IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2022 006863

FINDING INTO DEATH FOLLOWING INQUEST

Form 37 Rule 63(1)

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

Inquest into the Death of Erol Elmas

Delivered on:	30 September 2024
Delivered at:	Southbank, Victoria
Hearing Date:	30 September 2024
Findings of:	Coroner Paul Lawrie
Representation:	Ms Samantha Downes of Lander & Rogers for Forensicare
Counsel Assisting:	Ms Ann Kho, Coroner's Solicitor
Catchwords	Death in custody; Victoria Forensic Institute of Mental Health

I, CORONER PAUL LAWRIE, having investigated the death of EROL ELMAS,

and having held an inquest in relation to this death at Southbank on 30 September 2024

find that the identity of the deceased was EROL ELMAS born on 8 December 1990

and the death occurred on 30 November 2022

at Thomas Embling Hospital, 201 Yarra Bend Road, Fairfield Victoria 3078

from a cause which remains

1(a): UNDETERMINED

INTRODUCTION

1. Erol Elmas was 31 years old when he was found deceased at Thomas Embling Hospital (TEH). Mr Elmas had been a patient at TEH on a Custodial Supervision Order since 21 March 2016.[1] He had previously been admitted from 3 March to 19 September 2014.

2. Mr Elmas had a diagnosis of schizoaffective disorder and was prescribed lithium, quetiapine and amisulpride at the time of his death. It does not appear that Mr Elmas had any ongoing significant physical ailments.

3. Mr Elmas had a history of suicide attempts, suicidal ideation and self-harming behaviours, which included swallowing objects, tying ligatures around his neck and giving away personal possessions.

4. On 29 September 2021, during an episode of seclusion, Mr Elmas used a pair of underwear to try to strangle himself whilst simultaneously covering himself with a blanket and then forcing it down his throat. The psychiatric registrar who later conducted a review noted that Mr Elmas “want[ed] to get out of seclusion and that is why he is trying to kill himself”.[2]

[1] Pursuant to the *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic).

[2] Forensicare Medical Records 2021, p 340

PURPOSE OF A CORONIAL INVESTIGATION

5. Mr Elmas' 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.[3] The death of a person in care or custody is a mandatory report to the coroner, even if the death appears to have been from natural causes.[4]

6. 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.

7. 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.

8. Detective Senior Constable (DSC) Georgia Cousins acted as the Coroner's Investigator for the investigation of Mr Elmas' death. The Coroner's Investigator conducted inquiries on my behalf and compiled a coronial brief of evidence.

9. At the time of his death, Mr Elmas was detained in a designated mental health service[5]. Accordingly, he was a person who was in custody[6] for the purposes of the Act, and an inquest into Mr Elmas' death is mandatory[7] unless I consider the death was due to natural causes.[8] However, I have concluded as a preliminary matter, that there is insufficient evidence upon

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[3] Section 4 of the *Coroner Act 2008* ('the Act').
[4] Section 52(3A) of the Act.
[5] Section 3 of the *Mental Health Act 2014* provided that designated mental health services included the Victorian Institute of Forensic Mental Health, also known as Forensicare. The *Mental Health Act 2014* has since been repealed and replaced by the *Mental Health and Wellbeing Act 2022* from 1 September 2023.
[6] Section 3 of the Act.
[7] Section 52(2)(b) of the Act.
[8] Section 52(3A) of the Act.

which to find that Mr Elmas' death was due to natural causes. Accordingly, an inquest is mandatory.

10. The inquest itself proceeded in a manner which has become known as a "summary inquest". That is, where the evidence contained in the coronial brief appears settled and the circumstances of the case do not otherwise require the hearing of oral evidence.

11. This finding draws on the totality of the coronial investigation into the death of Erol Elmas, including the evidence contained in the coronial brief. 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.[9]

BACKGROUND

12. Mr Elmas grew up in the north-western suburbs of Melbourne with his parents and older sister. His parents separated when he was one year old, and he and his sister then lived with their father.

13. Mr Elmas began drinking alcohol at age 12 and then began using various illicit substances in his adolescence. At about this time he began to exhibit antisocial behaviour.[10] He was frequently found by his father to be in possession of knives. He spent a month at the Parkville Juvenile Justice Centre in 2007 after committing offences involving substance use and assaults.

14. In June 2008, Mr Elmas was detained pursuant to the *Mental Health Act 1986* after he was found in a drug-affected and suicidal state.

15. In late 2008, Mr Elmas left his father's house and went to live with his mother in Broadmeadows.

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[9] 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.

[10] Forensicare Medical Record 2014-2022, p 901.

16. Between 2009 and 2012, Mr Elmas served a sentence in prison for offences involving the stabbing of two people. Following his release from prison, he resided alone in private accommodation in Carlton and then moved in with his sister at her home.

17. Mr Elmas later spent a month in custody from March 2013 while awaiting trial on a charge of assault. He was convicted and received a suspended sentence in respect of that charge.

