his admission and management in the emergency department; the use of physical and chemical restraint in the emergency department setting; the circumstances in which Domenic came to escape the restraint; the use of force by police and security guards and the manner of restraint utilised,

60. I turn to consider each of these matters.

CIRCUMSTANCES OF ADMISSION TO THE EMERGENCY DEPARTMENT

61. The revocation of Domenic's RCTO necessitated his apprehension and return to an 'approved mental health service', in this case as has been seen, the emergency department of the Northern Hospital. The hospital shares a campus with the Northern Area Mental Health Service and it is submitted (and for my purposes in this inquest accepted) that the emergency department is a gazetted mental health service.

62. The appropriateness of placing a person with Domenic's history in a busy emergency department of a hospital while waiting for a bed in the appropriate approved mental health service is squarely raised by the circumstances of this case.

63. The revocation of the RCTO resulted in Domenic being apprehended on 22 March 2010. The apprehension was not timed to coincide with the availability of an appropriate psychiatric in-patient bed or in consideration as to where Domenic might most appropriately be returned.

64. The evidence of Associate Professor Sundrum was that the returning of an unstable psychiatric patient to a busy acute hospital emergency department was not an ideal method of management.[41] He accepted that it was likely that this would either cause or increase the level of agitation of the patient and that it was not surprising that Domenic reacted in the manner that he did.

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[41] Associate Professor Sundrum Transcript page 22, 25 and 35.21

65. This was also the evidence of emergency department specialist Dr Parry, who stated that he had worked in emergency departments in Australia and in the United Kingdom and that he had never seen a patient respond as Domenic had. This was because psychiatric patients were taken to psychiatric facilities and not generally dealt with in emergency departments.

66. His view was that it was not appropriate for psychiatric patients to be accommodated or managed in the emergency department. In his view, the fact that Domenic was brought to the emergency department and was managed in that location was largely responsible for the incident occurring at all.

67. Dr Parry stated:[42]

> *"I think my opinion of how this came all about is that Domenic was in the high end an environment where there's lots of stimulus, lots going on, lots of commotion, lots of other - you know, the police, other patients which heighten the situation. I think in an environment where he minimal stimulus, he would be given appropriate anti-psychotics and sedatives, I strongly feel that this would have all been avoided."*

68. His evidence was that it was the environment which triggered Domenic's response and that ready access to a psychiatric unit would be desirable.

69. Senior Sergeant Andrew Miles, an experienced Victoria Police officer responsible for the delivery of police operational training and tactical support, also gave evidence that his experience of emergency departments and the environment was that they were inappropriate places to attempt to safely detain mental health patients. He explained that this was partly because of the environs, including confined cubicle space, many unfixed objects which have the potential to make restraint difficult or to be used as weapons or missiles and because the environment is one which overstimulates the mentally ill patient resulting in agitation and aggression. He described the emergency department environment as being 'rich with risk'. [43]

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[42] Dr Chris Parry Transcript page 315.23

[43] Senior Sergeant Miles Transcript page 251-252.10

USE OF PHYSICAL AND CHEMICAL RESTRAINTS

70. The appropriateness of the physical and chemical restraints used in the circumstances was considered. The evidence is that advice was given by mental health clinicians that Domenic required physical and chemical restraint. In these circumstances and after assessment of the patient an order was made for restraint by sedation and by physical means. Arrangements were put in place for one on one nursing care and supervision of the effects of the medication and the restraint. The evidence is that such restraint was necessary and appropriate having regard particularly to the location in which Domenic was being detained, that is, in the emergency department.

THE FORCE USED IN THE INCIDENT

71. The evidence is that Domenic was a large and very strong man. At the time of this incident he was enraged and extremely violent. He had escaped from the restraint and had overpowered the security guard and indicated he was intending to leave lawful custody.

72. In order to gain physical control it was necessary for a large number of police and security personnel to become involved. The evidence is that three security guards and two police officers struggled to gain control of Domenic over a period of approximately 15 minutes, prior to the arrival of additional police back up support.

73. Antipsychotic medication was administered at 21.15 hours when Domenic first arrived. After that time sedative medication was administered. The sedative medication which had been administered earlier in the evening was ineffective to sedate or to control Domenic. Further medication of this type during the course of the struggle was also not immediately effective.

