IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2020 004903

FINDING INTO DEATH FOLLOWING INQUEST

Form 37 Rule 63(1)

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

Amended pursuant to section 76 (a) and (c) of the Coroners Act 2008 (Vic) on 30 April 2025[1]

Inquest into the Death of Joshua Gonzalez

Delivered on:	14 April 2025
Delivered at:	Southbank, Victoria
Hearing Dates:	5, 8, 9, 10 April 2024
Findings of:	Coroner Paul Lawrie
Representation:	Ms A. Dickens of Counsel instructed by Russell Kennedy for the Chief Commissioner of Police Mr R. Ajzensztat of Counsel instructed by HWL Ebsworth for Ambulance Victoria

[1] This document is an amended version of the Finding into Joshua Gonzalez's death dated 14 April 2025. Corrections as identified where relevant have been made pursuant to section 76 (a) and (c) of the *Coroners Act 2008* (Vic).

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Counsel Assisting:	Mr B. House of Counsel
Keywords:	*Mental Health Act 2014* – section 351; *Mental Health and Wellbeing Act 2022* – section 232; police handover; handover processes; suicide

I, Coroner Paul Lawrie, having investigated the death of Joshua Gonzalez, and having held an inquest in relation to this death on 5 to 10 April 2024 –

at Southbank, Victoria

find that the identity of the deceased was Joshua Gonzalez, born on 10 June 1985

and the death occurred on 5 September 2020

at 10 Kingsley Street, St Albans, Victoria

from:

1a: NECK COMPRESSION
1b: HANGING

I find, under section 67(1) (c) of the ***Coroners Act 2008*** ('the Act') that the death occurred in the following circumstances:

[2] As at the time of hearing. Senior Counsel from 8 August 2024

INTRODUCTION

1. On Saturday, 5 September 2020, between 5.45am and 7.27am, Joshua Gonzalez took his own life at his home address of 10 Kingsley Street, St Albans. Joshua was 35 years of age.

2. Joshua had hanged himself in a shed at the rear of the premises after welding a door shut to prevent access and releasing gas from LPG bottles. A major police response had been in place at the premises since about 5.20am.

3. A few hours earlier, Joshua had been at the Footscray Hospital after having been arrested by police and taken there for a mental health assessment. He had been discharged from the hospital and subsequently bailed from the Sunshine Police Station.

JOSHUA'S BACKGROUND AND RECENT EVENTS

4. Joshua was born on 10 June 1985. His parents separated when he was seven years of age and he initially lived with his mother, Montserrat Molina. At primary school, behavioural issues began to emerge and his mother described him as a "very angry" child.

5. At age eight (in 1993), Joshua moved to Glenroy to live with his father, Manuel Gonzalez, and had only irregular contact with his mother for many years after. His mother began a new relationship and had two daughters (half-sisters to Joshua), Sasha Leon Molina and Natarsha Leon Molina. Their father separated from Montserrat Molina in about 2008, and so their household then comprised the two girls and their mother.

6. Joshua continued living with his father and attended numerous primary and secondary schools, with changes of school being precipitated by his challenging behaviour. He left secondary school in Year 10.

7. Joshua then worked with his father at his cleaning business before being employed with a laser cutting business. He was fired from that employment over an incident where drugs were found at the workplace. He subsequently had several jobs as a forklift driver, but these were often short lived. In the two years prior to his death, he was unemployed.

8. In June 2019, he returned to live with his mother and his half-sisters at 10 Kingsley Street, St Albans (the premises) after being evicted from the premises he had been renting. Initially

he lived in the loungeroom, but after an altercation with his mother in June 2020, he resided in a shed at the rear of the property.[3]

9. Joshua had smoked cannabis since secondary school and, for at least the last two years prior to his death, he was a heavy user of cannabis, methylamphetamine and alcohol.

10. In the year prior to his death, Joshua presented to the Western Health, Sunshine Hospital, Emergency Department on two occasions in the context of a mental health crisis and suicidality.

11. On 4 February 2020, Joshua was apprehended by members of Victoria Police, pursuant to section 351 of the *Mental Health Act* 2014 (**MHA**)[4] and conveyed to Sunshine Hospital. The *Western Health Emergency Department Adult Flow Chart*[5] (**ED Flowchart**) records:

    a) the presenting history as "*Section 351. Patient taken approx. 1 box Panadol (approx. 20 x 500mg tablets)*";

    b) Joshua was observed between 9.22am and 1.16pm;

    c) Joshua self-discharged at approximately 1.20pm.

12. On 4 March 2020, Joshua was again apprehended by police, pursuant to section 351 of the MHA and conveyed to Sunshine Hospital. The Emergency Department records[6] include:

    (a) the presenting history was recorded as "*intentional self-harm related overdose of 20 x 500mg paracetamol at approx. 2200 last pm*".