18. In September 2013, Mr Elmas returned to living with his mother and remained close to his sister.

19. On the morning of 5 December 2013, Mr Elmas was in the grips of a psychotic episode caused by schizophrenia. It appears that this episode had been worsening over several days. Mr Elmas attended the Broadmeadows Turkish and Islamic Cultural Centre in Dallas. He was armed with a knife. In an unprovoked attack, he stabbed and killed one man, and seriously injured three other men.[11]

20. Mr Elmas was arrested at the scene and then charged with one count of murder and three counts of attempted murder. On 21 March 2016 he received a directed acquittal in the Supreme Court by reason of mental impairment and a Custodial Supervision Order was imposed for a nominal term of 25 years.[12] Thereafter he was confined at TEH.

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

Circumstances in which the death occurred

21. On 8 October 2022, TEH nursing staff observed symptoms indicative of a deterioration in Mr Elmas' mental state. They noted disrupted sleep, paranoid delusions, response to internal stimuli and thought-blocking[13]. Mr Elmas denied experiencing hallucinations despite staff witnessing overt responses to internal stimuli.

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[11] *R v Elmas* [2016] VSC 405

[12] Ibid

[13] Thought blocking occurs most often in people with psychiatric illnesses. A person's speech is suddenly interrupted by silences that may last a few seconds to a minute or longer. When the person begins speaking again after the block, they often discuss unrelated subjects. Thought blocking is also described as an experience of unanticipated, quick and total emptying of the mind.

22. Throughout 15 and 16 October 2022, staff observed that Mr Elmas had not had any substantial sleep and had been awake for 32 hours. The next day, Consultant Psychiatrist Dr Asiri Rodrigo assessed him via a telehealth consultation and noted the following[14]:

> *1. Preoccupied 2. Poor sleep 3. Muttering to self 4. lack of clarity in his expressions 5. quick to anger/ agitation 6. lability in mood 7. disorganization*
> *At least on one occasion he was concerned about his safety (plane crash)*

23. Dr Rodrigo's clinical impression was that there had been a lapse in Mr Elmas' mental state, and he noted a plan to continue monitoring for any further deterioration.

24. In the early hours of 19 October 2022, Mr Elmas was seen to be pre-occupied. Throughout the evening, his behaviour escalated to verbal aggression and hostility toward nursing staff.[15]

25. In the following days, Mr Elmas' mood was noted to be improving, and he was sleeping better.

26. Overnight from 22 to 23 November 2022, nursing staff observed that Mr Elmas was mostly awake.

27. On the morning of 23 November 2022, Mr Elmas barricaded himself in his room. When a nurse opened his door, Mr Elmas raised his fist and attempted to strike the nurse with an open palm.[16] He appeared paranoid and claimed that the nurse was going to poison him. He later voiced delusions of being infected with COVID-19 and that he was going to die soon. Extensive efforts were made by staff to administer his PRN medication and intramuscular (IM) olanzapine without success, and he became aggressive and threatening towards the nursing staff.[17]

28. Dr Rodrigo then conducted a mental state examination and noted Mr Elmas' "*affect was angry and distressed, restricted to dysphoric range…His thought process was perseverative at times disorganized…he appeared to be preoccupied and talking to self – suggesting he may*

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[14] Forensicare Medical Records 2022, p 548
[15] Ibid, p 551-555
[16] Ibid, p 611
[17] Ibid, p 612

be having perceptual abnormalities".[18] Dr Rodrigo further noted that Mr Elmas had a propensity to use violence to defend his room. However, no thoughts of self-harm were noted. Dr Rodrigo's clinical impression was that this was an acute relapse of schizoaffective disorder.

29. Mr Elmas subsequently agreed to take his medications at 5.15 pm, and Dr Rodrigo ordered an increased dose of oral amisulpride and the administration of 7.5mg diazepam.

30. Mr Elmas refused to leave his room after the mental state examination and administration of medication. Concerned that he may be in possession of a weapon, staff sought the assistance of Victoria Police to remove him from his room in order to place him in seclusion.

31. The Victoria Police Critical Incident Response Team (CIRT) attended. Mr Elmas had broken up furniture in his room and fashioned pieces into a shield and a stake. He refused to engage with CIRT negotiators and police entered his room at 7.47pm.[19] He was subdued after a Taser was used and he was struck three times with flexible baton rounds. Mr Elmas was then moved to a seclusion room, and the treating team took over physical restraint and administered IM 150mg zuclopenthixol acetate (Clopixol Acuphase), 10mg haloperidol, 2mg benztropine, 2mg lorazepam and 150mg paliperidone depot.[20]

32. At 7.52pm, Mr Elmas' treating team removed the restraints that had been applied by the CIRT members and used a blanket to restrain him.[21] Further observations were conducted at 8.04pm, and his vital signs were within normal limits except for a slightly elevated heart rate. The blanket was removed at 8.10pm.[22] Mr Elmas was subsequently placed on three-hourly observations while in the seclusion room.

