IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2016 5648

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)
Section 67 of the Coroners Act 2008

Findings of:	Sarah Gebert, Coroner
Deceased:	Mr J
Date of birth:	[redacted] 1994
Date of death:	28 November 2016
Cause of death:	Drowning
Place of death:	Waters adjacent to the Geelong Waterfront, Geelong, Victoria

INTRODUCTION

1. Mr J[1], born on [redacted] 1994, was 22 years old at the time of his death. He is survived by his father [redacted] and younger brothers, [redacted] and [redacted]. Tragically his mother [redacted], passed away after her son's death.

2. Mr J excelled at school and was described as both highly intelligent and athletic. He achieved an ATAR score of 95.2 and was accepted into Melbourne University to study commerce and engineering. Mr J was described by his mother as, *completely open and honest and just a loving son and member of the family.*

3. On 28 November 2016, Mr J was found deceased in waters adjacent to the Geelong Waterfront after he absconded from the University Hospital Geelong Emergency Department (**ED**).

THE CORONIAL INVESTIGATION

4. Mr J's death was reported to the Coroner as it fell within the definition of a reportable death in the Coroners Act 2008 (**the Act**). Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury.

5. 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.

6. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.

7. Victoria Police assigned Senior Constable Lachlan Cartledge (**SC Cartledge**) to be the Coroner's Investigator for the investigation into Mr J's death. SC Cartledge conducted inquiries on my behalf,[2] including taking statements from witnesses and compiling a coronial brief of evidence. The brief contains statements from witnesses, including Mr J's

[1] Referred to as '[redacted]' in this finding unless more formality is required.
[2] The carriage of the investigation was transferred from Deputy State Coroner English.

parents, treating health practitioners, the forensic pathologist who examined him, civilian witnesses and investigating officers, as well as other relevant documentation. Mr J's mother also provided correspondence to the Court dated 13 July and 4 October 2019.

8. As part of the investigation, this case was referred to the Coroners Prevention Unit (**CPU**).[3] CPU were asked to undertake a review of Mr J's health and medical management and answer questions regarding whether the management of Mr J's physical health took priority over the management of his mental health and issues raised by family regarding Mr J's care.

9. After receipt of the brief, a number of additional statements were provided by Barwon Health on behalf of the University Hospital Geelong which included relevant hospital policies.

10. This finding draws on the totality of the coronial investigation into Mr J's death, including evidence contained in the coronial brief, information from Mr J's medical records as well as the review conducted by CPU. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[4]

Background

11. Mr J had no significant psychiatric history. He lived with his parents and two brothers until mid-2015 when he moved in with a friend. At this time, he did not tell his family where he lived and withdrew from contact. He moved back into the family home in late 2015, though remained withdrawn from his family. Having deferred his studies, Mr J worked two jobs, beginning his day job at 7.00am and his night job at 5.00pm and often worked until late at night.

12. Mr J was sent home from work at around 7.30pm on 25 November 2016 due to erratic behaviour. On returning home, his mother also noted erratic behaviour and Mr J admitted that he had been using cannabis and ecstasy for some time. Mr J's mother took him to

[3] 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.

[4] Subject to the principles enunciated in *Briginshaw v Briginshaw* (1938) 60 CLR 336. The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

University Hospital Geelong. Mr J's mother said, *I explained to the nurse at the counter that my son Mr J had taken some drugs and he needed help. I was advised that there was nothing they could do and he would just need to wait for the drugs to leave his system.*[5] As Mr J was not triaged prior to leaving, there is no documentation of this presentation.

MATTERS IN RELATION TO WHICH A FINDING MUST, IF POSSIBLE, BE MADE

Circumstances in which the death occurred

13. At 12.23am on 27 November 2016 Mr J's work friend contacted police requesting a welfare check as Mr J presented as suicidal and psychotic. Police were unable to locate Mr J until approximately 4.20pm that day when reports were made of someone running into traffic, attempting to carjack a vehicle and abandoning a different vehicle on the wrong side of the road. When police arrived, Mr J was being restrained by a witness who was a passenger in the car that he attempted to carjack. The witness reported that Mr J was acting erratically. Mr J sustained facial injuries when he was pursued and restrained by the witness and appeared to police to be substance affected. An ambulance was called to transport Mr J to University Hospital Geelong pursuant to s351 of the Mental Health Act 2014.

14. Police accompanied the ambulance to University Hospital Geelong ED arriving at 5.24pm. Mr J was placed in cubical T18[6] due to the number of high acuity patients making the resuscitation bays unavailable.