74. The evidence suggests that during the course of the struggle to restrain Domenic, advice was sought from the psychiatric clinician, Nurse Edwards as to using antipsychotic drugs as an alternative to sedative drugs,[44] this advice and supervision not being immediately available in the emergency department. The evidence of psychiatric clinicians is that the use of antipsychotic medication was a more appropriate approach in Domenic's circumstances. This is evidence of the advisability of early specialist psychiatric management.

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[44] Exhibit 19 - Statement of Dr Shu Ooi dated 2010

75. It is possible that earlier intervention with additional anti psychotic medication may have resulted in earlier control of Domenic's violent behaviour and thus reduced the need for the level of physical intervention and restraint utilised or reduced the period of time in which it was required.

REMOVAL OF RESTRAINT BY THE ATTENDING NURSE

76. It is apparent that Nurse Jacobsen in caring for her patient made a clinical decision not to re-apply the leg restraints, which decision was informed by her concern to keep her patient calm, comfortable and with a view to preserving his dignity.

77. Nurse Vandenhurk's evidence was that Domenic was to be detained in the emergency department for at least 10 hours and that there was no guarantee that a bed would be able to be found the following day. In this context, her observation that it would be oppressive to keep a patient in restraint for such a long period of time would appear to be appropriate.

78. The decision by Nurse Jacobsen not to reapply the leg restraint was made on the basis of her observations of the demeanour of Domenic during the lengthy period she was caring for him. Whilst in retrospect the decision to move to partial restraint was inadvisable in view of the fact that he required significant escort to the toilet on the first occasion, it is not suggested by any clinician that Nurse Jacobsen failed to observe hospital procedure or protocol in deciding to move to a partial restraint environment.

79. It is apparent that the nursing care of a mentally ill patient is a difficult task in an emergency department and that the environment itself does not lend itself to forgiving an error of judgement as occurred in this case.

HEADLOCK AND ACTIONS OF THE SECURITY GUARD DAVIDSON

80. Whether obstruction of his airway during the course of the prone restraint and in particular during the period of neck hyperextension by headlock was a contributing factor is unclear. There was also the additional element of full body weight of the security guard and police officers on Domenic's torso which had the potential to compromise respiratory function.

81. It is apparent from the evidence that there was little understanding or appreciation of the issue of airways protection in the security officer Mr Davidson during the course of the struggle, a matter about which he had to be reminded by Nurse Jacobsen. I accept Nurse Jacobsen's evidence as to her observations in this regard and her verbal advice.

82. Whilst the forensic pathologist was reluctant to elevate the neck compression to having identifiably more significant weight with respect to the death because of the other complexities already taking place, his evidence was however that this type of restraint by headlock is always potentially lethal. Associate Professor Ranson stated:[45]

> *"What would be your view if that was - that type of action, that is a headlock was something that was being taught to security guards in their training?---Well, given - and I've given evidence on some of this sort of thing, and opinions before. I consider that neck pressure mechanisms are potentially lethal and I believe unless one - I suppose I would have to say that if a person was in an absolutely life threatening situation where you're prepared to and it's reasonable to use lethal force then I suppose they might have to be used but I would say that they should form no part of the otherwise physical restraint on an individual as they are potentially lethal."*

83. The evidence is that Domenic continued to struggle for some time after the obstruction to his airway during the course of the headlock was noted and resolved. Nurse Jacobsen's evidence was that his breathing improved after release, there was no evidence of stridor and Dr Teoh gave evidence that he was checking his vital signs throughout the struggle phase of the restraint.

84. Dr Teoh's evidence was that up until the arrival of the additional police back up, which arrived at 00.51 hours (and again at 00.53 hours), Domenic continued to struggle with intermittent periods of compliance. He stated that they then did again check for a respiratory response until after the back up police had donned personal protective equipment and were moving Domenic to the bed.

[45] Transcript page 59.15 and Transcript page 56.15.

85. In the period between police arrival to moving to the bed, a period of eight or nine minutes, Dr Teoh states that Domenic was not struggling and police reported that he was not moving. He did not resume struggling even when the lift commenced. It appears that Domenic was unresponsive for some time prior to being lifted onto the bed. By the time of the lift he was noted to be cyanotic.

