IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: 2015 5722

**FINDING INTO DEATH WITH INQUEST**

*Form 37 Rule 60(1)*

*Section 67 of the* ***Coroners Act 2008***

Amended pursuant to *Section 76 of the Coroners Act 2008* on 2 July 2019[1]

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| **Inquest into the Death of:** | Trajce Laboski |
| Delivered On: | 26 June 2019 |
| Delivered At: | 65 Kavanagh Street<br>Southbank 3006 |
| Hearing Dates: | 19 & 20 September 2018 |
| Findings of: | Acting State Coroner Caitlin English |
| Representation: | Ms D Foy of Counsel<br>Instructed by Ms J Moffatt of DTCH Lawyers<br>For North Western Mental Health, Melbourne Health |

[1] This document is an amended version of the Inquest Finding into Trajce Laboski's death dated 26 June 2019. A correction to paragraph 16 has been made pursuant to Section 76 of the *Coroners Act 2008* (Vic) In an email dated 27 June 2019, John Snowdon Chief Legal Officer at Northern Health advised the Court that the reference to 2.40pm in paragraph 16 of the Finding was in fact 2.40am. Paragraph 16 has been amended to reflect this correction.

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| | Ms N Hodgson of Counsel<br>Instructed by Mr J Snowdon of General Counsel<br>For Northern Health |
| | Ms A Wood of Counsel<br>Instructed by Ms L Rimon of Henry Carus & Associates<br>For Mr Laboski's family |
| | Ms E Gardiner of Counsel<br>Instructed by Ms J Gibbs of VGSO<br>For Victoria Police |
| | Ms A McTiernan of Counsel<br>Instructed by Mr M Temminghoff of Slater & Gordon<br>For Ms Christine Baker |
| Police Coronial Support Unit: | Acting Sergeant Sonia Reed |
| Counsel Assisting the Coroner: | Ms Sarah Gebert, Principal In-House Solicitor |

I, Caitlin English, Acting State Coroner having investigated the death of Trajce Laboski

AND having held an inquest in relation to this death on 19 and 20 September 2018
at Melbourne
find that the identity of the deceased was Trajce Laboski
born on 26 September 1988
and the death occurred on 10 November 2015
at 185 Cooper Street, Epping, Victoria
from:

I (a) Injuries sustained in descent from height

**in the following circumstances:**

**Background & chronology**

1. Trajce Laboski was a 27-year-old man at the time of his death. He lived in Epping with his parents.

2. Mr Laboski had a history of illicit drug use, namely cannabis and methamphetamines, which had had a negative effect on his mental health.

3. He had been admitted to the Northern Hospital on several occasions between 2010 and 2014. He was diagnosed with schizophrenia and was on prescribed medication.

4. In the twelve months preceding his death, Mr Laboski was living with his parents, had stopped taking drugs and had completed a metal fabrication course.

**Apprehension under Section 351 of the *Mental Health Act 2014***

5. On 9 November 2015 Mr Laboski caught up with a friend in St Kilda and returned home around 7pm.

6. His father described him as being agitated and withdrawn when he returned. Mr Laboski called a psychic hotline and shortly after this call, injected himself with testosterone, threatening suicide to his father.

7. At about 10.00pm, his father called 000 and police attended. Mr Laboski told them he had taken the testosterone and that he hoped to slip into a coma and die.

8. Police apprehended him under s 351 of the *Mental Health Act* (2014) and requested an ambulance.

9. Owing to the unavailability of an ambulance, police transported Mr Laboski to the Northern Hospital.

**Emergency Department at Northern Hospital**

10. At 11.25pm police arrived at the Northern Hospital with Mr Laboski. Mr Laboski was seen by Emergency Department Registrar Dr Rashmi Kumble.

11. Dr Kumble assessed his medical condition and performed a psychiatric risk assessment. She determined Mr Laboski required a psychiatric admission. Mr Laboski was transferred to the care of the hospital and police members were cleared to leave.

12. At 12.30 am on 10 November 2015 a notification was made to the emergency department mental health nurse for urgent review. Mr Laboski was moved to the pink internal waiting room where he sat with his father.

13. At 2am Nurse Christine Baker from the Clinical Assessment Team attended the Emergency Department to conduct an assessment with Mr Laboski.

14. Ms Baker requested the Associate Nurse Unit Manager Salima Matthew for a supervised blue or purple pod. As neither were available, Ms Baker agreed to start the assessment in a pink pod.

15. Ms Baker concluded Mr Laboski required hospitalisation for treatment and commenced the paperwork for him to be placed on an assessment order.

16. Prior to the paperwork for admission being completed, at around 2.40am Mr Laboski left the pod and exited the hospital through the main emergency entrance.

17. His father, and Ms Baker followed him a short time later but were unable to locate him.

18. Ms Baker returned to the hospital and called a Code Grey. Hospital security conducted a short search in the immediate area out the Emergency Department. Ms Baker called 000 to report Mr Laboski as a missing person.

**Notification to police**

19. The 000 was made to Epping police station. First Constable Monica Allen contacted Ms Baker to obtain the details about Mr Laboski being missing.

20. A missing person report was recorded and the duty patrol supervisor was notified. A police unit was tasked to patrol and attend Mr Laboski's address to establish if he had returned home.

21. At approximately 6am First Constable Allen was notified by the Mill Park Divisional van that Mr Laboski had not returned home and that there were no results from searches of the nearby area.

**Discovery**

22. At around 7.05am on 10 November 2015, James Kalinchev was at the Northern Hospital expansion project site where he worked as a plumber. As he was walking on the site, he noticed '*...a person lying face down on the ground ... wearing a blue hoodie, with the hood pulled up over his head and black track pants*'.[2]

23. Mr Kalinchev and site manager John Guerrero attempted to wake the person, then realised that he was not breathing. Mr Guerrero contacted emergency services.[3]

24. Police arrived at around 7.15am. They noted that the person matched the description of Mr Laboski which had been given to police after he left Northern Hospital earlier that morning.[4]

25. A positive identification of Mr Labovski was subsequently made. Police informed Mr Labovski's father that he was deceased.[5]

**Identification**

26. On 12 November 2015 Svetozar Laboski visually identified his son, Trajce Laboski, born 26 September 1988.

**Cause of death**

27. On 12 November 2015, Dr Jacqueline Lee, a Forensic Pathologist practising at the Victorian Institute of Forensic Medicine, conducted an inspection of Mr Laboski's body and provided a written report, dated 13 November 2015. In her report, Dr Lee concluded that a reasonable cause of death was '*I(a) Consistent with injuries sustained in descent from height*'.

28. Toxicological analysis identified the presence of the benzodiazepines diazepam and nordiazepam as well as the antipsychotics hydroxyrisperidone and olanzapine.

29. Testing was also performed for testosterone. The level found was greater than 120.0 nmol/L, while the expected reference range for testosterone levels is between 8.3 and 30.2 nmol/L.