    13. Joshua was examined by an emergency department medical officer, Dr Xiao Ho, who recorded, "[s]*tates he was feeling suicidal at the time, but not anymore. Frustrated at Centrelink's inability to find him employment. Now denies suicidal ideation and regrets taking overdose - impulsive action*."

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3 Sasha Leon [CB0093] – Exhibit 19

4 The *Mental Health Act 2014* has since been replaced by the *Mental Health and Wellbeing Act 2022* which came into operation on 1 September 2023. Section 232 is the new provision equivalent to section 351, and it is functionally identical. Throughout this finding, a reference to section 351 of the *Mental Health Act 2014* may be regarded as being applicable to section 232 of the *Mental Health and Wellbeing Act 2022*, unless stated otherwise.

5 CB2371 – 2376 – Exhibit 19

6 CB2368 – Exhibit 19

(b) Joshua was discharged and noted to be for "*EMH review – voluntary*".

14. Joshua had another presentation to the emergency department at 2.30am on 10 July 2020 complaining of left shoulder pain after falling over. He had been drinking alcohol and gave an inconsistent account of his injury to medical staff. His shoulder was found to be dislocated. A closed reduction was performed under sedation and Joshua was discharged a few hours later.[7]

OVERVIEW OF EVENTS FROM 4 - 5 SEPTEMBER 2020

15. At about 10.15pm on 4 September 2020, Sasha heard loud music coming from the shed where Joshua was living. She and her mother went to the shed and saw Joshua who was visibly under the influence of alcohol. An argument ensued and there was a physical confrontation during which Sasha was pushed over. At 10.27pm, Natarsha called 000 Emergency and requested the attendance of police.[8]

16. At 10.40pm, Natarsha called 000 Emergency a second time and told the operator that the situation had worsened, with Joshua threatening to kill his dog, pushing Sasha to the ground and "being obnoxious".[9]

17. At 10.45pm, First Constable Haberecht[10] and Constable Ferry arrived at the premises and spoke to Sasha and Natarsha. Haberecht and Ferry then questioned Joshua as he remained inside the doorway to the shed. They asked him to come out but instead he picked up a shifting spanner from a bench near the door. He was instructed by the officers to drop the spanner, and he quickly complied.[11] During this exchange, Joshua stated, "Shoot me… I'm gonna end up shot, that's what I want, that's what I want. I want to be shot at".[12] Joshua appeared to pick up another item and repeatedly asked the officers to shoot him, saying on one occasion, "I want to fucking die". Eventually, he revealed that his hands were empty.

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7 CB2357-8 - Exhibit 19

8 Exhibit 19 – Multimedia Exhibit 63, Audio_945719.

9 Exhibit 19 – Multimedia Exhibit 63, Audio_948717.

10 Ranks are stated as they were at the time of the events in September 2020 and may be omitted from time to time for ease of narrative.

11 Exhibit 19 – Multimedia Exhibit 10, 5:10 onwards.

12 Ibid, 5:21 onwards.

18. Joshua then tried to shut the door and retreat into the shed, but he was prevented from doing so by Haberecht and Ferry. They restrained Joshua, forcibly removed him from the shed and placed him in handcuffs. During the arrest, Joshua pushed Haberecht in the chest and bit Ferry's lower right arm.

19. At 10.51pm, Haberecht requested the attendance of an ambulance. It arrived at 11.24pm with paramedics Oliver Davis Hyde and Kevin Luc.

20. At 11.57pm, Joshua was conveyed to Western Health – Footscray Hospital, arriving at the emergency department at 12.11am on 5 September 2020.

21. At 12.18am, Joshua was triaged by triage nurse, Krishia Javier (RN Javier). His presenting condition was noted to be "*low covid: mental state – section 351, verbally physically aggressive towards sister police. Intoxicated marijuana use tonight*".

22. As Haberecht and Ferry remained with Joshua for his mental health assessment, Ferry spoke with Sergeant Reece and informed her of the assault and injury that he had sustained. Ferry was then informed that he would be relieved by Constable Trajkovski.

23. Dr Samcewicz-Parham saw Joshua twice during his time at the hospital – at 12.40am and at 1.35am.[13] The initial assessment was focused on Joshua's level of sedation and any other features that could explain his agitation. She found the Joshua was mildly sedated and his vital signs were all normal. Dr Samcewicz-Parham requested blood tests, but these were refused by Joshua.

24. Haberecht and Ferry did not have the necessary Victoria Police *Mental Disorder Transfer* (**MDT**) forms with them and so another police unit came to the hospital to deliver a book of these forms. Haberecht then proceeded to complete the MDT form[14] and recorded the time it was prepared as 2.05am.[15] The narrative of relevant events is recorded on the form as follows:

> *Att* [attended] *home address for family violence incident. Located male in back garage. Male argumentative with police, picked up a spanner, but dropped when*

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13 Dr Samcewicz-Parham [CB243] – Exhibit 15, paragraphs 3 and 13
14 FC Haberecht [CB081] – Exhibit 1
15 MDT form – Exhibit 3; also at CB2355 – Exhibit 19

police requested. Asked police to shoot him, said life isn't worth living. UOF[16] to be submitted.