VICTORIA POLICE POLICIES, PROCEDURES AND TRAINING IN RELATION TO RESTRAINT AND MANAGEMENT OF PSYCHIATRIC PATIENTS

86. Senior Sergeant Andrew Miles is responsible for the delivery of operational training to members of Victoria Police. It is apparent from his evidence that an extensive education and training program has been developed and delivered to Victoria Police members in relation to managing members of the community with mental health issues.

87. Police receive extensive training in relation to restraint and specifically in relation to the issue of positional asphyxia. It is apparent from Constable Franco's evidence that his training in relation to both safe restraint and managing mental health patients, together with his operational exposure to mental health patients was called into use by him in the decisions he made in relation to Domenic.

NORTHERN HEALTH POLICIES AND PROCEDURES IN RELATION TO RESTRAINT

88. Northern Health had adopted policies and procedures in relation to the use of chemical and mechanical restraint for patients being treated under the Mental Health Act and for those who do not fall under the Mental Health Act but require restraint.

89. The evidence is that at the time of this incident the policy was unclear as to the issue of removal of restraint in the emergency department and by whom it must be authorised.[46]

EXCITED DELIRIUM

90. During the course of this inquest there was some consideration of the relevance of a syndrome sometimes described as 'excited delirium' which has been the subject of some discussion and

[46] Exhibit 28 - Restraint Protocol Policy Northern Health as at 22 March 2010

debate in the scientific literature. I am not satisfied that the cause of death in this case can be attributed in this way.

91. It appears from the literature produced by Associate Professor Ranson[47] that there is ongoing debate as to the existence of this syndrome and the contribution of the particular physiological factors of an individual, as against the contribution of outside factors such as restraint leading to asphyxia. It appears that insofar as it exists, it exists as an accumulation of a number of factors which may differ from patient to patient and the particular circumstances.

92. Associate Professor Ranson was asked to comment upon this possibility and his evidence as to this matter was equivocal. He stated that he deliberately did not use that expression in relation to the cause of death in this case, as he had been unable to exclude a number of factors, including the effect of restraint upon respiration and cardio-respiratory functioning.

93. He stated that he considered the mechanism of death in this case as likely to have been related to a number of factors, any individual one of which he was unable to isolate. In answer to the proposition that that this was a case of 'excited delirium', Associate Professor Ranson's evidence was:

> *" I am resistant to the notion of using excited delirium as a natural explanation for a death that's occurred in a complex scenario involving the intervention of medical personnel, law enforcement personnel and so on..... Perhaps I should make a comment here. If we - I am not disagreeing with your proposition at all. My concern is that we do not use a syndromic label as excited delirium to, if you like, simply say this is a natural death. The setting in which excited delirium occurs does vary and there are different pathways to that fatal endpoint, but they often do involve the actions of third parties, chemicals, drugs, other behaviours and I think it is very pertinent to that pathway to death to consider those factors.*
>
> *Now what weight we give those factors, I can't say but I am resistant to the notion of using excited delirium as a natural explanation for a death that's occurred in a complex scenario involving the intervention of medical personnel, law enforcement personnel*

[47] Exhibit 5 – Restraint Asphyxiation in Excited Delirium – O'Halloran. American Journal of Forensic Medicine Pathology Volume 14-4 and Asphyxial Death During Prone Restraint Revisited. Ibid. Volume 21.

and so on. So with that rider then your - then I think your statement is entirely correct, that it may or may not have had a part to play in his death.

The reason I didn't in this particular case is as I've said before that this was complicated by other matters relating to the medical treatment issues and the long survival period with severe brain injury, making it much more difficult for me to exclude certain things that I would want to exclude before I used that diagnostic syndromic term. Psychological agitation may increase vulnerability to cardiac arrest as part of a psychotic state. People with a major psychiatric illness in psychotic states do have an increased risk of sudden death, not well understood and may be linked to underlying illness or medication."[48]

94. Associate Professor Ranson also commented that sedating medications could lead to respiratory depression, and that any form of major sedating drug has that potential.[49]

95. Associate Professor Ranson accepted the proposition that the combination of sedation, agitation, obesity and postural compromise by prone position with people on top of them, could lead to cardiac arrest. His evidence was however that in having regard to each of those elements he was unable to attribute the weight, which might be applied to any one of those factors.[50]

96. He also observed that there was a particular concern in relation to obese people in a face down situation, because the science establishes that obese people when face down may have a decreased ability to ventilate. He stated:[51] *Again, I cannot prove that was in existence here, again it is another factor that is possible. I cannot dissect out its relative weight."*