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[2] Coronial Brief (CB) 92
[3] CB 92, 95
[4] CB 112
[5] CB 113

**Coronial investigation**

30. Mr Laboski's death was reported to the coroner as it appeared to be unnatural and to have resulted, directly or indirectly, from an accident or injury and came within the definition of a reportable death in section 4 of the *Coroners Act* 2008.

31. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

32. The Coroner's Investigator prepared a coronial brief in this matter.

**Coroners Prevention Unit**

33. I requested the Coroners Prevention Unit[6] (CPU) to review Mr Laboski's medical management at the Northern Hospital.

**Mandatory Inquest**

34. As Mr Laboski left the Northern Hospital prior to his assessment being completed by Ms Baker, his legal status as a patient was unclear. If he was an involuntary or compulsory patient under the *Mental Health Act* 2014 then an Inquest is mandatory pursuant to section 52(2) of the *Coroners Act* 2008.

35. As Mr Laboski's legal status at the time of his death was in issue as to whether or not he was an involuntary patient, I decided to hold an inquest to explore this issue as well as Mr Laboski's care and management at the Northern Hospital.

**Direction Hearings**

36. Four directions hearings were held on 14 December 2017, 22 June 2018, 27 July 2018 and 12 September 2018. The purpose of the direction hearings was to determine the scope and witnesses to be called at the inquest. On 12 September 2018 I delivered a ruling granting

[6] The Coroners Prevention Unit (CPU) was established in 2008 to strengthen the prevention role of the coroner. The unit assists the Coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations. The CPU also reviews medical care and treatment in cases referred by the coroner. The CPU is comprised of health professionals with training in a range of areas including medicine, nursing, public health and mental health.

Christine Baker's application to be excused from attending the inquest and being called as a witness. I granted the application for Ms Baker to be legally represented at the inquest.

**Scope of Inquest**

37. The scope of the inquest was as follows:

    1. The interactions of Nurse Baker with Mr Laboski at the Northern Hospital on 10 November 2015;
    2. Mr Laboski's treatment at Northern Hospital, in particular:
        a. His legal status at the time of his death;
        b. Pod allocation
        c. Whether an assessment order under section 30 of the *Mental Health Act* (2014) could have been made by Dr Kumble and if so, why it was not.
    3. The co-delivery of psychiatric services by North Western Mental Health, a division of Melbourne Health, within Northern Hospital;
    4. The Northern Health construction site where Mr Laboski was found deceased;
    5. Changes to policy and procedure by both North Western Mental Health and Northern Hospital since Mr Laboski's death;
    6. Further prevention opportunities.

38. Prior to evidence being called, the Northern Health conceded it was inappropriate for Mr Laboski to have been placed in an unstaffed pink pod when he was assessed by Christine Baker and that should not have occurred.

39. Northern Health also conceded that the pallets stacked by the fence adjacent to the construction site should not have been left there.

**Inquest**

40. The inquest was held on 19 and 20 September 2018. Six witnesses gave evidence. Following the evidence, the parties exchanged submissions and legal argument was heard on 24 October 2018.

41. In this finding I intend to consider the evidence in the context of the scope. I have re-arranged the order of issues in the scope to fit a linear narrative.

42. With respect to scope items 1 and 2, I have considered these in chronological order, namely Dr Kumble's assessment of Mr Laboski, pod allocation, Mr Laboski's interactions with Christine Baker, and Mr Laboski's legal status following this at the time of his death.

43. Item 3 of the scope, namely the co-delivery of psychiatric services by North Western Mental Health, a division of Melbourne Health within Northern Hospital, provides the background context to the provision and division of medical and mental health services to patients at the Northern Hospital.

44. In 2014-2015 the Northern Hospital Emergency Department (NHED) had approximately 70 000 presentations. Mental health services are co-located within Northern Hospital but are provided to patients by North Western Mental Health (NWMH) staff who are employed by Melbourne Health, not Northern Health.

45. The policy and practice in the NHED is for Northern Health staff medically triage and medically assess mental health patients and make a referral to the Emergency Mental Health Clinician (EMHC) from NWMH to perform a mental health assessment.

46. The evidence at inquest sought to clarify the effectiveness of operational policies and guidelines that distinguish between care, management and security (the responsibility of NHED) and the mental health treatment (responsibility of NWMH) across the two healthcare organisations.

**Mr Laboski's treatment at Northern Hospital:**

- **Whether Dr Kumble could have assessed Mr Laboski under section 30 of the Mental Health Act 2014**

47. On 9 November 2015, Victoria Police transported Mr Laboski to NHED at 11.15pm.

48. Following his arrival, Mr Laboski was triaged by Nurse Anna Gibson at 11.37pm.

49. At midnight, Mr Laboski was medically assessed by Dr Rashmi Kumble in a purple pod [7] (a staffed pod) within the Emergency Department. Dr Kumble completed pathology screening and ECG to rule out any medical concerns from the 8 mg of testosterone he had injected.

50. In her statement, Dr Kumble stated:

> '*During my interview with Mr Laboski, I concentrated on the physical implications from the medication injected and also performed a psychiatric risk assessment.*' [8]

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[7] Exhibit 10
[8] Exhibit 10

51. After satisfying herself that Mr Laboski had no symptoms from the testosterone, Dr Kumble determined:

*'Mr Laboski needed psychiatric admission as he had no insight and has symptoms of psychosis secondary to his schizophrenia. He was not aggressive and not demonstrating signs of absconding accordingly I felt comfortable admitting him to hospital, and that it was appropriate to release the police.'* [9]

52. At 12.30am Dr Kumble made a referral to EMHC,

*'...for an urgent review, describing Mr Laboski's presentation and that he had been medically cleared and needed inpatient psychiatric admission due to his poor insight and psychotic symptoms.'* [10]

53. As one of the issues in scope for the inquest was whether Dr Kumble could have made a section 30 assessment order, Dr Kumble made a further statement and explained,

*'...in 2015, it was not general practice for Northern Hospital medical practitioners working in the [Emergency] Department to make Assessment orders in respect of patients arriving in police custody under section 351...exception...[being] patients [who] appeared to present a serious and imminent danger to themselves...'* [11]

54. In evidence Dr Kumble clarified she ensured Mr Laboski was medically safe and performed a *'brief'* psychiatric assessment. [12]

55. Dr Kumble clarified that whilst she formed the view Mr Laboski required psychiatric admission, that was best done by a mental health clinician, *'who could do it in a formal way and in a comprehensive way and assess whether he met the criteria for s. 29 and then make an assessment order.'* [13] *'The mental health clinicians usually make assessment orders and they're better versed with it than junior doctors.'* [14]

56. Dr Kumble confirmed she had never previously performed a section 30 assessment.

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[9] Exhibit 10
[10] Exhibit 10
[11] Exhibit 11
[12] T 106
[13] T 110
[14] T 115

57. She also advised Mr Laboski he would need to stay for '*further assessment*' but did not mention to him this would be by the EMHC. [15] She also indicated she knew from Mr Laboski that he did not want to be admitted to hospital. [16]

58. In cross examination by Ms Wood, Dr Kumble confirmed she spoke by telephone with Christine Baker, EMHC. She stated:

'*...so we discussed Tracje's presentation and that I've medically cleared him and...the fact that he was having hallucinations, was happy to stay for an assessment but did not want to be admitted.*' [17]

59. Dr Kumble confirmed she assessed Mr Laboski in a purple pod, and later saw him sitting with his father in the pink waiting room and did not have any concerns he would leave the hospital.[18]

60. Dr Dean Pritchard, the Deputy Director of Northern Hospital ED explained the junior medical staff see the patients according to their triage urgency and are required to perform a medical assessment as well as a basic psychiatric assessment. This is a mental state examination as well as a risk assessment. [19] They then discuss their assessment with a registrar, a more senior doctor on the floor.