25. The MDT form was signed by Dr Samcewicz-Parham.[17]

26. At 2.15am, Haberecht and Trajkovski arrested Joshua[18] and they activated their body worn cameras at about this time. At 2.23am, Joshua was discharged from the hospital.

27. At 2.30am, Haberecht and Trajkovski arrived with Joshua at the Sunshine Police Station. Senior Constable Rafal Mlodzik[19] then prepared a charge sheet and undertaking of bail to appear at the Sunshine Magistrates court on 4 May 2021.[20] At 3.15am, a family violence safety notice was issued to Joshua which specified Sasha as a protected person.[21] Joshua was then released on bail and declined assistance to obtain alternative accommodation.[22] He left the police station at approximately 4.00am.

28. At approximately 5.00am, Joshua's mother heard noises at the rear of the premises in Joshua's shed. She went outside and saw Joshua opening gas bottles and taking them to the shed.[23]

29. At 5.13am, Natarsha called 000 Emergency and reported that Joshua had returned to the premises, had taken gas bottles with him to the shed, and was threatening to kill himself.[24]

30. The first police units arrived at 5.20am.[25] Joshua had used a welder to seal himself in the shed and the smell of gas was evident. The police response included the Critical Incident Response Team (**CIRT**) and the Dog Squad. Firefighters also attended and a cordon was placed around the premises. All attempts to establish communication with Joshua were unsuccessful.[26]

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16 Use of Force form
17 MDT form – Exhibit 3; also at CB2355 – Exhibit 19
18 C Trajkovski [CB175] – Exhibit 6
19 'Detective Mlodzik' amended to 'Senior Constable Rafal Mlodzik' pursuant to section 76(c) of the *Coroners Act 2008* (Vic) in this paragraph and subsequent paragraphs where appearing.
20 CB781 and CB926 - Exhibit 19
21 CB706-707 - Exhibit 19
22 FC Haberecht, [CB082] – Exhibit 1
23 Montserrat Molina [CB111] – Exhibit 19
24 Exhibit 19 – Multimedia Exhibit 63, Audio_94785724.
25 C Daniels [CB060] – Exhibit 19
26 SC Ramirez [CB242] – Exhibit 19

31. At 7.23am, CIRT members breached a window inside the shed[27] and then gained entry to the area where Joshua was, via a side door. Joshua was found hanging with a chain around his neck.

32. Joshua was moved to the back lawn and assessed by paramedics. He was declared deceased at 7.40am.[28]

CORONIAL INVESTIGATION AND INQUEST

33. Detective Senior Sergeant Mark Ribbink[29] of the Victoria Police Homicide Squad acted as the Coroner's Investigator for the investigation of Joshua's death and compiled a brief of evidence. The coronial brief included statements and materials from:

    (a) Police members involved with Joshua following his apprehension pursuant to section 351 of the MHA until his release from custody at approximately 4.00am on 5 September 2020: First Constable Nathan Haberecht, Constable Richard Ferry, Constable Andrej Trajkovski and Sgt Rachael Reece;
    (b) Joshua's mother, Montserrat Molina;
    (c) Joshua's father, Manuel Gonzalez;
    (d) Joshua's half-sisters, Sasha and Natarsha Leon Molina;
    (e) Police members involved in the response at 10 Kingsley Street from 5.20am on 5 September 2020;
    (f) Ambulance Victoria paramedics;
    (g) Detectives involved in the subsequent investigation;
    (h) Dr Paul Bedford – Forensic Pathologist;
    (i) Montanna Leveque – Forensic Toxicologist.

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27 SC Caddy [CB056] – Exhibit 19
28 Paramedic Bridget Doheney [CB065] – Exhibit 19
29 'Detective Sergeant Jason Boyd' amended to 'Detective Senior Sergeant Mark Ribbink' pursuant to section 76(c) of the *Coroners Act 2008* (Vic) in this paragraph and subsequent paragraphs where appearing.

34. Also included[30] in the coronial brief were:

(a) The MDT form in respect of the apprehension of Joshua on 5 September 2020;
(b) Medical records from Western Health;
(c) Police body worn camera (**BWC**) recordings;
(d) Relevant portions of the Victoria Police Manual (**VPM**);
(e) Recording of calls to 000 Emergency on 4 and 5 September 2020; and
(f) Scale plan of 10 Kingsley St, St Albans and scene photographs.

35. I took over carriage of this investigation in October 2022 and, after a directions hearing on 16 November 2023, the scope of the inquest was set as follows:

1. The circumstances of Joshua's apprehension pursuant to section 351 of the Mental Health Act 2014 on 4 September 2020 and the mental health assessment performed at Footscray Hospital in the early hours of 5 September 2020, including:
(i) The communication of information between the persons involved in Joshua's apprehension and subsequent assessment on 4-5 September 2020;
(ii) The roles and responsibilities of Victoria Police, Ambulance Victoria and Footscray Hospital in the transfer and assessment of persons apprehended pursuant to s.351 of the Mental Health Act;
(iii) Joshua's mental health assessment, risk assessment, care and discharge planning;
(iv) Identification of any practice improvements implemented subsequently and/or further prevention opportunities.