15. On initial assessment, Mr J had obvious trauma to his face with a possible broken nose. He was drowsy and confused with a Glasgow Coma Score[7] (GCS) of 13 out of 15. Mr J had an elevated heart rate of 150 beats per minute and an increased respiratory rate of 22 breaths per minute. Initial assessment did not reveal any obvious significant chest, abdominal or limb injury. Mr J's blood gas was markedly abnormal showing an acidaemia and increased lactate[8] The initial priorities of his care were to manage the trauma and ensure there was no underlying serious injury. His neck was immobilised in a cervical collar. A

---

[5] Statement of [redacted] dated 12 June 2017, page 26 of Coronial Brief.

[6] University Hospital Geelong ED registered nurse Stacey Van Gerven stated that cubicles T18-T20 are "step down cubicles from the resuscitation bays".

[7] A commonly used scoring system to describe the level of consciousness after a traumatic brain injury. It evaluates eye, verbal and motor response. A normal response would be 15. Mr J lost points for having his eyes closed and being confused.

[8] Blood gas testing can often be done within the ED providing immediate blood results on a range of measures. Acidosis and increased lactate (Mr J's lactate was 15, normal range <1) could indicate shock.

bedside ultrasound (US) eFAST[9] scan was negative. Computed tomography (CT) scans of the brain, cervical spine, chest, abdomen and pelvis were performed.

16. After a discussion with Emergency Registrar Dr Mark Henderson, mental health clinician Neil Smyth of the Access Consultation & Liaison team signed a Mental Disorder Transfer form and the police left the hospital at approximately 6.15pm. An assessment order[10] was not completed upon the expiry of the s351.[11] The ED documentation indicated that a mental health referral was made at 6.41pm that stated "not for MH Ax [mental health assessment] at present"[12]. Dr Henderson stated that he had a discussion with a mental health clinician at Mr J's bedside at 6.20pm and advised that Mr J was unsuitable for a mental health assessment at that time.

17. At 7.11pm an Incoming Referral form was completed by Mr Smyth and at 8.35pm he completed the Consultation Liaison Psychiatry Referral form. Both of these indicated a need for surgery for facial injuries prior to mental health assessment.[13] Collateral information was sought from Mr J's parents and they were advised that treating his medical condition was a priority at that time. A plan was made for mental health input on the medical ward following surgery.

18. Mr J's vital signs improved with boluses of intravenous fluid. By 8.00pm his heart rate had reduced to 100 beats per minute, his conscious level had improved markedly with only subtle confusion remaining and the abnormalities on the blood gas had largely normalised. Interim CT scan reports revealed no significant injury.

19. At 10.11pm a code grey[7] was called as Mr J had become increasingly agitated and tried to abscond from the ED. Mr J was reviewed by Dr Henderson and the ED consultant on duty. Mr J admitted to taking ecstasy earlier that day. He was assessed as likely still drug

---

9 Extended Focused Assessment with Sonography for Trauma uses ultrasound to detect specific potentially life threatening conditions in the chest and abdomen. A negative scan is reassuring.

10 An assessment order is an order made by a registered medical practitioner or mental health practitioner that enables a person who is subject to the assessment order to be compulsorily (a) examined by an authorised psychiatrist to determine whether the treatment criteria apply to the person; or (b) taken to, and detained in, a designated mental health service and examined there by an authorised psychiatrist to determine whether the treatment criteria apply to the person.

11 A person apprehended under s351 of the Mental Health Act 2014 (Vic) is released from the custody of the police officer when- (a) the person is taken to a registered medical practitioner or mental health practitioner and is made subject to an assessment order; or (b) the person enters into the care of a public hospital, denominational hospital, privately-operated hospital or public health service within the meaning of the Health Services Act 1988 (Vic).

12 Barwon Health digital medical record, ED record, page 63 of 92.

13 Barwon Health digital medical record, Consultation Liaison Psychiatry Referral completed 27 November 2016 at 8.35pm by Neil Smyth, page 50 of 92. Barwon Health digital medical record, Incoming Referral completed 27 November 2016 at 7.11pm by Neil Smyth, page 81-82 of 92.

affected with a recent head injury. Mr J was considered not competent[14] to discharge himself against medical advice and so was held under a duty of care. Mr J was chemically and physically restrained (he was given sedation and restrained in 4 point restraints).

20. Dr Henderson obtained further history from Mr J's mother who was concerned for his welfare. [redacted] described a six month history of withdrawn behaviour. Mr J had no previous history of medical or mental health problems and up until six months prior had been a student at the University of Melbourne studying engineering.