97. Associate Professor Ranson commented that multiple factors came together to result in the death in this case:

"Whatever the cause of death is, is it fair to say that the agitation and the various

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48 Transcript page 49.21

49 Transcript page 50.19.

50 Transcript page 51.10

[51] Transcript page 53.30

contributing factors that exacerbated that, do you consider that it is the agitation itself that contributed? Are you able to say that?---Well, I think I've set out the sort of multiplicity of processes that can come together to cause death, and this is a well-recognised phenomenon. They will probably, I suspect, be - have different elements that are of different evidential weight, if you like, in terms of their cause and mechanism, or their involvement with a cause of mechanisms, and that there are some situations where certainly agitation becomes a major part of that process and there will be others no doubt where there are situations where airway issues and respiration becomes more significant.

But we certainly believe that there's a possible cascade that a person has - gets into problems, gets into difficulties, there's more struggling, there's more applied forces to the individual, there's more applied chemical, physical, other forms of restraint and that can add into a process of a person going down a, if you like, a cascade to them having a potentially fatal outcome. And this is well understood in a variety of literatures, particularly forensic pathology and emergency medicine literature and obviously intervention points to try and prevent that deterioration are really important, but of course they occur in a very complex and sometimes a very difficult to manage set of circumstances."

98. Dr Ranson described the presence and combination of all of these factors as "Creating a pathway leading to death"[52] and expressed the opinion that the important factor in avoiding such deaths was to identify intervention points to try and prevent that deterioration. In this case I am satisfied that such an intervention point would include modifying the agitation by managing patients in an appropriate environment.

THE TIMING OF THE CARDIO-RESPIRATORY ARREST

99. As he was lifted to the bed, Constable Whiting who assisted the lift noted that Domenic was limp and did not appear to be breathing. Nurse Jacobsen alerted Dr Parry who stated he was 'cyanosed' and had 'arrested'. CPR commenced at 01.00 hours approximately nine minutes

[52] Transcript page 61

after he was observed by Senior Constable Franco to be no longer struggling. Circulation returned after 10 - 12 minutes of resuscitation efforts.

100. I am satisfied that it is likely that the cardio-respiratory arrest, which resulted in the hypoxic brain injury, coincided with the time Domenic was observed to cease struggling, which occurred some minutes before staff proceeded to lift him onto the trolley, whereupon they noticed he was not breathing, cyanotic and in arrest.

101. Whilst one possible explanation for the extended period in which he was not struggling is exhaustion or passivity, as opposed to loss of consciousness or cardio-respiratory arrest. However, the length of time in which no movement was observed suggests that this was not the case.

102. The timeline from the beginning of the restraint in prone position until the time he was first observed as no longer resisting is approximately eight minutes. He was first observed not to be struggling or moving by Senior Constable Franco who arrived at 00.51 hours shortly after their arrival. Following this observation when Domenic was not moving, the evidence is that in this period of time his respiration or conscious state were not observed.

WOULD EARLIER IDENTIFICATION OF COLLAPSE AND CPR ALTERED THE OUTCOME?

103. Associate Professor Ranson was unable to state whether earlier identification of arrest and intervention by CPR earlier than approximately eight minutes after the likely arrest would have made a difference to the outcome.

104. Whilst his evidence was that ideally in any situation earlier implementation of resuscitation, he distinguished the circumstances in this case with those of an unexpected arrest for example. In this case, he said there were a number of compounding factors which made it difficult to conclude that earlier intervention would have resulted in a better outcome. Associate Professor Ranson stated:

> *"Well obviously the earlier you recognise someone is in cardio-respiratory arrest so that you can reverse that achieve an output and achieve oxygenation, the better the outcome usually. This isn't the same situation though as somebody simply suffering a*

cardiac arrest due to a heart problem and collapsing in the street where we have defined protocols for resuscitation and again we know that speeding that process up achieves a far better outcome. This is a much more complicated scenario. So whilst it is attractive to say of course if you pick it up earlier this will lead to a better outcome. I don't know as a matter of fact I could say that here because we're dealing with so many other competing factors, but as a matter of generality I would say of course you want to get respiration and cardiac function back as soon as possible".[53]

THE DECISION TO REVOKE THE RCTO AND THE TIMING OF THE APPREHENSION.