2. The Victoria Police operation to arrest Mr Gonzalez later on 5 September 2020.

36. The inquest was conducted over four days from 5 to 10 April 2024. The following witnesses were called:

(a) Senior Constable Nathan Haberecht;

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30 Not an exhaustive index to the coronial brief.

(b) Sergeant Jonathon Potter;

(c) Senior Constable Richard Ferry;

(d) Senior Constable Andrej Trajovski;

(e) Oliver Davis Hyde[31];

(f) Sergeant Rachael Reece[32];

(g) Senior Sergeant Justin Morley[33];

(h) Dr Anne-Maree Kelly – Senior Emergency Physician, Western Health

(i) Dr Lidia Samcewicz-Parham; and

(j) Dr Michael Bryant – Deputy Director Footscray Hospital Emergency Department

37. Following the inquest, draft recommendations were sent to Safer Care Victoria for its comment. This resulted in the recommendations herein being directed to the Victorian Department of Health rather than Safer Care Victoria.

FINDINGS

38. Much of the inquest was concerned with the communication of information regarding Joshua's behaviour when he was apprehended. This included statements made by him indicating suicidality. The various stages when information was communicated (or there was an opportunity to do so) were examined. The first of these stages occurred when police members spoke with paramedics at the scene.

Information transmitted from police to paramedics

39. In his written statement Haberecht recalled:

> *Gonzalez made several requests for C/FERRY and I to shoot him. GONZALEZ made other comments, including "I'm ready to die" and "I guarantee I'm going to get shot".*[34]

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31 'Oliver Davis-Hyde' amended to 'Oliver Davis Hyde' pursuant to section 76(a) of the *Coroners Act 2008* (Vic) in this paragraph and subsequent paragraphs where appearing.

32 'Senior Sergeant Rachael Reece' amended to 'Sergeant Rachel Reece' pursuant to section 76(a) of the *Coroners Act 2008* (Vic) in this paragraph and subsequent paragraphs where appearing.

33 'Inspector Michael Moreley' amended to 'Senior Sergeant Justin Morley' pursuant to section 76(c) of the *Coroners Act 2008* (Vic) in this paragraph and subsequent paragraphs where appearing.

34 FC Haberecht [CB078] – Exhibit 1

40. Ferry recalled in his statement:

> *GONZALEZ shrugged his shoulders and said "shoot me" … "Shoot me, I'm gonna get shot, that's what I want, that's what I want"*[35]

41. This was a key ingredient in the decision by Haberecht and Ferry to apprehend Joshua pursuant to section 351 of the MHA.

42. Ambulance Victoria paramedic, Oliver Davis Hyde made a written statement dated 4 May 2023.[36] In this statement he detailed his involvement with Joshua from his attendance at the St Albans residence until handover to medical staff at the Footscray Hospital. These details were derived from the *Electronic Patient Care Record* (**ePCR**) which was completed by Mr Davis Hyde contemporaneously, if not iteratively.[37] Mr Davis Hyde asserted in his written statement, and repeated in evidence, that he had no independent recollection of events. I accept this to be the case. I note that Mr Davis Hyde's statement was not made until 4 May 2023, and I accept that it was at about this time he was first asked to recall the events of some two years and eight months earlier, not having been made aware of the significance of his involvement before this. It is likely these features have contributed to the absence of an independent recollection.

43. Mr Davis Hyde accepted that the police body worn camera recording included Ferry advising him and Mr Luc that Joshua had asked police to shoot him. Specifically, Ferry reported in the recording, "told us to shoot him a few times" and "He said he wants to die a bunch of times". Further, Joshua said in front of both him and Mr Luc, "go on, shoot me"[38] (the **suicidality statements**). Having reviewed the body worn camera recording, Mr Davis Hyde conceded that there was no reason why he would not have heard these statements at the time.

44. It was submitted on behalf of Mr Davis Hyde and Ambulance Victoria that a cautious approach should be taken to Mr Davis Hyde's concession in that it did not amount to a concession that he did hear the statements at the time they were made or that he fully

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35 C Ferry [CB210] – Exhibit 5
36 Exhibit 8
37 Exhibit 9
38 T160

appreciated their significance at that time.[39] I accept that a cautious approach is required to such evidence, particularly when the witness is commenting on a recording rather than describing their independent recollection, and where the events in question are several years past.

45. I also note that the focus and priorities of paramedics is likely to be different to the focus and priorities of police members when attending a scene such as the one presenting itself on this night. Not the least of the differences from the perspective of the paramedic will be the need to assess the subject's physical health. Moreover, it is not the paramedics that are exercising a power in respect of the subject, it is the police members, and it is in that regard that the paramedics are performing a supporting role.