61. In the hypothetical example of a patient who was an imminent risk to themselves, Dr Pritchard stated: '*I would expect our junior HMO's to escalate to a senior doctor. I wouldn't expect our junior HMO's to enact the Mental Health Act, as it has significant ramifications for the patient, but immediate escalation to a senior clinician.*' [20]

62. When asked whether there was ever an occasion when a doctor might make an assessment order, Dr Pritchard volunteered that he had made one himself and described circumstances of '*...evidence of acute violence and aggression and physically attempting to leave...*' [21]

63. He acknowledged Dr Kumble had the legal power to make a section 30 assessment order if the circumstances of a particular case met the 'practice' stipulated by Northern Hospital, and in his view she should also escalate the matter with senior staff.

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[15] T 112
[16] T 118
[17] T 121
[18] T 129
[19] T 243
[20] T 245
[21] T 263

**Analysis**

64. Dr Kumble accepted responsibility for the treatment and security of Mr Laboski from Victoria Police. When Dr Kumble told the police Mr Laboski was being '*admitted*' to hospital it is clear she meant '*to the emergency department and basically taking hand over from the police to the emergency department.*' [22]

65. It is not clear what processes were in place in Northern Hospital Emergency Department for a patient awaiting a mental health assessment, with respect to who has responsibility for ensuring their care and safety whilst awaiting a mental health assessment.

66. One aspect of this is the Northern Hospital 'practice' whereby a Northern Health doctor would only enact the Mental Health Act or conduct a section 30 assessment if a patient was '*aggressive, agitated and seeking to leave.*' [23]

67. Dr Kumble followed Northern Hospital practice whereby she completed a medical assessment and a brief mental or risk assessment. As Mr Laboski was not agitated or seeking to leave, or a 'danger to himself', Dr Kumble did not seek to conduct an assessment under section 30 of the Mental Health Act. Mr Laboski was willing to remain for '*further assessment.*'

68. Dr Kumble's actions were in accordance with Northern Hospital practice.

69. Although Dr Kumble's brief mental health assessment of Mr Laboski's presentation was that he should be admitted as an involuntary patient, he did not meet the hospital's criteria whereby his behaviour (an imminent danger to himself or others) warranted Dr Kumble assessing him such to make an assessment order under the Mental Health Act.

70. Northern Health submitted as Mr Laboski was calm and co-operative whilst waiting therefore any action by Dr Kumble to make an involuntary assessment order under section 30 would have been contrary to section 29 and therefore unlawful, as he was not an imminent danger to himself or others. '*Put simply, while he was waiting to remain for further assessment (to be undertaken by an EMHC in accordance with ED protocol), Trajce did not meet the criteria for involuntary treatment or detention.*' [24]

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[22] T 108
[23] Submissions Transcript, 24 October 2018 p 16
[24] Submission on behalf of Northern Health dated 5 October 2018 p 5

71. I do not accept this argument. Dr Kumble had determined he '*needed psychiatric admission*'[25] '*due to his poor insight and psychotic symptoms*'[26] and was empowered to make an assessment order but for the Northern Hospital practice which was to wait for an assessment by an EMHC. The evidence is that Mr Laboski was calm during his assessment by Ms Baker who decided he met the criteria for involuntary admission and quickly came to opinion he was *'acutely psychotic'* [27]. I am of the view it was on the basis of the practice of Northern Hospital that Dr Kumble did not proceed with a section 30 assessment rather than that the circumstances were not warranted under the Mental Health Act.

72. The practice of the Northern Hospital in the Emergency Department, is that a mental health assessment is made by an EMHC. It was Dr Pritchard's evidence that junior medical staff, if contemplating a section 30 assessment, should seek advice from senior medical staff if the circumstances warrant it.

73. In counsel's submissions on behalf of NWMH she contended that '*what happened at North Western Mental Health is exactly what would have happened at any hospital with an emergency department and a mental health service.*' [28] The difference between the emergency mental health clinician and the registered medical practitioner in ED is one of *'skill and training…'*

'*The mental health clinician is skilled and trained in undertaking mental health assessments, they are bound by particular policies, protocols, practice guidelines, training and knowledge to undertake a proper adequate and thorough mental health assessment.*

*When medical practitioners speak of mental health assessments, they are usually doing a short series of questions, whereas a mental health clinician has been trained to ask a variety of questions in particular ways. And the practice is simply no different to the practice in any public mental health service...*' [29]

74. In submissions on behalf of Ms Baker, counsel noted '*Dr Kumble ..could have completed the Section 30 – involuntary patient admission, but didn't, notwithstanding the fact that the emergency department was overburdened, with between 70-78 patients ...and understaffed...There was no other emergency mental health practitioner to assist [Ms] Baker in the work load that night, which included another four or five patients who had been*

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[25] CB 23
[26] Exhibit 10
[27] CB 20
[28] Submissions Transcript, 24 October 2018 p 31
[29] Submissions Transcript, 24 October 2018 p 31

*apprehended pursuant to section 351 of the Mental Health Act. There was no Supervisor on duty, for [Ms] Baker to 'escalate up the channels' that she needed assistance.'* [30]

75. Section 28(1) of the Mental Health Act provides: '*An Assessment Order is an Order made by a registered medical practitioner or mental health practitioner …*'

76. I find Dr Kumble had the power to make a section 30 Assessment Order for Mr Laboski but did not do so because of the Northern Hospital practice whereby assessments are only carried out by doctors in extreme circumstances where people represent an imminent danger to themselves or others.

77. A series of decisions were made by staff and Mr Laboski's father to keep information from Mr Laboski so he would not abscond. They chose to omit information that he was waiting to be assessed by an EMHC because they were aware of the potential consequences (ie, that he might leave). Northern Hospital cannot logically contend that Mr Laboski was '*compliant*' and therefore not within section 29 of the Mental Health Act when his compliance was solely due to this pretext.

78. It does not appear there was a treatment plan for Mr Laboski other than for him to wait to be assessed by the EMHC: this was in accordance with Northern Hospital practice which, rather than being patient centred care, prioritised the hospital processes over the needs of the patient.