33. On 24 November 2022 at 10.35 am, Dr Rodrigo and a psychiatry registrar conducted a medical review. His heart rate was recorded at 138 beats per minute, and his pulse volume was considered good, but he refused an electrocardiogram (ECG).[23] He tried to kick staff and

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[18] Forensicare Medical Records 2022, p 614
[19] Ibid, p 614
[20] Ibid, p 616
[21] Ibid, p 617
[22] Forensicare Medical Records 2022, p 615
[23] Forensicare Medical Records 2022, p 623

this restricted their ability to examine his injuries arising from the action to remove him from his room. His night medication was withheld due to him being sedated and having had an insufficient intake of fluids.

34. On the morning of 25 November 2022, a registered nurse noticed Mr Elmas had blood on his shoulder which was believed to be from his nose. Mr Elmas adopted a fighting stance and shouted, "*open the door, come and fight*".[24] At 3.15pm, he was restrained to administer 10mg haloperidol, 150mg zuclopenthixol and 2mg lorazepam.[25] At a review at 10.44pm Mr Elmas denied having any physical health problems.

35. On 26 November 2020 at 10.30am, Consultant Psychiatrist Dr Kylie Lloyd sought to review Mr Elmas. He was seen to be asleep and did not respond and was mildly tachypneic.[26] It was decided that physical observations would be attempted during the next review.

36. At 2.00pm, Mr Elmas was reviewed by psychiatry registrar, Dr Suben Mahendranathan, who noted he was asleep. His breathing was also noted but it appears that his vital signs were not otherwise recorded.[27]

37. At 5.00pm, staff could not enter the seclusion room for a medical review because Mr Elmas was blocking the door. He was agitated, refused medication and threatened staff with violence.

38. On 27 November 2022, Dr Lloyd reviewed Mr Elmas at 11.23am and noted that he was sedated and unrousable but was moving his legs while asleep.[28] Dr Lloyd also noted he had not eaten breakfast. Mr Elmer's fluid balance status was unclear, and Dr Llyod had not received a full set of vital signs. Dr Lloyd further noted, "*respirations consistent with sleep: slower, deeper with insp snore. Nil exp stridor. Able to view face, not pale*". Dr Lloyd's clinical impression was that Mr Elmas remained at an ongoing elevated risk of violence

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[24] Seclusion Observation Record, p 35
[25] Forensicare Medical Records 2022, p 627
[26] Ibid, p 642
[27] Ibid, p 643
[28] Ibid, p 649

despite being heavily sedated. His plan was to reduce the dosage of zuclopenthixol acetate (to 100mg) and for observation of vital signs to be conducted as soon as possible.

39. At 12.55pm, while a staff member was delivering a meal through the door, Mr Elmas stood up and made threats towards them, ordering them to leave. No physical observations were conducted as entering the seclusion room was deemed to be too risky at that time.[29]

40. At 1.38pm, 1mg lorazepam, 2mg benztropine, 100mg zuclopenthixol acetate was administered by intra-muscular injection, and a medical review was conducted while Mr Elmas was under restraint. His vital signs were not obtained as he attempted to kick staff.[30]

41. In the following hours, Mr Elmas was asleep on and off. Nursing staff noted he was intense and aggressive at times. He requested his treating team not to enter the seclusion room and refused to have any physical observations conducted. Nursing staff continued visual observations from the door.

42. On 28 November 2022, the period of seclusion was ceased at 8:10am.[31] Mr Elmas was initially settled but quickly escalated and became verbally aggressive. Consultant Psychiatrist, Dr Rose Clarkson reviewed him a short time later and noted he was preoccupied with his intra-muscular medications. He was noted to have said, *"won't take any oral meds [and] will just divert them"* as he preferred all medications by injection and said he felt better after receiving his medications.[32] Dr Clarkson also noted that Mr Elmas did not express suicidal or self-harm ideation or violent ideations during the review.[33]

43. Dr Clarkson's plan was to administer the second dose of the paliperidone depot on 30 November 2022 and commence short-acting haloperidol (as required) to taper quetiapine and cease olanzapine in order to aid in monitoring his physical health. Throughout the rest of the day, Mr Elmas was observed to be psychotic and openly responding to internal stimuli. He

[29] Forensicare Medical Records 2022, p 649
[30] Ibid, p 650-651
[31] Ibid, p 655
[32] Ibid, p 658
[33] Coronial Brief of Evidence (CB), Statement of Dr Rose Clarkson, p 16

went to bed at approximately 5.00pm and was observed throughout the night to be asleep. That evening the frequency of observations was increased to hourly intervals.[34]

Immediate circumstances surrounding death

44. On the afternoon of 29 November 2022, Mr Elmas was seen to be acutely unwell and refused his oral medications. He became verbally aggressive and again threatened violence towards staff members. The treating team decided to medicate him urgently to reduce the risk of violence and attempted to de-escalate him in order to do so. However, Mr Elmas became increasingly intimidating and threatened to fight staff. It was later reported that he assaulted multiple staff members by punching, pulling hair, and kicking.