46. I am satisfied that the statements concerning Joshua's wish that police shoot him were made in front of Mr Davis Hyde. I cannot say whether he failed to hear these statements or whether he heard them but was not activated by them because of some other focus. In any event, these circumstances highlight the importance of a structured approach to the handover of information when a person has been detained for a mental health assessment – a matter to which I will return.

<u>At Footscray Hospital – a chronology</u>

47. Based on all the evidence, I have concluded that the order and timing of principal events at Footscray Hospital are as follows:

12.11am	Ambulance arrival
12.18am	Triage assessment
12.26 to 12.32am	Bedside handover to nurse (ED)
12.40am	First examination by Dr Samcewicz-Parham
1.01am (approx)	Hospital copy of ePCR added to nursing notes
1.35am	Second examination by Dr Samcewicz-Parham
2.05am	MDT form compiled by Haberecht

[39] Ambulance Victoria & Davis Hyde submissions at paragraphs 9 to 14.

2.10am	MDT Form signed by Dr Samcewicz-Parham
2.15am	Joshua[40] arrested by Haberecht and Trajkovski
2.23am	Joshua discharged from hospital into police custody[41]

Information delivered to Dr Samcewicz-Parham

48. The ambulance arrived at Footscray Hospital at 12.11am on 5 September 2020. Haberecht, Ferry and Mr Davis Hyde did not have any independent recollection of the events at the hospital. The principal issue under examination was whether any of the details of Joshua's suicidality statements were passed on by either the police members or the paramedics to Dr Samcewicz-Parham.

49. The *Western Hospital Emergency Department Clinical Sheet*[42] (**ED Clinical Sheet**) records the triage information. It shows that the triage assessment was performed by a nurse at 12.18am[43] and includes the following notes:

> **Presenting Problem:** LOW COVID: MENTAL STATE – SECTION 351, VERBALLY PHYSICALLY AGGRESSIVE TOWARDS SISTER POLICE. INTOXICATED MARIJUANA USE TONIGHT.
>
> **Nursing Assessment:** CGS 9 CURRENTLY HANDCUFFED RESTRAINED, T 36.5 RR 14, 10MG IM MIDAZOLAM GIVEN BY AV. PEARL, STRAIGHT TO RESUS.

50. I consider that these notes are clear on their face. Given the extent of the details that have been recorded and the absence of any note concerning the suicidality statements, I conclude that neither the police members nor the paramedics told the triage nurse about the suicidality statements. I make no criticism of this, given the nature of the triage process, but it is important to note that the information was not available from triage.

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40 'Gonzalez' amended to 'Joshua' pursuant to section 76(a) of the *Coroners Act 2008* (Vic) in this paragraph and subsequent paragraphs where appearing.

41 CB2347 – Exhibit 19

42 CB2341 – Exhibit 19

43 This is sufficiently consistent with the triage time of 12.20am recorded in the Ambulance Victoria Electronic Patient Care Record (ePCR) – Exhibit 9

51. The next structured opportunity for the handover of information from police members and/or paramedics occurred at 12.26am. Mr Davis Hyde was taken to the ED Flowchart[44] and he explained that it recorded the "bedside handover" that occurs between paramedics and the nurse in an Emergency Department cubical, after triage. Mr Davis Hyde referred to this being the "second handover". From this, it may be concluded that the triage process, at least from Mr Davis Hyde's perspective, was the "first handover". He further explained that the notes taken at triage are usually entered [directly] into a computer.[45] This appears to be consistent with the appearance of the ED Clinical Sheet. The notes on the ED Flow Chart are handwritten and record under the heading "Presenting History":

> *000 called for abuse towards family*
> *Physically and verbally aggressive towards AV+ police*
> *? kicked out of home living in mum/sisters*
> *Marijuana + alcohol use tonight garage/bungalow*

52. The lack of an agreed nomenclature for the usual assessment stages does not assist clarity. For want of a better title, I will refer to this event as the "bedside handover" – that is the first assessment after triage, performed in the ED by a nurse, usually in an examination cubicle. I again conclude based on the notes in the ED Flowchart that no detail concerning the suicidality statements was communicated during the bedside handover.

53. The ED Flowchart records "AV Handover Time" as 12.32am and this matches the "Off Stretcher" time recorded in the ePCR. This appears to be the time the bedside handover was concluded.