79. The advice from the Chief Psychiatrist states:

'*Once a hospital accepts the care of a person under section 351, they have an obligation to take reasonable steps to arrange for the person to be examined as soon as possible, in accordance with section 30 of the Act.*' [31]

80. I find that the hospital had a duty to keep Mr Laboski safe whilst waiting for that assessment, which I will consider in the following section which considers pod allocation.

- **Pod allocation**

81. The second aspect with respect to who has responsibility for ensuring Mr Laboski's care and safety whilst awaiting a mental health assessment concerned his movement around the ED and pod allocation.

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[30] Amended submissions on behalf of Christine Baker dated 3 October 2018, p14
[31] CB 59

82. When Mr Laboski was brought to the Northern Hospital by police, he was initially triaged by Nurse Anna Gibb.

83. He was then seen by Dr Kumble in a purple pod for triage where he was medically assessed, tests taken, as well as a brief mental health assessment.

84. Following this he and his father waited for the 'further assessment' in the pink internal waiting room.

85. He was then assessed by Christine Baker in an unstaffed pink pod for a mental health assessment.

86. The chronology and decision making following his assessment by Dr Kumble is relevant to the scope of the inquest.

87. Evidence was given that the evening of 9 November 2015 was one of the busiest nights ever experienced at the Northern Hospital Emergency Department. At the beginning of the night shift, there were 26 patients waiting to be seen, and a total of 78 patients in the Emergency Department.

88. There were 38 staffed pods. On a normal ratio, this means one allocated nurse to every 3 pods. There are also unstaffed pods, which means there is no nurse dedicated to the patient in that pod. The blue pod area is for high acuity patients with complex needs.

89. In addition to Mr Laboski, there were three other patients who had been brought in by Victoria Police pursuant to section 351 of the Mental Health Act, who were also awaiting a mental health assessment.

90. Dr Kumble noted that shortly after finishing her assessment of Mr Laboski, she noticed him and his father '*sitting in the purple pod waiting room within the ED.*'[32]

91. Salimma Mathew was the Associate Nurse Unit Manager (ANUM) on shift in the Northern Hospital Emergency Department on 9-10 November 2015.

92. In her statement she states on 9 November 2015 Mr Laboski was placed straight in cubicle purple 34 where he was assessed by the triage nurse, as every bed in the blue pod was occupied.[33] In her evidence she stated:

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[32] T 110
[33] Exhibit 13

*'Normally we do the triage and move them to the cubicle. This particular time, because he was 351 and with the suspicion of steroid injection, I was alarmed. And I said, let's take him to the cubicle, do the assessment there.'* [34]

93. At around 12.30 am she stated she had a discussion with Dr Kumble about Mr Laboski being allowed outside for a cigarette and she went to check on him. *'He appeared settled and calm and I agreed that he could go and have a cigarette.'* [35]

94. Ms Matthew stated that due to high demand and following discussion with Dr Kumble, she moved Mr Laboski to the pink discharge waiting area. Dr Kumble, in her evidence, could not recall being consulted about this.

95. In her evidence Ms Matthew stated that if Dr Kumble thought Mr Laboski was well enough to go outside for a cigarette she made the decision to move him back to the waiting room.

*'So I have decided if Dr Kumble thought he was safe enough to go [for a cigarette], then he's safe enough to sit in a waiting area, where he can sit with the dad. Where I can utilise this cubicle for an acutely medically unwell patient...it was like playing chess...'* [36]

96. Mr Laboski was waiting in the pink waiting room with his father. In this space Mr Laboski and his father had what Ms Mathews described as 'nice chairs' and as the space was outside the nurses station she stated *'...and I can actually view them directly from here [from] time to time.'* [37]

97. Ms Matthew stated that at about 2am, Christine Baker, EMHC *'...arrived and requested provision of a cubicle so that she could assess Mr Laboski in a more private and appropriate environment.'* [38]

98. Ms Matthew stated: *'At this point I had no cubicle free so I asked the EMHC to take Mr Laboski to one of the cubicles in the pink pod. The clinician was not enthusiastic about this...Unfortunately the pink pod cubicles were not staffed at that time.'* [39]

99. Ms Matthew stated Ms Baker asked for a *'nurse to cubicle'* and stated, *'Mr Laboski might need an admission.'* [40]

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[34] T 140
[35] Exhibit 13
[36] T 143
[37] T 144
[38] Exhibit 13
[39] Exhibit 13
[40] T 144

100. Counsel for Ms Baker noted that the far from being a low stimulus area, the pod allocated was next to the ambulance entrance, and across the corridor from the internal waiting area. [41]

101. Ms Matthew explained that she asked the clinician to start her interview in the pink pod, and said '*...go ahead with the interview, meanwhile I will try and arrange a cubicle for you. That's how she took Mr Laboski to pink area, one of the cubicles.*'[42]

102. On this basis, Ms Baker took Mr Laboski to a pink cubicle. [43]

103. Ms Matthew confirmed in evidence Ms Baker was unhappy about having to assess Mr Laboski in a pink pod. [44]

104. In the meantime, Ms Matthew moved a patient out of purple 33 to the green pod to make space for Mr Laboski. She then heard a Code Grey. She went to the front desk for details and was told by Ms Baker '*...that Mr Laboski had run out of the interview while she was interviewing him in the presence of his father.*' [45]

**Analysis**

105. Ms Matthew, as NHED ANUM was in charge of bed and pod allocation in ED.

106. The issues raised by Mr Laboski's family were that his movement around the NHED were unacceptable and further, queried why Ms Baker proceeded with the assessment in the pink pod, and why were there no arrangements to secure the environment. [46]

107. Ms Mathew was asked about the expected response time for an EMHC to assess a patient. Ms Mathew stated: '*...It is up to the mental health technician what time they come down. We have no control over them...*' [47] When asked what was a '*reasonable*' time within which to expect an assessment Ms Mathew stated '*Sometimes they will be waiting all night. Sometimes within [a] couple of hours.*' [48]

108. It was Ms Mathews stated, when asked whether there were enough mental health practitioners on duty that night, '*We normally have one... It was not enough.*' [49]

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[41] Amended submissions on behalf of Christine Baker dated 3 October 2018, p11
[42] T 145
[43] T 145
[44] T 170
[45] Exhibit 13
[46] Submissions on behalf of the family dated 5 October 2018 pp 4 & 6
[47] T 169
[48] T 169
[49] T 174-5

109. On night shift there was no-one to supervise the EMHC. [50]

110. When asked whether she considered asking Ms Baker to wait until a staffed pod or a bed was ready for Mr Laboski, Ms Mathew stated she did not want to risk that Ms Baker would say she will go and assess another patient and '*I'd have to wait another half an hour or one hour.*'[51]

111. Northern Hospital has conceded it was inappropriate for Mr Laboski to have been assessed by Ms Baker in a pink pod.

112. Counsel for North Western Mental Health submitted Ms Baker did not choose the pod but '*was required to do so by reason of the number and acuity of patients in the blue pods in ED at the time.*' [52]

113. Counsel for Mr Laboski's family contend the assessment by Ms Baker should have been deferred until a secure pod was available. [53]

114. I accept the submissions for the family that the communication between Northern Hospital and North Western Mental Health was inadequate on the night. There was no discussion about where Mr Laboski should be seated whilst awaiting his mental health assessment. When Ms Matthews allocated the pink pod to Ms Baker, she noted her reluctance but there was no full and frank discussion about this. Ms Matthew did not want to wait until an appropriate cubicle became available because she was worried Ms Baker would leave and assess another patient in the meantime. Ms Mathew likened it to '*chess*' when she described moving patients to around the emergency department to accommodate the number of presentations.