105. As indicated in the proceeding I did not consider it necessary to review the appropriateness of the decision to revoke the RCTO and apprehend. The issue was the manner of the exercise of the power, not the exercise of the power itself.

106. The decision to revoke the order was made it appears on a non-urgent basis as a significant period of time elapsed before clinicians and police were arranged to attend at Domenic's home. Attendance at his premises occurred at 20.00 hours and Domenic was his bedroom with the lights out. The apprehension took place at a time planned to accommodate the availability of clinicians and police and could be described as a 'non-urgent' apprehension. There was no evidence of any immediate risk to public or family members at the time of the apprehension.

107. The management by both clinicians and Victoria Police members of the apprehension at Domenic's home and in the conveyance to hospital was appropriate and controlled. The evidence does however satisfy me that the apprehension of Domenic on that evening, absent the availability of an appropriate mental health in patient bed, meant that he was placed in an undesirable environment. This placement led to a heightening of his levels of anxiety and aggravation and resulted in his aggressive and violent behaviour.

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[53] Associate Professor Ranson – Transcript page 58.2

FINDINGS AS TO CAUSE AND CONTRIBUTION

108. I find that Domenic Chiodo died on 2 April 2010 and that the cause of his death was Cardio-respiratory arrest in the setting of prone restraint of an agitated obese male with schizophrenia and coronary artery disease who had been sedated.

109. I find that the level of chemical restraint utilised was in the circumstances necessary for the protection of staff and the public and that it was reasonable and appropriate.

110. I find that the level of force utilised in order to restrain Domenic was necessary for the protection of staff and the public. The evidence does not support a finding that the level of force was inappropriate or excessive.

111. I find that the force used during the course of the struggle together with the exertion by the resistance shown by Domenic was likely to have been a contributing factor to his collapse and cardio-respiratory arrest.

112. Whilst it cannot be entirely excluded as a factor, I am unable to be satisfied at the requisite level of certainty that the neck restraint of itself caused reduction of air supply such that the cardio-respiratory arrest was the result.

113. Whilst it cannot be entirely excluded as a factor, I am unable to be satisfied at the requisite level of certainty that the restraint in prone position with full body weight being placed on his torso of itself caused reduction of air supply such that cardio-respiratory arrest was the result.

114. I find that there were a number of factors, as discussed in these paragraphs 108 to 113 which in combination contributed to the cardio-respiratory arrest which combined to result in the cardio-respiratory arrest.

115. I find that the removal of full physical restraint and the reverting to partial restraint involving only the wrists, resulted in Domenic's attempt to escape lawful custody leading to the struggle and the removal of the full restraint was indirectly a contributing factor in his death.

116. The lack of availability of in-patient psychiatric mental health facility beds resulted in Domenic being managed in an entirely inappropriate environment for a man with a serious mental illness, indirectly contributed to the death.

117. I am satisfied that had Domenic been transferred immediately after apprehension to a properly resourced in-patient mental health facility rather than being temporarily managed in the emergency department cubicle, the psychiatric management in particular medication management was likely to have been different, his response was likely to have been different, and the death would likely have been prevented.

118. I find that the lack of availability of public mental health in-patient beds on the evening of 22 March 2010 was indirectly a contributing factor to the death.

COMMENTS

I make the following comments connected with the death pursuant to s67(3) of the Coroners Act 2008.

119. It is appropriate to note that this man was a mental health patient, albeit with an extensive forensic history. The decision to revoke and apprehend him on 22 March 2010 was made upon mental health grounds. He was not in custody because of any further criminal activity or wrongdoing. Domenic was an unwell mental health patient made additionally unstable because of his non-compliance with medication, a consistent issue with this type of patient. His behaviour and responses on the day of the incident were generated by his illness and must be understood and responded to in that context.

120. When viewed in this way his management in an emergency department cubicle with little specialist mental health assistance and little or no privacy was an unfortunate state of affairs.

121. The evidence of the nursing and medical staff suggests that the system is overwhelmed by the numbers of mental health cases required to be managed in public hospital emergency departments. The evidence is that these facilities are not designed for mental health patients in crisis and that the environs are not designed, nor equipped to accommodate such patients safely, securely and with dignity.