54. Dr Samcewicz-Parham stated emphatically that neither police or paramedics mentioned to her concerns regarding suicidality or told her of the suicidality statements.[46] Haberecht was equally emphatic that he would have mentioned the threats that Joshua had made, although he conceded that he did not have an independent recollection of what he had said to Dr Samcewicz-Parham. Haberecht explained, "I can't think of any other mental health job where I've omitted details from a doctor that I felt were relevant in relation to our powers to detain".[47]

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44 CB2345 – Exhibit 19
45 T177-8
46 CB244 – Exhibit 15
47 T036

55. It is curious that the only contemporaneous notes made by Dr Samcewicz-Parham on the ED Clinical Sheet which appear to relate to the mental health aspects of Joshua's presentation are limited to the following:

> 35M presents with section 351
>
> police called as being aggressive towards sister
> in the context of admitted etoh and thc intoxication
> AV crew arrived
> spitting and aggressive given 10mg IM midazolam
> bit police – put under arrest

56. On the face of the ED Clinical Sheet (and noting that Dr Samcewicz-Parham did not have the MDT form at the time of her examinations), a proper basis for an apprehension by police pursuant to section 351 of the MHA is not revealed. All that is described is violent behaviour by Joshua – there is nothing describing a potential mental illness. However, having considered the form and extent of these notes, and the likely circumstances in which they were made, I am not satisfied that they meaningfully assist in answering the question whether or not details of the suicidality statements were communicated to Dr Samcewicz-Parham.

57. Ultimately, the clash between the accounts of Haberecht and Dr Samcewicz-Parham is beside the point. I am satisfied that Haberecht believed he had communicated the suicidality risk but there are several reasons why Dr Samcewicz-Parham did not receive the information. Haberecht may have assumed that the information would be passed on by the paramedics or he may have directed comments to Dr Samcewicz-Parham which went unheard or were not properly apprehended. In raising these possibilities, I am mindful of the realities of the environment in the Emergency Department and the many practical challenges faced by those who work there. The usual challenges were exacerbated by the need for face masks as part of COVID-19 measures.

<u>Assessment by Dr Samcewicz-Parham</u>

58. The hospital copy of the ePCR[48] was printed at 1.01am. Mr Davis Hyde explained that after the document was printed, his practice was to deliver it to the patient cubical and put it next to the nursing notes.[49] I accept it is likely he followed his usual practice on this

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48 CB2353 – Exhibit 10
49 T158-9

occasion. The ePCR does not include any detail concerning the suicidality statements but records the patient history as follows under the heading, "Cause":

> **metal health / behavioural**
> Description
> 35 YOM called Joshua, tonight has become physically aggressive towards relative after using cannabis and drinking alcohol and 000 has been called. Police have attended and have had to handcuff patient due to his agitation and physically aggressive nature and called for AV.

59. The first time Dr Samcewicz-Parham saw Joshua was at, or shortly before, 12.40am.[50] She explained that the information recorded under the heading "Clinical Note" on the *Emergency Department Clinical Sheet*[51] was contained in a "rolling note" commenced at 1.30am.[52] The notes relating to her first examination of Joshua at or about 12.40am are as follows:

> A- own patent
> B- 96% RR14
> C- HS dual
> D- PEARL, GCS 14, eyes closed rousable slightly slurred, verbally aggressive
> no evidence of external trauma
> no lacerations /bony deformity
> scalp bruises/injry

60. This information is confined to a physical examination of Joshua and there is nothing relating to an assessment of his mental health.

61. At approximately 1.35am, Dr Samcewicz-Parham saw Joshua again. The notes relating to this second examination were identified as follows:

> observed for 2 hours, normal obs
> GCS improved
> refused bloods and not safe to take
> standing and steady on feet
> obs normal
> speaking full sentences
> admits to etoh + THC this evening

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50 T297
51 CB2343 – Exhibit 19
52 T298

imp drug intoxication
- improving
plan:
- discharge to police custody

62. Again, the information is confined to a physical examination of Joshua and there is nothing relating to an assessment of his mental health.

63. On the same page is a note of information received by Dr Samcewicz-Parham from the Emergency Mental Health (**EMH**) clinician which reads:

> no known psych hx
> previous conduct behaviour issue

64. Dr Samcewicz-Parham explained that the notes made on the ED Clinical Sheet were not necessarily chronological and that the information from the EMH clinician was received after she had conducted the first examination.[53] The fact of Joshua having a relevant history of mental health presentations was not revealed in this inquiry because the source for the information was limited to emergency department presentations at Footscray Hospital[54] – a matter to which I will return.

65. The content and extent of the notes indicate that the focus of both assessments was upon Joshua's physical presentation. That is not to say however that elements of a mental health assessment were not included, but the contemporaneous notes are scant in this regard. The relevant contemporaneous entries are limited to the result of the inquiry from the EMH clinician and the fact that the origin of Joshua's presentation was his apprehension pursuant to section 351 of the MHA.

66. Dr Samcewicz-Parham made a retrospective note[55] on 23 September 2020, 18 days later, after learning of Joshua's suicide. In the retrospective note Dr Samcewicz-Parham records by way of introduction:

> I recall the patient and the clinical interaction and assessment.
> Further to the notes written by myself on the evening I would further like to add this [sic] assessment finding from my target mental health assessment.

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53 T303
54 T318
55 CB2343 – Exhibit 19

67. The remainder of the retrospective note contains some detail to support a conclusion that Dr Samcewicz-Parham had an independent recollection of Joshua when she made the note. However, the fact that it was made 18 days after events that were unexceptional is striking, and it is a poor substitute for a contemporaneous note which properly records a clinician's observations and conclusions relating to a mental health assessment.