45. At 2.22pm, Mr Elmas was able to be held down on the floor and medications were administered by intra-muscular injection. He then began another seclusion period and was noted to be pacing around the seclusion room for approximately 30 minutes. He also smeared a liquid substance on the windows. Following this, he slept at times and was seen to have normal respiratory effort.

46. At 4.15pm, Mr Elmas complained to a nurse that he felt he was choking and unable to breathe. After sitting up he reported feeling better and then said he was okay. At 4.30pm, he was reviewed by psychiatry registrar Dr Thilina Perera and Dr Clarkson. He was initially sleeping on a mattress and his respiration rate was noted to be 20 breaths per minute with no increased effort.[35] Mr Elmas was woken and spoke to Dr Perera via the intercom; he was observed to be sitting on the mattress and gesturing to her. When asked whether he had difficulty breathing, he indicated that he was no longer having any difficulty and gestured with two thumbs-up (presumably to indicate that he felt physically well). Dr Perera later told him to alert staff if he had any concerns, and he returned to lie on the mattress. Dr Perera noted the plan to constantly observe for signs of respiratory distress (such as shortness of breath and high respiratory rate) and to conduct physical observations at the next review.[36]

[34] Forensicare Medical Records 2022, p 659
[35] Ibid, p 662
[36] Ibid, p 662

47. During the visual observations between 6.15pm and 7.15pm, a nurse observed periods of intermittent fast breathing while Mr Elmas was asleep. When he was woken up, his respirations were even and within normal limits.[37] Nursing staff later noted Mr Elmas was lying on the mattress obscured by the blanket, and when he got up from the mattress, he tucked a wrap into his underwear. He then placed a pair of underwear over his pants and another pair over his face. After that, he threw a cup of yoghurt onto the observation window, partially obscuring it, and yelled out that he did not want the nurse to enter.

48. Staff later entered the seclusion room to conduct a medical review and administer medication. Mr Elmas began balling his hands into fists and using the mattress as a shield. The medications were not administered, and staff retreated from the room. The treating team then discussed the safest way to administer his medication, and a plan was made to enter the seclusion room when additional staff were available at 7.00am the next morning.[38]

49. Further, the nurse in charge escalated the inability to administer medication to the on-call consultant psychiatrist, Executive Director of the hospital and Executive Director of Clinical Services. Concerns as to whether Mr Elmas may need to be transferred to an Emergency Department for administration of medication and physical health monitoring were also raised.[39]

50. Between 8.10pm and 9.05pm, Mr Elmas was breathing rapidly at times, and his respiration rate was recorded at 27 breaths per minute. The rapid breathing was noted to be "*only for brief periods before returning to baseline*".[40] He then made a hole in the seclusion blanket, and began wearing it like a poncho and pulled out one of his dreadlocks.

51. Between 10.00pm and 11.00pm, Mr Elmas was observed hyperventilating and his respiration rate was recorded as 48 breaths per minute at 10.05pm.[41] A nurse further noted that he was not engaging and remained supine on the mattress, with the blanket covering his face and body. At 10.16pm, the nurse heard a strange breathing noise. Mr Elmas stood up and then

[37] Forensicare Medical Records 2022, p 663
[38] Ibid, p 666
[39] CB, Statement of Dr Jasques Claassen, p 14-15
[40] Forensicare Medical Records 2022, p 666
[41] Ibid, p 668

lost balance, slipped, and fell backwards against a bench. He was observed not to hit his head and, when asked, replied he was okay and denied any head strike. At 10.29pm, his respiration rate was recorded at 49 breaths per minute.[42]

52. At 10.40pm, Dr Palawinnage completed a medical review from the open door. Mr Elmas was seen to be lying on the mattress, covered with blankets. Dr Palawinnage noted regular breathing initially, but when approached, Mr Elmas began rapid breathing and vigorous limb movements. After the medical review, Mr Elmas stood up, keeping his face covered by the blanket, and was observed shadow boxing at 10.45pm. He continued to shadow box at 10.57pm while lying supine.[43]

53. At 11.00pm, Mr Elmas was observed lying on his mattress, and he repositioned himself without difficulty. Registered psychiatric nurse (RPN) Andrew Davidson noted "*loud, clear respiration…increased rate as per handover received from previous shift*". It does not appear however that the respiration rate was recorded.[44]

54. RPN Davidson later updated Mr Elmas' risk assessment to reflect the recent deterioration in his mental state and the recent incidents. Self-harm was assessed as high (in response to hair pulling), but the suicide risk was assessed as low. The risks of medication non-adherence and physical decline were assessed as high.[45]