115. The submissions by the family note Ms Baker did not believe the pink pod was sufficiently secure. [54]

116. Ms Baker, as the EMHC, ultimately made the decision to assess Mr Laboski in the pink pod. She was aware of his history as she knew him previously and had access to alerts and his prior history. She did not put in place potentially mitigating strategies, such as asking for a security guard or telling Mr Laboski's father not to leave him alone. She also left the pod herself to go to a computer at the nurses station.

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[50] T 175
[51] T 177
[52] North Western Mental Health submissions dated5 October 2018, p 2
[53] Submissions Transcript, 24 October 2018 p 60
[54] Submissions on behalf of the family dated 5 October 2018 p 2

117. I find that NWMH was chronically short staffed that evening with only one EMHC and no ability for additional resources. The Northern Hospital 'practice' of doctors not making section 30 Assessment Orders meant there was no extra assistance available to Ms Baker.

118. The submissions from Northern Hospital note: '*The difficulty faced by Northern Health in providing care to Tracje on the evening of 9-10 November 2015 was the ever-increasing number of patients and the high acuity of those patients' health care needs, in an already overly full ED.*' There is some irony in this submission given the practice of Northern Hospital, structure with North Western Mental Health and the self-imposed demarcation of duties and responsibilities regardless of the provisions of the Mental Health Act.

- **Interaction between Mr Laboski and Christine Baker**

119. At approximately 2.00am Mr Laboski was assessed by EMHC Ms Baker.

120. Mr Laboski's father described his son's mood as '*excellent until Ms Baker came.*' [55]

121. Mr Laboski's father made a statement [56]in which he described Ms Baker questioning Ms Laboski's belief in psychics. He described his son as becoming '*...agitate[d]...as she was being rude to him.*' When he wanted to leave she stated '*No, you're not going home, it's not up to you, it's not up to your Dad, it's up to me how long you are here...No, it's not up to you or your dad, I'll be the one who decides how long you stay in the Psych Ward.* ' [57]

122. In her statement Ms Baker states:

> '*My assessment of Tracje at this point was that he was acutely psychotic, insightless re his need for treatment and that he met the criteria under the mental health act to be detained as a compulsory patient under an assessment order, for inpatient treatment.*
>
> *As Tracje became more agitated, I suggested to him that we find another cubicle, where we could talk further about his beliefs and how we could help him.*'[58]

123. Mr Laboski stated his son's response was '*If I'm going to the psych ward, I may as well kill myself.*' [59]

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[55] T 47
[56] Exhibit 1
[57] Exhibit 1
[58] CB 20. Following the inquest and submissions, by letter dated 9 November 2018 Slater & Gordon solicitors for Ms Baker advised that Ms Baker had instructed 'she had not advised Tracje that he was to be admitted as an involuntary patient at the time he left the ED.' The letter was sent to the court and interested parties following the forensic examination of the evidence.
[59] Exhibit 1

124. Mr Laboski senior noted that the assessment was in a cubicle near the reception desk and then Ms Baker moved to the reception desk and started doing paperwork on the computer, and she called Mr Laboski senior over to the computer. The evidence supports the fact that Ms Baker did move to the computer, leaving Mr Laboski in the pod. It was at this point Mr Laboski states his son '*...got up from the bed, and walked away and left through the main emergency exit of the Hospital.*' [60]

125. Mr Laboski senior stated Ms Baker said to him, '*This is why we don't do assessments here. We're supposed to do it down the back and with security present.*' [61]

126. In cross examination Mr Laboski senior agreed he had called police to take his son to hospital '*...because he was having thoughts of taking his own life...*' [62] He was asked if he was relieved that Ms Baker said he would be admitted, '*In one way, yes. But in the way that she said it, and in the way that she handled Trajce was not at all satisfied.*' [63]

127. He stated:

*'I'm angry towards her because she didn't do what she, what she'd done the first time with him...take him to the back to have security, that's the main thing with him, and her way that she treated and talked to us, her arrogance, her... 'Oh, I know you from the last time'.* [64]

128. Mr Laboski senior stated it was only after Tracje had run away that on returning to the hospital Ms Baker said *'Oh, this is why we don't examine in these pods but we examine these kinds of people in the back over there.' She knew that she'd done wrong.*' [65]

129. Mr Laboski senior noted his interest was in what happened that night and *'what did the hospital, the mental health team ...what have they tried to fix in order that this won't happen to any other parent.*' [66]

130. Ms Baker was excused from giving evidence at the inquest on medical grounds. Ms McTiernan of counsel appeared at the inquest on her behalf and Ms Baker's statement was part of the coronial brief. Ms McTiernan indicated she did not have instructions from Ms Baker.

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[60] Exhibit 1
[61] Exhibit 1
[62] T 42-43
[63] T 43
[64] T 55-56
[65] T 57
[66] T 72-73

131. It was put to Mr Laboski senior he believed it was Ms Baker who made the decision for the assessment to take place in the pink pod. He replied, '*...I don't know what she was told or she wasn't told or what to do or how to do her job. She should know how to do her job.*' [67]

132. Mr Laboski senior was present the whole time that Ms Baker assessed his son and he estimated it took about half an hour.

133. In cross examination by Counsel for Ms Baker, Mr Laboski senior stated Ms Baker moved to the nurse's station and called him over. She said to him, '*Come over, let's finish the paperwork to admit him*'. [68]

134. Mr Laboski senior denied when it was put his son was '*argumentative*' with him. [69]

135. Parts of Ms Baker's statement were put to Mr Laboski senior in cross examination. He denied stating to his son that he was not going to take him home. [70]

136. Mr Laboski senior agreed that Ms Baker said to his son and to himself, '*It's not up to you whether you're admitted or not, its up to me.*' [71]

137. Counsel for Ms Baker put to Mr Laboski senior that she had noted in the medical records '*Father reports high level of aggression towards them. Fearful of how he will react to them blames them for him being taken to hospital tonight.*' Mr Laboski senior responded that referred to when his son was on drugs, namely ice, in 2010, 2012, not in 2015. [72]

138. Mr Dermanakis gave evidence that having read Ms Baker's statement, he was satisfied she undertook a proper mental health assessment of Mr Laboski. [73]

**Analysis**

139. In his statement and evidence, Mr Laboski senior describes his son as becoming *agitated* during his assessment by Ms Baker, '*as she was being rude to him*'. [74]

140. This description of her manner and demeanour, as described by Mr Laboski's father, was not challenged by Counsel for Ms Baker in cross examination.