Subsequent information – the MDT Form

68. The MDT form reads as follows under the heading "Circumstances":

> *Att* [attended] *Home address for a family violence incident. Located Male in back garage. Male argumentative with police, picked up a spanner but dropped when police requested. Asked police to shoot him, said life isn't worth living. …*

69. This information appears handwritten in a small space (6 lines) provided at the foot of a sensitised form. It is hardly an ideal medium to be the sole means of transmission of information that may be germane to a mental health assessment.[56] At best, it provides a means for recording a very basic summary of the circumstances leading to apprehension.

70. The MDT form was compiled by Haberecht at 2.05am and signed by Dr Samcewicz-Parham at 2.10am. I am satisfied it was presented to her shortly before she signed it. Dr Samcewicz-Parham conceded that she did not read it at that time[57] and stated that her copy (the Agency Copy) was handed to her as Mr Gonzalez was leaving the ED with the police.[58]

71. It is not surprising that Dr Samcewicz-Parham did not read the MDT form at or about the time of signing it. On this occasion the form was being presented to her when she had completed her examinations of Joshua, rather than before that process, as intended. Dr Samcewicz-Parham stated that she had to attend to other urgent clinical priorities in the ED[59] and I accept this to be the case.

72. Amongst other matters, the MDT form is designed to record the time and date of transfer of the apprehended person from police custody to the doctor or mental health practitioner for assessment. So much is clear from the box provided for the signature of the doctor which includes the words, "Insert transfer of custody time & date below". Dr Samcewicz-Parham has noted this time as 2.10am but it is not the time Joshua went from police custody

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56 A conclusion also reached by Dr Bryant – T367
57 T333
58 Dr Samcewicz-Parham [CB310] – Exhibit 16
59 Dr Samcewicz-Parham [CB245] (1st statement) – Exhibit 15

to the custody of the doctor, which was in fact approximately an hour and a half earlier. It was simply the time Dr Samcewicz-Parham signed the form.

73. It is unfortunate that Haberecht did not have any MDT forms with him when he arrived at the hospital, as would usually be the case. Although it was not clearly explained, the absence of the forms from the kit for Haberecht's unit appears simply to have been an oversight[60] and I make no criticism of this. However, the initial absence of the forms did lead to a departure from the intended process surrounding them namely, that an MDT form should be provided to the doctor prior to their assessment of the apprehended person.

Access to records from Sunshine Hospital

74. On 4 February 2020, Joshua was apprehended by members of Victoria Police under section 351 of the MHA and taken to the Sunshine Hospital. The ED Flowchart records the presenting history as: "*Section 351. Patient taken approx. 1 box Panadol (approx. 20 x 500mg tablets)*". Joshua was observed between 9.22am and 1.16pm and self-discharged at approximately 1.20pm.[61]

75. On 4 March 2020, Joshua was again apprehended under section 351 and taken to the Sunshine Hospital ED for assessment. The *Emergency Department Clinic Sheet*[62] for that attendance forms part of the medical records available in the coronial brief and records that Joshua had taken an overdose of paracetamol. Apparently, he had been feeling suicidal at the time he did this and cited his frustration at not being able to find employment. He denied ongoing thoughts of suicide and said he regretted his actions. The paracetamol overdose was found to be non-toxic and Joshua left the ED that afternoon after some five hours in the hospital. It appears that Joshua simply left rather than being discharged in the usual manner, but this did not prompt a call to police as the attending doctor was "not concerned"[63] for Joshua. I presume this to mean that there were no concerns at that time for either Joshua's physical or mental health, and he was to be discharged in any event.

76. Dr Samcewicz-Parham was unaware of these two earlier events and was asked to hypothesise whether knowledge of the records pertaining to them would have altered her assessment of Joshua on 5 September 2020.[64] She found this a difficult exercise but

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60 T028
61 CB2371 – 2376 -– Exhibit 19
62 CB2387 – Exhibit 19
63 CB2387 – Exhibit 19
64 T319

conceded that it would have been useful information and "may have made me push a little bit harder or asked [for] more detailed information …".[65]

77. There is insufficient evidence to conclude that the availability of this information would have led to a different assessment outcome on 5 September. Nonetheless, it is abundantly clear that anyone conducting a mental health assessment should have such patient history information available to them in order to properly inform the assessment. Furthermore, I conclude that it is likely this information would have led to a greater focus on Joshua's suicidality in the assessment conducted by Dr Samcewicz-Parham had it been available to her.