55. At 11.40pm, RPN Davidson noted a decline in respiration, but no other changes in position or signs of distress were evident.[46] It then became difficult to see his respiratory effort and the treating team assembled and opened the seclusion room. They attempted to rouse Mr Elmas verbally, but he did not respond. The duress alarm was activated at 11.57pm and a medical emergency was called at 11.58pm.[47]

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[42] Forensicare Medical Records 2022, p 668
[43] Ibid, p 668
[44] Ibid, p 669
[45] Ibid, p 667
[46] Ibid, p 669
[47] Ibid, p 669

56. The treating team entered the seclusion room at 12.01am (on 30 November 2022) and found that Mr Elmas was not responding to physical stimuli.[48] A seclusion blanket was observed to be over his head, one around his neck (poncho style), along with a pair of underwear around his neck. These were removed and cardiopulmonary resuscitation commenced at 12:02am. Despite the resuscitation efforts Mr Elmas was unable to be revived and was pronounced deceased at 12.21am.[49]

Identity of the deceased

57. On 1 December 2022, Erol Elmas, born 8 December 1990, was visually identified by his father, Yilmaz Elmas.

58. Identity is not in dispute and requires no further investigation.

Medical cause of death

59. Forensic Pathologist, Dr Paul Bedford from the Victorian Institute of Forensic Medicine conducted an autopsy on 2 December 2022 and provided a written report of his findings dated 28 March 2023.

60. The autopsy revealed no significant underlying natural disease that may have caused or contributed to death.

61. Dr Bedford commented that there is no unequivocal evidence to suggest the use of blankets and underpants caused respiratory obstruction. However, the possibility could not be excluded entirely.

62. Dr Bedford noted overall minor bruises and abrasions across Mr Elmas' body, with significant bruising over the left chest and thigh. A further forensic investigation of the left thigh region revealed a significant inflammatory and infective process in this area, and this correlated with the reported elevated C-reactive protein. Accordingly, Dr Bedford considered it was possible that the death was related to sepsis, but he did not favour this hypothesis.

[48] Forensicare Medical Records 2022, p 669
[49] Ibid, p 670

63. Dr Bedford concluded that the observed injuries were not of an extent to lead to death.

64. Toxicology analysis of post-mortem samples revealed the presence of zuclopenthixol, hydroxyrisperidone, haloperidol, olanzapine, amisulpride, lorazepam, temazepam, levetiracetam, and paracetamol in keeping with the recorded administration of these drugs. The concentration of zuclopenthixol was noted to be elevated, but Dr Bourke concluded that, in the setting of chronic therapeutic use and tolerance, it was unclear whether this was likely to have led to death.

65. Biochemistry results did not reveal any evidence of renal failure or dehydration.

66. Dr Bedford's ultimate opinion is that the medical cause of death was undetermined.

67. I accept Dr Bedford's opinion.

INVESTIGATIONS PRECEDING THE INQUEST

Coroners Prevention Unit Review

68. As part of my investigation, I requested the Coroners Prevention Unit[50] (CPU) review this matter and provide advice. The Health and Medical Investigations Team (HMIT) within the CPU was directed to consider the medications administered to Mr Elmas. The Mental Health and Disability Team (MHDT) within the CPU was directed to consider the appropriateness of suicide risk assessment and the clinical management in the seclusion room immediately proximate to the death.

Health and Medical Investigations Team Review

69. The HMIT noted Mr Elmas presented with agitated delirium in the setting of chronic schizoaffective disorder. His previous history of obesity with a body mass index of 34.1 and the absence of other significant past clinical history were also noted. He was last administered intra-muscular medications (100mg long-acting paliperidone and 10mg short-acting

[50] The Coroners Prevention Unit is a specialist service for coroners created to strengthen their prevention role and provide them with expert assistance by reviewing a range of reportable and reviewable deaths and collecting and analysing data relating to reportable and reviewable deaths.

haloperidol)[51] shortly after 2.22pm on 29 November 2022, and further attempts to administer medications were unsuccessful.

70. The HMIT commented that the overall clinical treatment and management of Mr Elmas was challenging, given his presentations of psychosis and the considerations of the need to adopt the least restrictive options and simultaneously maintain the safety of staff.

71. The HMIT further commented that a decision to convey Mr Elmas to an Emergency Department for medical investigation and treatment would be equally challenging given the need for patient and staff safety. This is because agitated delirium is known to have high mortality and morbidity, which increases in the setting of physical restraint.

72. The HMIT opined that the administration of medication was unlikely to have contributed to Mr Elmas' death, given the peak action of haloperidol is four to six hours after intramuscular injection. Signs of haloperidol toxicity include restlessness, tremor and rigidity – and I note that, save for behaviour that may be considered to be "restlessness", other signs of toxicity were not reported.