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[67] T 57
[68] T 62
[69] Counsel for Ms Baker quoting from Medical records p 35, T 62
[70] T 63
[71] T 64
[72] T 69
[73] T 224
[74] CB 15

141. Whilst Mr Laboski senior drew a link between her manner and his son's agitation, it is also the case that his son was clearly upset by the prospect of his imminent admission. He stated '*Dad, let's go home, I've had enough*,' and '*I'm not going there, I'm not nuts*,' and, '*If I'm going to the psych ward, I may as well kill myself.*' [75] Dr Kumble had also noted in her evidence that Mr Laboski did not want to be admitted.

142. Prior to his assessment by Ms Baker, Mr Laboski's demeanour was described in evidence by Dr Kumble as being '*completely calm*' [76] and there being '*no arguments.*' [77]

143. Ms Mathew described him as '*calm and compliant sitting politely with his father in the waiting room,*' [78] and '*calm and co-operative...At no point did I find him agitated or restless or anything like that.*' [79]

144. In his evidence, Mr Laboski's father described his mood as *excellent*, until Ms Baker arrived [80] and as '*co-operating...He ..wasn't angry...He was calm.*' [81]

145. In his statement Mr Laboski's father described him as '*polite and co-operative*' and not telling him about waiting for the CAT team: *'We didn't tell him this as he was calm.*' [82]

146. Neither Dr Kumble or Ms Mathews or Mr Laboski's father advised Mr Laboski he was waiting to be assessed by the EMHC and Mr Laboski's father says in his statement, '*We didn't tell him this as he was calm and we didn't want him to run away.*' [83]

147. Mr Laboski's father stated that when Mr Laboski walked out, '*I thought he was just going home ...he was calling, 'I've had enough, I've had enough, let's go home' so I thought he's going out to wait for me outside so we can go home after. Because he didn't want to go to the psycho ward.*' [84]

148. Whilst Mr Laboski's agitation coincided with Ms Baker's assessment. Mr Laboski knew Ms Baker and knew she was the EMHC. Mr Laboski's father perceived her manner as rude, the reality is that Ms Baker's assessment was the first time that night that Mr Laboski was told he

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[75] CB 15
[76] T 111
[77] T 123
[78] T 177
[79] T 184
[80] T 47
[81] T 51
[82] CB 14
[83] CB 14
[84] T 26

is going to be admitted to hospital as an involuntary patient. At this point, Mr Laboski's father's fears were realised as his son walked out of the Emergency Department.

149. Mr Laboski's father had, in fact, foreshadowed the possibility of this prospect earlier in the evening when his son wanted to go outside for a cigarette. Mr Laboski senior stated:

'*Tracje wanted to go out and have a smoke. I was worried to as I thought he might run away. He promised he wouldn't, I went out with him and he had a smoke and he was fine. We did this approximately 3-4 times.*' [85]

150. The submission by counsel for the family was that there was overwhelming evidence of Ms Baker's careless and inappropriate conduct which should be the subject of criticism by this court. [86]

151. I accept Mr Laboski senior was passionate in his evidence and aggrieved by Ms Baker's manner towards his son.

152. I am satisfied from the evidence that regardless of Ms Baker's bed side manner, Mr Laboski was at risk of leaving the hospital as he did not want to be admitted, and that risk was realised from the point Ms Baker told him he was going to be admitted. It was Ms Baker's decision, based on her assessment of his symptoms on presentation, her conclusion being:

'*My assessment of Tracje at this point was that he was acutely psychotic, insightless re his need for treatment and that he met the criteria under the Mental Health Act to be detained as a compulsory patient under an assessment order, for inpatient treatment.*' [87]

153. I agree with the submission by Ms Foy for North Western Mental Health that Ms Baker was '*the first and only person who told [Mr Laboski] that he was likely to need an inpatient admission, an admission that he had earlier told others, such as Dr Kumble, he did not want. ...It is more likely than not that his demeanour would have changed, irrespective of the manner of the person, who told him that he needed a psychiatric assessment and /or admission...It is more likely that the prospect of psychiatric admission without his consent was the cause of his departure.*' [88]

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[85] CB 14
[86] Submissions Transcript, 24 October 2018 p 60
[87] CB 33
[88] Submission from North Western Mental Health, p 5 - 6.

154. I do not accept the submission of behalf of the family that Ms Baker's *'careless and inappropriate interactions'* [89]with Mr Laboski were a cause of his death. I have noted however, that Ms Baker could have done more to alleviate the risk of Mr Laboski absconding.

**Mr Laboski's legal status of the time of his death**

155. In his statement Mr Dermanakis, Area Manager for Northern Area Mental Health Services gave evidence on behalf of NWMH. His evidence was that Mr Laboski had absconded whilst his assessment by Ms Baker was in process, *'There is documentation that suggests he absconded at approximately 0230hrs.'* [90]

156. Mr Dermanakis was unable to clarify but it appeared the assessment order was not written until after he absconded.

157. He agreed it was well before 3 am that Ms Baker made a determination that Mr Laboski required in-patient treatment, but that the assessment order was not signed until 3am. [91]

158. He agreed with the opinion in the coronial brief from the Chief Psychiatrist that Mr Laboski was in the care of the hospital until his examination under section 30 of the *Mental Health Act* is completed, despite the fact he may have absconded from the hospital's care. [92]

159. Mr Dermanakis stated that as before 2.40am *'it is my understanding that he was voluntary at that time'*[93] and not subject to any order under the Mental Health Act.

160. Mr Dermanakis stated that many people are unhappy about being made an involuntary patient and noted the Mental Health Act requires that they are informed they will be involuntarily detained, *'...its absolutely best practice to make sure that someone's very clear what the intended action is...Given that you will be trying to limit their liberty...you must give them a copy of the assessment order, once completed...'* [94]

**Analysis**

161. As part of the coronial investigation advice was sought from the Chief Psychiatrist, Dr Neil Coventry about the process when an apprehended person is taken to a public hospital for assessment.

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[89] Submissions on behalf of the family dated 5 October 2018 p 3
[90] Exhibit 17
[91] T 206
[92] T 202
[93] T 224
[94] T 226

162. Dr Coventry advised that once custody of the person transfers from the police, the hospital is responsible for the person's care.

163. He noted that:

*'Hospital staff will seek the person's cooperation to remain until they can be examined under section 30 of the Act and will use all reasonable clinical and operational means to support the person to stay. For example clinical staff may be assigned to remain with the person or move them to a low stimulus area.'* [95]

164. Dr Coventry stated that once the hospital accepts care under section 351, there is an obligation to take reasonable steps for the person to be assessed as soon as practicable in accordance with section 30 of the Mental Health Act. [96] The hospital had a duty of care to keep Mr Laboski safe until his assessment.