21. A plan was in place for Mr J to have a mental health assessment the following morning and it was noted several times that his mother was to be in attendance for the assessment, as per her request. Mr J briefly slept and from 12.21am until around 8.30am he was noted to be awake but settled. Mechanical restraints were removed at 1.40am. According to Dr Martin Leung, Emergency Physician, Mr J had been cleared of any serious injuries at this time and was being observed overnight for psychiatric review in the morning[15] and tertiary review by the general surgical team.[16]

22. The following was documented in Mr J's medical and nursing record:

- 6.28am: Lying in bed watching television, given cup of water
- 6.56am: Settled, tolerated diet and fluids, for Mental Health review this am
- 7.28am: Handed over to morning staff: awaiting tertiary survey and further plan.

23. Between 7.00am and 7.25am the Access Consultation & Liaison team had a handover and clinician Arjuna Kern was advised that Mr J had been in ED overnight awaiting surgical admission for facial injuries and was on the consultation liaison list for review that day. At 8.12am ED nurse Sharon Simpson called to advise that Mr J was ready for mental health assessment in ED.

24. Sometime between 8.17am-8.30am[17] Mr J again attempted to leave the hospital via a window in the Short Stay Unit (adjacent to ED) and another code grey was called. Nurse Simpson attempted to direct Mr J back to his bed to which he was initially co-operative and the code grey was stood down. This incident lasted approximately two minutes. Shortly

[14] Assessed as not having the decision-making capacity to make informed decisions about his own care.
[15] Statement of Dr Martin Leung dated 5 May 2017, page 60 of coronial brief.
[16] Barwon Health digital medical record, ED record, page 63 of 92.
[17] Mental health documentation indicated that a call was received from ED at 8.17am advising that Mr J had left. ED notes indicate that Mr J left at 8.30am.

afterwards Mr J attempted to leave, yelled "let me out" and was stopped by security. Another code grey was called, and Mr J became physically aggressive towards the security officer[18] Nurse Simpson advised the security officer to let Mr J leave. The code grey team arrived shortly after Mr J left the triage area in ED (though was still at the hospital) and the police and Mr J's mother were notified a few minutes later.

25. At 8.35am, police were called to attend the vicinity of the Hospital to locate and conduct a welfare check on Mr J. He was said to be on foot and travelling west on Ryrie Street.

26. There were six Triple Zero callers who reported seeing Mr J walking in the middle of the road in front of traffic, trying to hail a cab and sitting on cars. He was visually distinctive as he was in shorts only and had white hospital stickers on his chest. His locations were reported variously as Ryrie Street, Moorabool Street, Gheringhap Street, James Street and Yarra Street. The calls were made between 8.38-8.53am.

27. Police units (WGL306 & WGL251) patrolled the Geelong Central Business district but were unable to locate Mr J.

28. At approximately 8.40am, it appears that Mr J walked down to the Geelong Waterfront on Eastern Beach Road behind the Geelong Carousel. Mr J was observed to jump a retaining wall located next to Alexander Thompson Jetty on the Geelong Waterfront and dive into the water.

29. The witness, who was on a nearby boat, stated that Mr J did not appear right. He swam out approximately 20 metres from the base of the retaining wall and approximately 5 metres from the end of the Jetty. She checked him again and lost sight of him. A short time later she observed Mr J face down in the water. She alerted her partner who went looking for him around the boat and the jetty. He got onto a smaller boat to go further out and have a look and it was at this time that Mr J was located fully submerged on the seabed in approximately 4 metres of water.

30. Police were called at approximately 9.17am and attended at the Alexander Thompson Jetty. The nearby Carousal, which is a Children's Amusement Centre located on the foreshore, had CCTV cameras which were positioned outside the premises.

[18] Nurse Simpson described this as "a small scuffle" in her statement.

31. Detective Senior Constable Damian McKeegan[19] stated,

I viewed CCTV footage of cameras positioned outside the Carousel. This footage showed at 8.46am, on Monday 28th November 2016, a male person dressed in only shorts and socks walking along the waterfront towards the carousel from a westerly direction. Upon reaching the carousel, the male turned left and walked along the boardwalk beside the Carousel, until out of view. Another CCTV camera view from the Carousel towards Cunningham Pier, at 8.46.35am, shows ripples on the water, where [the witness] *indicated the male had entered into the water from the bluestone blocks.'*

32. On arrival Police used a boat to locate Mr J and a decision was reached to contact Water Police and Search and Rescue who subsequently retrieved him from the water.

33. The evidence suggests that the police, having received a job for a welfare check on Mr J at 8.35am, only had approximately 11 minutes to commence a search and to locate him before he entered the water at around 8.46am.