73. The HMIT concluded that the medications administered were appropriate and reasonable in the circumstances.

Mental Health and Disability Team Review

Suicide/Self-Harm Risk Assessment

74. Mr Elmas had a history of a single suicide attempt and having made multiple suicidal gestures during his admission at TEH. The MHDT noted Mr Elmas was asked about thoughts of self-harm on 18 November 2022 and 23 November 2022, and he was recorded on those occasions not to have expressed any such thoughts. His risk of self-harm and suicide, as well as his risk of physical decline, were rated as low at that time.

[51] CB, Statement of Dr Rosemary Clarkson, p 18.

75. Similarly, on 28 November 2022, Mr Elmas did not express suicidal or self-harm ideation during the review conducted by Dr Clarkson. The last risk assessment conducted by RPN Davidson reflected the recent deterioration in his mental state and the recent incidents.

76. Although the MHDT noted the process for conducting the risk assessments did not appear to meet the usual requirements for a thorough risk assessment, which would include a discussion with specific questions asked of the patient, the MHDT acknowledged the challenges arising from Mr Elmas' resistance to communication and lack of engagement.

77. The MHDT explained that a low risk of self-harm or suicide means that there are no or few risk factors with a low level of monitoring required. A rating of medium means there are several factors that require an increase in observation. Whereas a high-risk rating is an indicator of suicide risk.

78. It is evident from Mr Elmas' patient records that there was nothing to suggest he was displaying or voicing suicidal ideation or behaviours. The MHDT opined the risk ratings for Mr Elmas' self-harm and physical decline risk ratings were appropriate.

79. The MHDT also noted that, while no changes were made to the treatment plan at the time the risk assessment was updated (at 11.00pm on 29 November 2022), Mr Elmas was already on constant observation. Any higher level would require nursing staff to be within arm's reach, which the MHDT considered was not feasible due to the risk of violence towards staff.

80. Considering Mr Elmas' lack of engagement with nursing staff for more than a week and the reduction in communication during the time his mental state was deteriorating, the MHDT concluded that it would have been difficult to determine if Mr Elmas had any plans or intention to end his life. The MHDT considered any suicidal or self-harming behaviour would be a consequence of the deterioration in his mental state. Therefore, the plan to optimise his psychotropic medication as quickly as possible was appropriate, as this would have reduced the overall risk in all domains.

Supervision during seclusion

81. Seclusion is a restrictive intervention mandated under the *Mental Health Act*. Restrictive interventions may only be used after all reasonable and less restrictive options have been tried or considered and found unsuitable. Furthermore, a person may only be secluded if necessary to prevent imminent and serious harm to themselves or another person. The principles of least restriction require seclusion to be ceased as soon as possible, which requires regular communication with the patient to establish opportunities for ending the seclusion period at the earliest opportunity. It is apparent that the nursing staff made continual efforts to engage Mr Elmas to assess his suitability for cessation of seclusion.

82. When a person is secluded, they must be monitored in accordance with the requirements of the *Mental Health Act* as follows:

> *A registered nurse or registered medical practitioner must clinically review a person in seclusion as often as is appropriate, having regard to the person's condition, but not less frequently than every 15 minutes. Subject to subsection (4), an authorised psychiatrist [or delegate] must examine a person kept in seclusion as often as the authorised psychiatrist is satisfied is appropriate in the circumstances to do so, but not less frequently than every 4 hours.*[52]

83. The MHDT noted that overall, Mr Elmas was monitored constantly by appropriately qualified nursing personnel in accordance with the requirements of the *Mental Health Act*.

Physical health observation in seclusion (vital signs)

84. The MHDT noted most of the medical reviews were conducted from the open door to the seclusion room due to the ongoing risk of interpersonal violence. Mr Elmas frequently refused to allow staff to enter the room and would lash out physically or with verbal threats when they tried to do so. The final occasion when Mr Elmas was subject to complete physical health observations (when all his vital signs were recorded) was 24 November 2022.

85. The MHDT observed that Mr Elmas' vital signs were not obtained or recorded in accordance with the Forensicare *Recognising and Responding to acute deterioration* procedure. This

[52] Sections 111 and 112 of the *Mental Health Act 2014*

states that vital signs must be taken "*at least every four hours if the consumer is in seclusion; or more often as clinically indicated... When any acute change in physical state is suspected (for instance; dizziness, shortness of breath…)"*.[53]

86. Other than Mr Elmas' respiration rate (measured from outside the seclusion room) he did not have a full set of vital signs taken four hourly or when his respiration rate was high or when he complained of difficulty breathing. The MHDT acknowledged this was due to the risk of violence he posed to staff and their inability to enter the seclusion room. To obtain vital signs, it is likely Mr Elmas would have had to be restrained, which itself poses a risk to physical health. Furthermore, there was no guarantee that the vital signs would have been adequately obtained under those circumstances, especially if Mr Elmas were to have struggled with staff.