165. Although Mr Laboski was not moved to a low stimulus area, Ms Matthews did note he and his father were moved to the waiting area outside the nurses' station where the chairs were more comfortable. Mr Laboski was also permitted by staff to go outside for a cigarette with his father on a number of occasions. Mr Laboski was not told he was awaiting a mental health assessment, which also appeared to be intentional, so as to maintain his co-operation.

166. Dr Coventry advised that a person only becomes a compulsory patient if and when they are made subject to an assessment order under section 30 of the Act. The submission from NWMH supports this position.

167. In her submissions, counsel for NWMH noted section 34 of the Mental Health Act which states that an assessment order comes into force when it is made. The order must be in writing and the person subject to the order given a copy.

168. Counsel for the Laboski family argued in her submission that there was no specific requirement in the Mental Health Act for the assessment order to be in writing. She argued that just because the order was not in writing until 3 am, does not mean it was not in existence prior to that.

169. I accept the advice from the Chief Psychiatrist that *'The apprehended person only becomes a compulsory patient if and when they are made subject to an Assessment order under section 30 of the Act.'* [97]

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[95] CB 59
[96] CB 59
[97] CB p 60

170. The wording of section 34 (1) of the Mental Health Act states:

*'An Assessment Order comes into force when the Order is made and remains in force, unless the Assessment Order is extended in accordance with this section or revoked in accordance with section 37 –*

(a) *Subject to subsection (1A), in the case of a Community Assessment Order, for a period of 24 hours; or...'*

171. The time limits specifically prescribed for these orders indicates to me they come into force when they are written.

172. It is clear a patient is rarely happy about being made subject to an assessment order, and the context and timing is when a person has high risks and is vulnerable.

173. Mr Laboski left the hospital prior to the Assessment Order being finalised I find he was not an involuntary patient when he left the ED.

**The co-delivery of psychiatric services by North Western Mental Health, a division of Melbourne Health, within Northern Hospital:**

174. The submission from the family raised three issues of concern regarding the co-delivery of services by NWMH within Northern Hospital. These were: absence of training, the lack of communication and the inadequate number of mental health practitioners.

175. Mr Dermanakis noted Mr Laboski's death was a sentinel event and subject to a root cause analysis by Northern Health.[98] Five opportunities were identified for development, although he was not able to say whether they had been implemented, as he was not employed by Northern Health. However he was able to state that there had been an improvement in the two health services working more collaboratively as there are now twice daily huddles in the morning and the afternoon '*the senior emergency mental health staff and ED staff get together to look at the plans for any mental health consumer...timeframes...There is also work that's being done separately and together about the escalation processes.*'[99]

176. When asked about paragraph 5 of his statement regarding *'workplace environment safety inspections*' he was unable to comment about implementation as it concerns how Northern Health operates in their emergency department.[100]

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[98] Exhibit 15
[99] T 199
[100] T 200

177. Mr Dermanakis confirmed that a manager from the emergency mental health team was part of the root cause analysis, given the co-delivery of services within Northern Hospital.

178. Mr Dermanakis confirmed that on the evening in question, Ms Baker was the sole clinician overnight, there was no direct supervision, but she could contact an on call manager for further advice if she required.

179. In cross examination by Ms Wood, when asked whether staff from Northern Hospital ED and staff from Mental Health services '*get together...and have specific training in relation to the delivery of mental health services within the emergency department*' Mr Dermanakis responded '*...it doesn't happen... regularly.*' [101]

180. Mr Dermanakis confirmed that the current policy requires assessments now take place in a supervised pod. [102]

181. Mr Dermanakis was asked by Ms Foy about the system in place between Northern Hospital and North Western Mental Health, '*There are regular interface meetings at a number of different levels...including clinical [monthly]...as well as managerial [bi-monthly]...where issues are raised and discussed and action plans determined...forums to discuss any tensions or...differences of opinion...we call them liaison meetings...*'[103]

182. Mr Dermanakis' evidence was that two hours was a reasonable time for a patient to wait in ED for a mental health assessment, although there are a number of factors that affect that timing. [104]

183. He noted that the mental health clinician will consult with the nurse unit manager as to to whom should be seen first. [105]

184. With regards to pod allocation, Mr Dermanakis explained that the current preference is for a resus 3 bed allocation and if that was not available then priority would be to the blue pods because those cubicles are furthest away from exit points and closest to be able to be monitored.[106]

185. On the other hand, Ms Wood for Mr Laboski's family argued that the lack of training, communication, leadership, the inadequate number of mental health staff on the night all

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[101] T 205
[102] T 209
[103] T 221
[104] T 221
[105] T 222
[106] T 223

highlight sub-standard administrative arrangements between the two organisations on the night in question. [107]

186. Counsel for NWMH submitted the co delivery model was relevant to two issues, firstly pod allocation and secondly, the waiting time for a mental health assessment in ED. She submitted in other health services, it is always the domain of the senior ED consultant and senior nurse to control allocation of ED beds or pods. Further, the waiting time for a mental health patient in ED is dependent on the availability of mental health staff and particular demands at the time. '*The circumstances for Trajce are no different from any patient having to wait for a medical practitioner or for an on-call consultant if required.*' [108]

187. I find the structure of the two health organisations impedes the quality and responsiveness of patient care.

188. The NHED is responsible for ensuring Mr Laboski's safety whilst waiting for his mental health assessment.

189. The fact that Mr Dermanakis could not in his evidence advise whether improvements arising from the root cause analysis had been implemented illustrates the effects of the co-delivery of services.

190. The fact that Ms Matthews and Ms Baker did not have a discussion about allocation of the pink pod and that Ms Matthews did not want to wait for the assessment for fear Ms Baker would go and assess another patient illustrates the '*absence of adequate coordination*' and communication as submitted on behalf of the family[109]

191. The structure between the two health organisations in reality means that responsibilities under the Mental Health Act are devolved to North Western Mental Health rather than to clinical staff in ED to be used when necessary.

**The Northern Health construction site where Mr Laboski was found:**

192. Dr Dean Pritchard, Deputy Director of the Northern Hospital Emergency Department gave evidence Mr Laboski exited from the main entrance to the Emergency Department and then would have walked around the front of the hospital down the road between the hospital and the plaza, maybe 300 metres to walk, but 100 metres as the crow flies. [110]

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[107] Submissions Transcript, 24 October 2018 p 58
[108] Submission from North Western Mental Health p 9
[109] Submissions on behalf of the family p 6
[110] T 234-235

193. Northern Hospital conceded the pallets stacked by the fence adjacent to the construction site should not have been left there.

194. I am of the view that given the proximity of the entrance where Mr Laboski left the Emergency Department to the building site, the stacked pallets gave Mr Laboski an easy and opportunistic way of accessing the building site.

**Changes to policy and procedure at Northern Hospital and North Western Mental Health since Mr Laboski's death:**

195. Dr Pritchard indicated that there is a new policy regarding people brought to ED subject to section 351 *Mental Health Act* that they get received through resus 3 and are placed in an area furthest from the exit without any direct exits to the outside. [111]

196. There were references sprinkled through the evidence from witnesses highlighting differences to operations since Mr Laboski's death.