Identity of the Deceased

34. On 28 November 2016, [redacted] visually identified his son, Mr J, born on [redacted] 1994.

35. Identity is not in dispute and required no further investigation.

Medical cause of death

36. Senior Forensic Pathologist Dr Michael Burke from the Victorian Institute of Forensic Medicine (VIFM), conducted an examination on 30 November 2016 and provided a written report of his findings dated 8 June 2017.[20]

37. The post mortem examination showed no evidence of any injury that would have contributed to or led to the death and there was no evidence of any significant natural disease process.

38. Toxicological analysis showed the presence of methylenedioxyamphetamine (MDA) in urine and cannabis was identified in the blood.

39. Dr Burke provided an opinion that the medical cause of death was '1(a) *Drowning*'.

---

[19] Coronial Brief at page 96.
[20] This is an amended report ad superseded any previous reports.

40. I accept Dr Burke's opinion.

FURTHER INVESTIGATIONS

Family Concerns and Questions

41. Mr J's family raised a number of concerns and questions which included:

- *Arrived in handcuffs the day before following assault – is this a red flag that he was a danger to himself and others?*
- *Why did his mental health assessment not take place earlier?*
- *After 10.00pm – code grey - what were the results of the blood work, did the sedative he was given cause further confusion?*
- *Was the restraint appropriate?*
- *Got up two more times in the night – were there more code greys? Wasn't this a sign he was at risk of absconding?, why was he not re-strapped?*
- *Mum told he would not be released, promised to receive a call at the end of the shift, begged not to let him go*

Barwon Health root cause analysis

42. Barwon Health provided an executive summary of the root cause analysis (**RCA**) conducted into Mr J's death. The following four recommendations were made:

- Submit a report to the Chief Operating Officer of alternative entrance changes/strategies to increase the security for staff, patients and visitors in relation to exit doors from ED to the waiting room.
- Develop and implement a procedure outlining the requirement and planning of mental health risk assessments when patients experiencing a mental illness or behavioural disturbance present to the ED.
- A mental health representative to attend code greys and undertake a mental health risk assessment, which will be documented in the patient's medical record. The code grey procedure would be updated to reflect this and audits of compliance with mental health and medical assessments post a code grey to be undertaken annually.

- Roster and base two security guards in the ED at all time.

43. Dr Michael Sheridan, Director ED, University Hospital Geelong, stated in response to the question, *What were the circumstances that made it unsafe to prevent Mr J from leaving the hospital at approximately 8.30am on 28 November 2016*?

A code grey was called at approximately 8.29am. The Code Grey team is not based within the ED, they cover the entire University Hospital site. This team comprises of 4 to 6 men who are specifically trained in physical restraint. They ordinarily take 1-2 minutes to arrive at any location in the hospital from their base. They are a valuable resource who can help manage those very challenging patients. The Code Grey Team had not arrived by 8.30am due to the short time Mr J took to move towards the Emergency Department exit. At the exit point our security guard attempted to physically restrain Mr J and physically block the exit with his body, but Mr J became more agitated and physical in his attempts to leave, including a physical altercation with the lone security guard in the presence of a senior nursing staff member. It was deemed, in a spilt second decision, that this one security guard attempting to restrain Mr J while awaiting the Code Grey team to arrive was in fact likely to put those staff members (security and nursing) at risk of personal injury and at that point they stepped back. Mr J subsequently opened the Emergency Department exit door and left the Emergency Department via the waiting room.[21]

CPU advice

44. The CPU undertook a comprehensive review of the evidence in this case including Mr J's medical records.

Mental Health Assessment

45. Dr Henderson stated that due to Mr J's need for medical assessment and the likelihood that a mental health assessment would not be meaningful during the very acute period where his behaviour was very disturbed (to the extent that he required sedation), the mental health assessment was initially delayed. Dr Henderson reported that Mr J presented with a significantly impaired conscious state (Glasgow Coma Scale fluctuating between 11-14), had a recent head injury, was suspected to be significantly affected by substances and potentially had severe injuries that had not yet been investigated. The RCA executive

[21] Statement dated January 2018.

summary also indicated that Mr J's tachycardia required further medical intervention before he would be suitable for a mental health assessment.

46. The CPU considered that Dr Henderson's decision to delay the mental health assessment and prioritise medical investigations and treatment during the early stages of Mr J's admission was reasonable. Mr J was assaulted and the extent of these injuries, particularly whether they were life threatening, was not yet known.