122. In this case, there was no reason for Domenic to be admitted to the emergency department other than that there was no mental health service in-patient bed available in which to place him.

123. In the absence of a sound medical reason for admission to an emergency department, care of mental health patients requiring admission should be delivered in appropriately designed and staffed in-patient mental health facilities.

124. Additional mental health in-patient beds are required to enable public mental health services to deliver safe and effective mental health care and to protect the staff and patients at the health services from violent and dangerous behaviour.

125. It was apparent from the evidence that the security guard Mr Davidson had little insight into the complicated issues relating to management of mental health patients and in particular prone position airway protection. This is a matter about which Victoria Police officers are well trained and informed.

126. The evidence satisfied me that there is a lack of appropriate training of security personnel in this area and in the context of hospital security guards who are often dealing with psychiatrically ill patients, more extensive and specific training is desirable.

127. Domenic was not served well by the regulatory or mental health service regime on the day of his apprehension.

128. An incident review recommended that a new and discrete area be constructed for the admission of psychiatric patients at the hospital emergency department. Construction was scheduled to commence in August 2012 to transform the existing resuscitation rooms (including that room in which Domenic was located) for such purposes.

129. Whilst purpose designed facilities are desirable, on a cursory view of the proposal, the location of the room suffers from the same problem which attenuated Domenic's management at that location. That is, immediately inside the doors from the ambulance bay entry, high traffic area, high noise area, highly stimulating environment and located in an emergency department.

130. The hospital policies in relation to physical restraint have been reviewed in light of this incident and amended to provide for clarity as to the circumstances in which restraint may be removed and the authority required to be sought in making the decision to remove restraint. This now includes a directive that a medical officer must authorise removal and that the decision is one as to restraint or no requirement for restraint and in the event that there is a requirement for restraint it must include arms and leg restraint.[54]

131. The hospital has also reviewed its published clinical guidelines in relation to chemical restraint in the emergency department setting.[55] These guidelines appear to be directed to circumstances where the patient requires assessment for possible medical issues.

132. They are comprehensive guidelines directed to assist emergency department staff when responding to and managing patients who are violent as a result of drug use or alcohol intoxication or as a result of a psychiatric illness, at a point where unlike in Domenic's case, diagnosis has not been made, the cause of the behaviour is unclear and medical management of some type is required.

133. Victoria Police also advised that they are working in conjunction with the area mental health service to develop a tripartite proposal for a new service model for mental health services in the Northern and North West area mental health service, Northern Health and Victoria Police North West Metro Region.

134. One of the proposed elements of this model will be that psychiatric patients will be admitted directly to the Northern Corridor psychiatric units, upon the principle that clients should not be admitted to emergency departments unless there is a compelling clinical reason to do so. The status of this proposal is at this time unclear.

135. It is apparent that the health services have attempted to respond to the events of this incident within the confines of the resources available.

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[54] Exhibit 36 - Email Northern Heath Emergency services, police advice dated 3 September 2012 **(SUPRESSION ORDER APPLIES)**

[55] Exhibit 37- Northern Health Chemical and restraint reviewed policy dated July 2012

RECOMMENDATIONS

I make the following recommendation(s) connected with the death pursuant to s72(2) of the Coroners Act 2008:

136. That upon revocation of mental health community treatment orders, that the patient be transferred to a dedicated mental health facility in-patient unit and that they not be admitted to acute hospital emergency departments unless there are sound medical reasons for such admission.

137. That the timing of apprehension of patients pursuant to a revoked community treatment order be determined (where possible having regard to the urgency of the apprehension) by reference to the availability of in-patient mental health beds.

138. That additional in-patient mental health beds be made available to the public mental health system in Victoria, which include safe and secure assessment facilities to which a mental health patient may be taken for assessment when an order is revoked.

139. That insofar as there continues to be a requirement to receive mental health patients in emergency departments that training modules of the type delivered to Victoria Police in relation to management of mental health patients, including restraint and safety in managing airways in prone positions, be delivered to hospital security staff.

140. I direct that a copy of these findings be provided to the family of Mr Domenic Chiodo, the Interested Parties; The Honourable Mr David Davis MLC, Minister for Health (Victoria); The Office of the Chief Psychiatrist; The Secretary, Department of Health (Victoria); The Chief Commissioner Victoria Police.

Signature:

CORONER PARKINSON
Date: 22 February 2013