197. Dr Pritchard spoke to the Risk Reduction Action Plan. [112]

198. The first aspect of this is a North Western Mental Health, Ambulance Victoria and Victoria Police Liaison Committee in collaboration with other agencies to ensure the hospital has pre-arrival notification of all section 351 patients. [113] Dr Pritchard stated that 5- or 10-minutes notification about the impending arrival of a patient gave staff the ability to '*find some space.*'[114]

199. Dr Pritchard explained '*the daily huddle*' whereby at a 9.15 am meeting all senior leaders in the ED involving in-patient bed access as well as our mental health team discuss patient numbers, bed availability and staffing numbers. He explained there was an escalation tier and a further meeting at 4.15pm to ensure problems have been addressed, '*...and whether or not going into the evening we're going to need more staff to cope, whether it's emergency, mental health, cardiology or even trying to pull in more staff to the wards to open up some more beds.*' [115]

200. Ms Mathews evidence described these daily communications as 'bed meetings' between the nurse in charge and the EMHC teams at 9.15 am and 3.30pm.

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[111] T 240-241
[112] CB 54
[113] T 246
[114] T 247
[115] T 250

201. The second change related to the standardisation of cubicle allocation to reduce the movement of mental health patients around the ED during their episode of care. Dr Pritchard described the ED as now having more opportunities to move patients to various places.

202. The third improvement concerned hospital bed management which impacts on the number of patients in ED. The fourth improvement related to escalating processes between the two health services when there is a high demand for mental health services.

203. Despite all these improvements, Dr Pritchard clarified there is still only one emergency mental health clinician rostered on overnight.

204. North Western Mental Health Service has advised that an EMHC will only perform assessments the blue pod area (or staffed cubicles) of Northern Hospital ED.

205. The formal communication plan of twice daily huddles is in place and has improved management of mental health patients because it includes an assessment of mental health capabilities.

206. Work is underway to provide a low stimulus area in ED for mental health patients. The DHHS, Northern Health and architects are working on creating a Behavioural Assessment Unit.

207. The Northern Hospital also has a surge code, so an escalation can be implemented when necessary if patient numbers in ED exceed 40. This entails an hospital wide mobilisation to create beds.

**Conclusions**

208. I find the 'practice' at Northern Hospital of medical staff not conducting section 30 assessments mitigated against Mr Laboski receiving optimal care on the evening of 9-10 November 2015.

209. On that evening, of all evenings, the busiest on record, could have alleviated pressure on the NWMH and patient wellbeing.

210. Dr Kumble's initial assessment, that Mr Laboski had no insight and had psychotic symptoms was exactly the same as that of Ms Baker's two hours later.

211. The Northern Hospital 'practice' meant that on one of its busiest nights in the Emergency Department, when multiple patients were being brought in on section 351's by police could potentially have been fast tracked, were not.

212. The Mental Health Act clearly stipulates registered medical practitioners have the power to make such assessments and this practice occurs in other major hospitals in Melbourne.

213. Prior to his assessment, Mr Laboski was 'managed' in the NHED by sheer good fortune and luck and the support of his loving and devoted father. He and medical staff did not tell Mr Laboski why he was waiting, for fear her would abscond. Whilst I can understand the motivations, it can hardly be said to be reasonable or optimal health care and practice to use a practice such as omitting information to prevent absconding. The evidence from Ms Matthews of the NHED that night described her navigating a precarious balancing act between resources and patient need.

214. This is illustrated by the decision by both health practitioners, Ms Matthews and Ms Baker to assess Mr Laboski in the pink pod, against their better judgement, with no steps being taken to try and mitigate the risk they were well aware of. Unfortunately, there was no discussion between them regarding potential consequences of this decision and Ms Baker did not take any steps to mitigate the potential risk.

215. From the evidence I have heard, there is no change to the 'practice' at Northern hospitals regarding doctors not making section 30 assessments, and there is still one EMHC rostered on at night.

216. The recommendations which follow are aimed at requiring Northern Hospital and North Western Mental Health to *together* consider the safety and contemporary nature of their respective roles in the emergency department.

217. I do not accept that Ms Baker's demeanour caused Mr Laboski to abscond which led to his death. Whilst Ms Baker may have been brusque or short, she was under pressure that evening and was the first one to tell Mr Laboski that he needed to be admitted, which had been kept from him whilst he was waiting.

218. All the evidence supports that there was a real fear he would abscond if he knew the reason he was waiting, which was unfortunately realised once he was told by Ms Baker.

219. I note the concessions by Northern Health that Mr Laboski should not have been assessed in the pink pod and that the pallets should not have been left next to the building site.

**Finding**

I find that Trajce Laboski born on 26 September 1988 died from I(a) Injuries sustained in descent from height on 10 November 2015 at 185 Cooper street Epping.

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

**Recommendations**

1. Melbourne Health North Western Mental Health and Northern Hospital undertake a review of the actual wait times of people awaiting an assessment by the Emergency Department Mental Health clinicians, especially out of business hours to, (1) establish if the two hours noted as a reasonable wait time is the average for patients in the emergency department out-of-hours, and (2) address any sustained variance that suggests wait times for patients out-of-hours is on average greater than the two hours considered as reasonable.

2. Melbourne Health North Western Mental Health and Northern Hospital review the current service model of care provided to patients in the Emergency Department who have a mental illness or who require assessment for a possible mental illness, for opportunities to integrate patient care processes to (1) identify patient needs, (2) increase the communication of critical information, (3) develop shared and comprehensive care planning and (4) the prevention of harm.

3. Northern Hospital Emergency Department in consultation with North Western Mental Health, review the contemporaneousness and appropriateness of the practice that currently removes medical practitioner responsibilities under the *Mental Health Act* 2014 and assigns responsibility for its use to North Western Mental Health clinicians. The review should be informed by (1) escalation processes in the Emergency Department, (2) an understanding of the intent of sections 28 – 30 of the Mental Health Act, (3) an understanding of the Mental Health Act safeguards for a patient who is subject to the Act including their rights and responsibilities, and (4) advice regarding the obligations regarding section 30 of the *Mental Health Act* 2014 from the Chief Psychiatrist in Victoria.

I direct that a copy of this finding be provided to the following:
Mr Svetozar Laboski, Senior Next of Kin

Senior Constable Peter James Englehart, Victoria Police, Coroner's Investigator

Mr John Snowden on behalf of Northern Health

Ms Alicia Muscara, Slater & Gordon

Ms Lauren Rimon, Henry Carus & Associates

Ms Jan Moffatt on behalf of Melbourne Health, North Western Mental Health

Ms Jacinta Gibbs, VGSO

Ms Sania Ciciulla, Hall and Willcox Lawyers

Signature:


**CAITLIN ENGLISH**

**ACTING STATE CORONER**

Date: 26 June 2019