87. The MHDT opined that Mr Elmas' vital signs were supposed to be recorded on a Standard Observation Chart that is colour-coded so that when they are outside of normal parameters, the appropriate escalation pathway can be followed. For instance, on 29 November 2022 at 10.05pm and 10.30pm, Mr Elmas' respiratory rates[54] were within the *Red Zone,* which requires the calling of a medical emergency. The escalation response did not happen until RPN Davidson noticed a decline in Mr Elmas' respirations approximately one hour later at 11.40pm when a medical emergency was called at 11.57pm. Accordingly, there was an opportunity for an earlier escalation of concerns about Mr Elmas' physical signs which was not taken. However, it is not possible to say whether an earlier escalation (with an assumption that earlier close physical observations could be made feasible) would have revealed the signs, if any, present prior to his respiratory arrest. In this regard it is significant to note that 10 minutes after the second observation of a high respiration rate (at 10.29pm), Mr Elmas was seen to stand up and resume shadow boxing.

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[53] Forensicare *Recognising and Responding to Acute Deterioration Procedure*, v.1.4, updated 20 October 20.
[54] See paragraph 51.

Forensicare SAPSE review

88. Forensicare conducted a Serious Adverse Patient Safety Event (SAPSE) review as Mr Elmas' death met the criteria of a sentinel event[55] and the review report was provided to the Court. The SAPSE review included the following findings:

<u>Findings</u>

(a) Staff concern about being harmed by a consumer with a history of aggression who was known to assault staff, resulting in a decision not to enter seclusion to undertake physical observations, which should have triggered a medical emergency.

(b) A Standard Observation Chart, which specifies actions required when abnormal observations occur or when staff are concerned about the consumer, was not used to monitor vital signs.

(c) Lack of standardised physical monitoring, deterioration, detection and escalation pathways.

(d) Lack of physical health care integration into the Model of Care.

<u>Lessons to be learned</u>

(a) Mr Elmas had an Advance Statement in place which gave instruction not to perform cardiopulmonary resuscitation. End-of-life instructions are more appropriately detailed in a (medical) Advance Care Directive (medical), not an Advance Statement. Mr Elmas' request appears not to have been known by staff at the time. It was identified that further work on the use of Advance Care Directives and integration with the patient's care pathway is required.

(b) There was a lack of clear instructions on the requirements for a medical examination during a seclusion episode.

[55] See Safer Care Victoria's Victorian Sentinel Event Guide, Category 11 – All other adverse patient safety events resulting in serious harm or death.

(c) There was a lack of specific instructions to staff on 15-minute observations and constant observation requirements during a seclusion episode.

89. The SAPSE review arrived at the following recommendations:

(i) Forensicare to establish a standardised system for the management of physical health including monitoring, detection of deterioration, escalation pathways, policies, procedures and training for staff.
(**Recommendation 1**)

(ii) Forensicare to require the use of the Standard Observation Chart for all physical observations, including during seclusion episodes, and revise the Standard Observation Chart for applicability for both hospital and prison services.
(**Recommendation 2**)

(iii) Provide specific instructions on requirements for medical examination during seclusion episodes.
(**Recommendation 3**)

Seclusion Procedure Updates

90. Forensicare advised that it had reviewed and updated its Seclusion Procedure in light of these recommendations. Notably, in response to Recommendation 1, the Seclusion Procedure was updated to detail the steps nursing staff must take when a patient is displaying physical health indicators of concern – such as vomiting, shortness of breath or confusion. Particularly, these must be escalated to the Associate Nurse Unit Manager.

91. As part of the response to Recommendation 2, the Seclusion Procedure update requires that each time a patient's observations are taken in seclusion, an Authorised Psychiatrist or Registered Nurse will record these observations in the standard observation chart and a Form 142 – Restrictive Interventions Observation Form[56]; and include a non-contact physical

[56] Form 142 is a standardised form created by the Department of Health to be used by designated mental health services in Victoria.

observation tool, which outlines the key physical indicators of airway, breathing, circulation, disability and exposure. This tool provides clinicians with clear guidance on instances when a patient's physical health must be investigated and their care escalated to the Associate Nurse Unit Manager.

92. Forensicare advised that annual audits are also conducted with the view to ensure standards of care align with its other relevant policies and procedures.

93. In response to Recommendation 3, Forensicare advised that the definition of "medical examination" for the purposes of its Seclusion Procedure will "*include a review of a person's physical and mental state, risk assessment and physical observations required for assessment of adverse effects of medication, medication prescribed, ingestion of alcohol, illicit drugs, overdose, and risk from deliberate or accidental self-harm, and the need for continuing seclusion. The examination will be as thorough as the circumstances allow".*

94. The Seclusion Procedure now provides that when an Authorised Psychiatrist conducts a medical examination during seclusion, they must:

    (a) ensure the examination is as thorough as the circumstances permit;
    (b) ensure the examination covers mental and physical health status;
    (c) review every person who is secluded at least every 24 hours; and
    (d) document the medical examination in the clinical record, including the risks, mental state, physical health and reasons seclusion could not be ceased.