47. Furthermore, the impact of physical injuries (including his head injury) on Mr J's mental state was not yet known and it would be difficult to ascertain whether his behaviours were due to his physical injuries until further medical investigations had been undertaken. While the Access Consultation & Liaison team had not assessed Mr J, there was evidence that Dr Henderson explored his mental state as a part of the ED assessment. Dr Henderson determined that Mr J was confused and agitated at times with disturbed behaviour. He recognised the risks associated with these symptoms and that a mental illness may be one potential cause (with other possibilities being substance intoxication and physical injury). Dr Henderson and ED nursing staff appropriately managed this by monitoring Mr J for changes in his mental state, using de-escalation techniques, sedating medications and mechanical restraint when required. Dr Henderson stated that his shift ended shortly after midnight. The medical record indicated that until 12.21am, Mr J's mental state continued to fluctuate with periods of agitation and uncooperative behaviour.

48. Between 12.21am and the referral to the Access Consultation & Liaison team at 8.12am Mr J was noted to be awake, settled, did not require additional sedation and was awaiting a mental health assessment in the morning. Mechanical restraints were removed at 1.40am and were not reapplied for the remainder of the admission. Mr J's mother asked to be present for the mental health assessment.

49. The CPU noted that there was no documentation in the medical record between 1.44am when it was noted "shackles removed at 0140 as per EDMO [ED medical officer]. Pt [patient] currently settled" and 6.28am when it was noted "given cup of water, asking if can eat. Will check with EDMO. Laying in bed watching telly"[17]. Given there was no documentation of behavioural disturbance, no mention in statements of behavioural disturbance and no medications given, it appeared that Mr J remained settled between 1.44am and 6.28am.

50. Barwon Health clarified that from Mr J's admission to the Hospital in the evening of 27 November 2016 until approximately 6.28am on 28 November 2016, Mr J was located in a monitored cubicle. [22] The cubicle was located in a 'step down' area with three cubicles in total. The cubicles were separated by solid walls to their sides between each bay and a curtain to the central hallway. One nurse was primarily allocated to observing and monitoring the three cubicles overnight.

51. Barwon Health advised that the overnight nurses recall that Mr J was asleep for a few hours, and became more coherent and medically stable as the morning progressed, including getting up to go to the toilet and returning to his trolley. As at approximately 6.28am, Mr J was considered to be medically stable, leading to his movement to a non-monitored cubicle.

52. The CPU noted that further notes at 6.56am and 7.28am indicated that he was settled, compliant, eating and drinking. Associate Nurse Unit Manager (ANUM) Eliza Baxter stated that it was decided that Mr J's mother would return to ED at 7.30am prior to mental health review and if it was appropriate for Mr J to be assessed earlier, Nurse Baxter would call Mr J's mother. Mr J's mother stated that she did not receive contact overnight and when she called ED at 7.40am she was told that Mr J would have a mental health assessment between 8.30am and 9.30am.

53. The CPU identified that there may have been a missed opportunity in facilitating an earlier mental health assessment, which may (or may not) have resulted in admission to the acute mental health ward, administration of psychiatric medication, completion of an assessment order and/or an increased level of supervision (such as one-on-one nursing). Whether or not there was an earlier opportunity for a mental assessment to have taken place, is discussed later.

54. As already noted, the medical record indicated that Mr J's mother requested to be present for the mental health assessment.

55. The CPU considered that despite a request by a parent to be present, delaying any assessment presents additional risks and that an appropriate approach in these circumstances is for a mental health assessment to take place as early as practicable and then have the patient remain in hospital until mental health staff are able to speak with the parents about the outcome of the assessment.

[22] Correspondence dated 22 October 2020.

Management of Absconding

56. The CPU noted that an email from Mr J's mother on behalf of the family (mother [redacted], father [redacted], and brothers [redacted] and [redacted]) stated that Mr J was mechanically restrained for less than four hours, was sedated during this time and restraints were removed once the sedation had worn off. Mr J's family asked whether it was Barwon Health policy to mechanically restrain a person while sedated and then remove the restraints once sedation wears off.

57. According to the medical record, Mr J was mechanically restrained at 10.15pm and given midazolam, as he attempted to leave the hospital and it was deemed that he was not competent to discharge himself against medical advice due to being drug affected and a recent head injury. Mr J was noted to be asleep at 11.22pm, and awake but settled at 12.21am and 1.30am. Nurse Stacey Van Gerven stated that Mr J was settled approximately one hour after being restrained. Restraints were loosened at 1.30am and removed at 1.40am. Nursing observations were documented every 15 minutes from 10.15pm to 1.30am. Dr M. Leung completed a Physical Restraint Order authorising physical and chemical restraint at 8.30am. Barwon Health clarified that this Order was made between the two Code Greys called in the morning and no other Physical Restraint Orders were able to be located on the medical record.

Mechanical Restraint

58. According to the Barwon Health *Restraint Procedure Manual* that was in place at the time of Mr J's death, any form of restraint should only be considered after a comprehensive assessment, use of preventative strategies and where alternative options have been exhausted. Restraint should be used on a time-limited basis, and restraints must be removed as soon as less restrictive options are identified. This procedure is informed by the Chief Psychiatrist's *Guideline for Restrictive Interventions in Designated Mental Health Services*, which also states that restrictive interventions (which includes mechanical restraint) should be a last resort and for the briefest duration.

59. The CPU considered that the decision to release Mr J's restraints at 1.40am was reasonable. He had remained settled for most of the duration of restraint and slept for a brief period. In line with best practice, restraints could have been released earlier as he was settled for one hour and 20 minutes while still restrained and restraint should be removed at the earliest possible time. After restraints were released, Mr J remained awake but did

not present with further agitated behaviours for over 6.5 hours. It would not be reasonable to restrain a patient solely for the purpose of preventing absconding in the absence of other risks. If other risks are present (such as a risk of harm to self or others), this risk should be imminent and unable to be managed in a less restrictive way. Mr J was considered a risk of accidental harm if he absconded due to being drug affected and having a head injury. He was also considered a risk of harm to others in the ED due to his agitated and aggressive behaviour, with this risk being imminent immediately prior to being mechanically restrained. From 1.40am onwards, there was no evidence that Mr J was at imminent risk of harm to himself or others and therefore it would not have been appropriate to use mechanical restraints after that time. It would not be appropriate to use mechanical restraints based solely on previous episodes of aggression when no current aggression is exhibited. When Mr J's behaviour escalated shortly prior to his absconding, he initially responded to verbal de-escalation and therefore it was appropriate not to use mechanical restraints. Shortly afterwards, his behaviour again escalated and it was felt that he posed a risk of harm to staff if they attempted to physically restrain him.

60. Dr Michael Sheridan stated that managing highly agitated or aggressive patients in the ED is a daily occurrence. As such, ED staff are required to complete annual Management of Violence and Aggression Training (MOVAIT) and optional 30-minute education sessions are held monthly. Security staff are required to complete theoretical and practical training in the management of highly agitated and aggressive patients as a part of their induction.

61. Members of the code grey team complete a three-day training course, with non-clinical members of the team also completing an annual refresher course.

62. Despite the training of ED and security staff, Nurse Simpson felt that it was unsafe for ED staff to assist security to manage Mr J at the point of his departure. Barwon Health recognised the deficits in the ability of ED and security staff to restrain patients with the training currently in place, and this was addressed by rostering a second security guard in ED at all times.

Sedation

63. According to a communication from Barwon Health, the medication charts from Mr J's ED presentation were unable to be located after his death. Nursing notes indicated that 6mg of midazolam in increments was given after Mr J attempted to leave at 10.15pm[23]. Fiona

[23] Barwon Health digital medical record, ED record, page 62 of 92.

Nelson stated that Dr Henderson administered this medication and from his usual practice, Dr Henderson believes that he would have administered 1-2mg boluses over four doses, likely 2mg, 2mg, 1mg and 1mg between 10.05pm-10.25pm. Dr Henderson did not recall prescribing any other medication, nor did the medical officer responsible for Mr J's care after Dr Henderson finished his shift (Dr Suzanne Rayner) or the ED consultant Dr Alistair Mackinlay.

64. Mr J presented as intermittently agitated from the time he arrived in ED, however this appeared to be managed without sedation or restraint until 10.05pm. From 12.21am Mr J was noted to be calm and settled and therefore there was no indication to provide additional sedating medications. When Mr J's behaviour escalated again shortly before he absconded, he initially responded to verbal de-escalation techniques before again becoming behaviourally disturbed a few minutes later and leaving ED. Dr Sheridan stated that the final episode of behavioural disturbance occurred in the space of 1-2 minutes. Given Mr J initially responded to verbal de-escalation it was reasonable that he was not given further sedation at that time. When his behaviour escalated again, it appeared based on Dr Sheridan's statement that there was insufficient time to administer sedation. As such, it was reasonable that sedation was not administered during that time. The level of sedation administered and the times at which it was administered appeared reasonable.

65. Managing Mr J's behavioural disturbance with verbal de-escalation to prevent use of sedation and restraint was in line with Barwon Health and Chief Psychiatrist guidelines and procedures.

66. Administering more sedation than clinically necessary risks a number of physical health complications including respiratory depression, apnoea, respiratory arrest and cardiac arrest. Additionally, Mr J was thought to have a possible head injury which presents additional complications when administering sedating medications. The effects of sedating medications are similar to the symptoms of a head injury. The use of sedating medications can make it more difficult to identify a deterioration in symptoms of the head injury, and the head injury can make it more difficult to identify adverse effects of sedating medications. As such, sedating medications should be used with caution in patients who have a head injury or suspected head injury.