95. Forensicare confirmed that all staff have been notified of these updates in July 2023. It also advised that, most recently, following the SAPSE review, it has implemented further updates to the Seclusion Procedure. In particular, the procedure further requires that:

    - If the vision to a seclusion room becomes obstructed, resulting in an inability to adequately assess the consumer, the relevant clinician must escalate the consumer's care to the Associate Nurse Unit Manager, Nurse Unit Manager or Clinical Administration.
    - Registered Nurses to monitor and record respirations during seclusion observations.

- Whilst patients are permitted to wear their clothing in seclusion, all risk items are to be removed prior to a consumer being placed in seclusion, and any concerns for patient safety related to clothing are to be immediately escalated to Operations and Clinician Administration to formulate a risk management plan;
- Staff to consider the history of a consumer when identifying the level of access to potentially dangerous items a patient is allowed whilst in seclusion.

96. The latest update of the Seclusion Procedure also provides a detailed escalation pathway in the event a risk is identified that prevents staff from entering the seclusion room. The escalation pathway includes:

- escalation to Clinical Administration whilst a Registered Medical Practitioner or senior Registered Nurse ensures constant observations are conducted whilst continued attempts are made to enter seclusion;
- attendance at the unit by Clinical Administration to discuss risk-related issues and assist with the development of a plan to enter seclusion safely;
- if, following the attendance of Clinical Administration, the risk of harm to staff remains high and staff are unable to enter, Clinical Administration is to escalate to the Operations Manager or Authorised Psychiatrist;
- if the Authorised Psychiatrist or senior Registered Nurse is unable to enter seclusion within four hours after the previous review, they are to complete a report identifying the *Mental Health and Wellbeing Act 2022* breach. The Operations Manager is then required to notify the Executive Director, Chief Operating Officer or Chief Executive Officer.

Consumer Observation and Engagement Procedure Updates

97. Forensicare also advised that its Consumer Observation and Engagement Procedure had been updated as part of its response to Recommendation 2. The updated procedure includes a table that details the observation requirements for low, moderate, high and imminent extreme-risk patients. When a patient is rated as high risk, the responsible clinician must maintain a direct line of sight. When a patient is rated as an imminent extreme risk, the clinician must constantly be in sight and within arm's reach with no physical barrier.

Other responses to Recommendation 1

98. As a further part of its response to Recommendation 1, Forensicare appointed a Nurse Practitioner to support the improvement of physical health outcomes for patients at TEH. This role includes undertaking primary and secondary consultations regarding patients' physical health and providing clinical leadership.

99. With the aim of standardising system improvements, in 2023, Forensicare completed a benchmarking program that compared its system for the management of patients' physical health against that of other Victorian health services.

FINDINGS AND CONCLUSION

100. The standard of proof for coronial findings of fact is the civil standard of proof on the balance of probabilities, with the overlay of caution required by *Briginshaw v Briginshaw*.[9] Adverse findings or comments against individuals in their professional capacity, or against institutions, are not to be made with the benefit of hindsight but only on the basis of what was known or should reasonably have been known or done at the time, and only where the evidence supports a finding that they departed materially from the standards of their profession and, in so doing, caused or contributed to the death under investigation.

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

   a) the identity of the deceased was Erol Elmas, born 8 December 1990;

   b) the death occurred on 30 November 2022 at Thomas Embling Hospital, 201 Yarra Bend Road, Fairfield, Victoria;

   c) the cause of death is undetermined; and

   d) the death occurred in the circumstances described above.

102. Despite extensive post-mortem pathology, biochemistry and toxicological investigations, I am unable to determine the cause of Mr Elmas' death. Furthermore, I cannot say with sufficient certainty whether an escalated response after Mr Elmas was noted to have a high respiration rate at 10.05pm and 10.29pm on 29 November 2022 may have led to a different outcome.

103. Having considered all the evidence, I am satisfied that there are no suspicious circumstances associated with the death of Mr Elmas. I am also satisfied that Mr Elmas was provided with appropriate medications at dosages that were within accepted clinical ranges for his presentation.

104. I am further satisfied that Forensicare has appropriately reviewed the management and care provided to Mr Elmas. The issues identified in the Serious Adverse Patient Safety Event review, and the consequent recommendations are properly directed toward the improvement of clinical practices. I am also satisfied that it has taken appropriate steps in response to those recommendations.

I convey my sincere condolences to Mr Elmas' family for their loss.

PUBLICATION

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

DISTRIBUTION

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

Melek Elmas, Senior Next of Kin

Victorian Government Solicitor's Office, on behalf of the Victorian Attorney General

Lander & Rogers, on behalf of the Victoria Institute of Forensic Mental Health (Forensicare)

News Corporation Australia

Signature:

Coroner Paul Lawrie

Date: 30 September 2024

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an inquest. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.