Was there an earlier opportunity for assessment?

67. In a submission to the Court, Barwon Health disagreed that *it reasonably had an earlier opportunity to assess Mr J.*[24] It was noted that at the time of Mr J's death there was one Mental Health Access Team clinician rostered overnight between 9.00pm and 7.30am on 27/28 November 2016. Overnight, that clinician was responsible for:

a. Attending the ED to review patients requiring urgent mental health assessment at the request of the ED, including those presenting to the ED under section 351 of the *Mental Health Act* 2014; and

b. Responding to calls to the mental health telephone triage service.

68. Barwon Health said that in relation to each assessment, the clinician was required to complete an Integrated Assessment report. The report was 5-6 pages long.

69. Further, at the time of Mr J's death the Court was advised that the Mental Health Access Team's principal office was located in the Swanston Centre, a 5 minute walk from the ED. The Access Team had a small office that was annexed to the ED which allowed clinicians to prepare their contemporaneous reports following patient assessments. All handovers were completed in the Swanston Centre. Clinicians often completed their paperwork in the principal office prior to handover.

70. Barwon Health further advised that so far as the night of 27/28 November 2016 was concerned, the overnight Mental Health Access Team clinician:

(a) Recalls spending much of the evening in the ED assessing patients.

(b) Recalls that the presentations requiring mental health assessments in the ED were high.

(c) Recalls that Mr J had been restrained and sedated.

(d) Whilst he is unable to recall specifically when he left the ED to return to the Swanston Centre, as the overnight shift ends at 7.30am, unless there was an emergency, it was his usual practice to return to the Swanston Centre at approximately 5.30am to 6.00am to attend to administrative tasks (completion of reports) and handover (7.00am to 7.30am).

[24] Letter dated 22 October 2020 from K & L Gates on behalf of Barwon Health.

(e) Handover to the morning staff on 28 November 2016 would have included information that Mr J was in the ED and would require a mental health assessment.

(f) His shift ended at 7.30am.

71. The Court was advised that the *day* Mental Health Access Team clinicians commenced their shift at 7.00am. Two clinicians were rostered to commence at 7.00am; however on the morning of 28 November 2016, only one clinician commenced at 7.00am as the other clinician rostered on had called in sick. The *day* Mental Health Access Team clinician on 28 November 2016 was involved in handover from 7.00am to 7.30am. The clinician would then attend to reviewing the relevant medical records and prioritising patients for review, whilst also attending to patients requiring urgent mental health assessment, and telephone triage. A second Mental Health Access Team clinician commenced at 8.30am that morning.

72. Based on the above assessment, Barwon Health advised that between 6.28am and 8.30am, a mental health assessment of Mr J was not possible at this time.

73. I note that Barwon Health did not express disagreement with the view that patients in ED who require mental health assessment should be referred at the earliest opportunity, or that the earliest opportunity for a mental health assessment to be performed on Mr J on the morning of 28 November 2016 was about 6.30am.

CHANGES MADE SINCE DEATH

74. Barwon Health noted that since Mr J's death there have been a number of changes made to the Mental Health Access Team and the hospital's Assessment under the Mental Health Act Procedures.

75. Of note they included:

(a) The Mental Health Access Team has been restructured. The Mental Health Access Team's principal office has now relocated from the Swanston Centre to the ED. There is now at least one Mental Health Access Team clinician situated in the ED at all times. In addition, overnight, there is now an additional clinician rostered on who is primarily responsible for responding to calls to the mental health telephone triage, but also attends to mental health assessments within the ED as necessary.

(b) So far as the hospital's procedures are concerned, in circumstances where a patient is admitted to the hospital under section 351 of the Mental Health Act 2014 and an

immediate mental health assessment is not possible due to the patient's state (e.g., intoxication), the following changes have been made:

(i) The mental health clinician will make a notation on the ED clinical file of recommendations regarding risk management in the ED based on collateral information obtained and documented past history;

(ii) The ED must contact the Access Team at the earliest point that mental health assessment can occur, regardless of time; and

(iii) Prior to discharge from the ED, all patients that have presented to the ED under section 351 of the Mental Health Act 2014 must be discussed with a consultant psychiatrist.

Conclusions

76. Mr J's mental health assessment was initially delayed to prioritise medical assessment and treatment. This was appropriate in the circumstances, as the severity of Mr J's medical condition was unknown, he was unable to engage in a meaningful mental health assessment and until appropriate medical investigation and interventions had occurred it would be impossible to determine whether his presentation was caused by a head injury, substance intoxication or a mental illness.

77. Mr J had signs of a potentially serious injury causing the significantly abnormal vital signs and blood gas abnormalities present on initial assessment. Mr J was managed according to the initial trauma management guidelines as per the Victorian Trauma system. It was recognised he had a significant mental health issue which required a comprehensive assessment, but this could not take place until he was alert and coherent.

78. The assessment and management of patients who are drug affected and have a head injury is difficult. The initial management priorities should be to resuscitate and stabilise the patient's physical condition. The abnormalities of the vital signs and blood gases on initial assessment could be caused by a physical injury or illness but could also be caused by drug toxicity and extreme agitation. It would only become apparent after a period of resuscitation and observation which was the case.

79. Based on the available evidence, a meaningful mental health assessment could not have occurred on the evening of 27 November 2016.

80. The restraint and sedation procedures utilised in ED were appropriate and in line with best practice. Restraint and sedation both pose additional risks and as such, should not be used to prevent absconding in the absence of other risks. Similarly, restraint and sedation should be used as a last resort option to maintain the safety of the patient and others and should be used for the briefest duration possible. Restraining Mr J when he was behaviourally settled to prevent him from leaving hospital would not have been appropriate. Similarly, administering sedation when Mr J was behaviourally settled would not have been appropriate, would have increased the risk of medical complications and would have further delayed mental health assessment and treatment.

81. It would appear the earliest opportunity for a mental health assessment to be performed on Mr J would have been on the morning of 28 November 2016 at about 6.30am when he was noted to be lying in bed watching television. From the nursing records Mr J appeared to have been cooperative and compliant on the morning of 28 November 2016, sitting in his cubicle watching television, eating and drinking. I agree with the CPU's recommendation that mental health risk assessments be performed at the earliest opportunity on patients with an acute behavioural disturbance as soon as the patient is awake and coherent.

82. Barwon Health did not disagree that an earlier assessment would have been appropriate, but detailed why they did not reasonably have an earlier opportunity to conduct such an assessment (between 6.38am and 8.30am).

83. They also set out the changes which have occurred since Mr J's death. In particular I note that there is at least one mental health clinician situated in the ED at all time and two security guards are also situated in the ED at all times.

84. In any event, based on the available evidence, I am not able to say whether an earlier assessment would have altered the outcome.

FINDINGS AND CONCLUSION

85. Pursuant to section 67(1) of the Coroners Act 2008 I make the following findings:

a. the identity of the Deceased was Mr J, born [redacted] 1994;

b. the death occurred on 28 November 2016 in waters adjacent to the Geelong Waterfront, Geelong, Victoria from *Drowning*; and

c. the death occurred in the circumstances described above.

Intent

86. Mr J had a relatively recent onset of symptoms of a possible mental illness. This appeared to be in the context of illicit substance use. Mr J's erratic behaviour resulted in an incident causing him physical injuries requiring hospital treatment. His mother said that he was more withdrawn from the family in the six months before his death. A mental health assessment was delayed to enable physical assessments to have taken place.

87. From the nursing records Mr J appeared to have been cooperative and compliant on the morning of 28 November 2016, sitting in his cubicle watching television, eating and drinking. It would appear Mr J had a rapid deterioration in his behaviour and became extremely agitated very quickly.

88. It was unclear what his intentions were following him leaving the hospital, and there was some evidence from witnesses that he appeared *disorientated, erratic* and was observed to *be walking in the middle of the road in front of traffic.*

89. Having considered all the circumstances in this matter, I am not satisfied with the required certainty, that Mr J had the capacity to form the intention of taking his own life.

90. I convey my sincere condolences to Mr J's family and friends for their loss and the tragic circumstances in which the death occurred.

COMMENTS

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

91. Mr J's case serves to highlight the following,

To reduce risks to the patient and others, patients in ED who require mental health assessment should be referred at the earliest possible opportunity. Factors may be present that preclude a patient from engaging in a meaningful mental health assessment immediately on arrival, however a referral should be made as soon as practicable after addressing these factors.

While collateral information from families is an important aspect that forms a comprehensive mental health assessment, this should not contribute to significant delays in assessment. Mental health services are available to public hospital EDs 24 hours per day, 7 days per week to reduce delays in mental health assessment and treatment. A timely mental health assessment is particularly important when the patient presents with unpredictable or impulsive behaviours.

92. Pursuant to section 73(1B) of the Act, I order that this finding (in redacted form) be published on the Coroners Court of Victoria website in accordance with the rules.

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

[redacted], senior next of kin

Barwon Health

Office of Chief Psychiatrist

Senior Constable Lachlan Cartledge, Victoria Police, Coroner's Investigator

Signature:

SARAH GEBERT

CORONER

Date: 26 February 2021