78. Dr Kelly explained that the records of Joshua's previous section 351 mental health presentations were not visible to ED staff on 5 September and the reason was essentially attributable to the existence of separate databases. Dr Kelly gave evidence that:

> *…it's definitely always a problem. Basically, there's a mental health database that is completely and utterly separate and opaque to Emergency Departments. So a patient might've presented twenty times in the last three days to hospitals other than ours, and we'd never know, unless the mental health clinician looked for it and told us. So we don't have any access to that mental health database, in terms of checking.*[66]

79. Dr Kelly further explained that no one in the ED has access to the mental health database and, unless there is a mental health clinician on duty, there is no way to access it. Although most large hospitals in Melbourne are supposed to have a mental health clinician on duty at all times, the exigencies of staffing meant this is not always the case. If an ED clinician wants to access the mental health database and there was no mental health clinician on duty, they would have to resort to calling another hospital to make an inquiry on their behalf. Dr Kelly further stated:

> *In a previous role, I was involved in quality and safety with the Safer Care Victoria for a long period of time and had conversations with the mental health team there, about information sharing and that a failure to share information was a safety risk, but it was felt that mental health patients were vulnerable and if all*

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65 T320
66 T225

access to information should be limited to mental health services and that was a conversation, not a policy, but it was – that was the conversation and there's been no change to that.[67]

80. The concern for the general vulnerability of mental health patients is well founded but it must be recognised that a person is likely to be most vulnerable at a time of crisis which has resulted in their apprehension under section 351 of the MHA. It is not acceptable that a busy ED clinician should have to use *ad hoc* processes to gather information about a person's mental health history, or history of presentations.[68] It is clear that such information may be an important ingredient in an assessment, and it must be readily accessible whether or not a mental health clinician is on duty.

Improvement of communication of information from first responders in the ED setting

81. In order to improve the transmission of important information concerning a person apprehended under section 351, Dr Kelly suggested the use of a structured conversation or structured handover wherein the police who recognised the risk speak directly with the clinician.[69] Dr Samcewicz-Parham strongly agreed that it would be of benefit.[70] Dr Bryant explained that it was becoming more common throughout medicine to have a structured conversation for the transfer of care[71] and there was no real obstacle to this being implemented for handover from police.[72] Dr Bryant considered that the structured conversation should be driven by a form designed for that purpose.

82. Mr Davis Hyde explained the use of the mnemonic IMIST-AMBO[73] used for patient handover from paramedics. This mnemonic was designed to capture information related to the person's physical health and was not well suited to the mental health context.[74] It remains however, a good example of a structured conversation for handover which ensures critical subjects are addressed.

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67 T226
68 Dr Bryant described such processes as "not friendly" – T386
69 T219
70 T316
71 T359
72 T388
73 I – identification, M – mechanism / medical complaint, I – injuries, T – treatment and trends, A – allergies, M – medication, B – background history, O – other information: T145
74 T274

83. The implementation of a structured conversation for the handover from police was supported by Western Health in its submissions.[75] However the submissions on behalf of the Chief Commissioner of Police contended that any recommendation in this regard was unnecessary because of the training that has been implemented since the commencement of the *Mental Health and Wellbeing Act 2022* (**MHWA**) and the requirement for all handovers from police to be recorded on body worn camera. The new training is called "PRIME" – *Police Responding in Mental Health Events*. It is embedded in police and PSO foundation training and is delivered, in part, by a mental health clinician.

84. I accept that this training is an important part of police having a better understanding of the processes and what may be required of them when a person is handed over after being apprehended under the MHWA. However, training should not stand alone. It should be supported by a tool that may be easily used by police and medical staff to guide the communication of information during a handover in a busy environment – this is the structured conversation.

Discharge from Footscray Hospital

85. Dr Samcewicz-Parham's ultimate impression of Joshua, after her second examination, was described in her first written statement as follows:

> *...He appeared clinically to be mildly intoxicated, However, he was able to follow instructions and talk coherently. I considered his thought pattern to be logical and he displayed no features of psychosis as he could answer my questions logically, follow simple commands, he was not interacting with external stimuli and was not talking to himself ...*
> *... I concluded that Mr Gonzalez's behaviour was likely related to alcohol and marijuana intoxication having found no evidence of psychosis, obvious head injury or infection. From my assessment, he did not meet the criteria to be put on an assessment order under the Mental Health Act 2014 (Vic) as I did not consider that he had a mental illness.*[76]

86. Dr Ann-Maree Kelly is a senior Emergency Physician and Academic Head of Emergency Medicine employed by Western Health. Dr Kelly provided a statement[77] which included

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75 Western Health submissions at paragraphs 25 – 27
76 Dr Samcewicz-Parham [CB245] – Exhibit 15
77 AM1.2 – Exhibit 14

the results of a study in 2019 examining 438 patient encounters (over 119 days) resulting from apprehension pursuant to section 351 of the MHA.

87. 308 patients (70% of the total study) within the total of 438 encounters involved suicidal ideation or suicide attempt as the reason (or contributing reason) constituting the need for an assessment. Of this number, just 25 patients (8.1% of the subset) were subject to a compulsory psychiatric admission. 29 patients (9.4% of the subset) had a voluntary psychiatric admission. 158 patients (51.3% of the subset) were discharged with plans for follow up by a general practitioner or Western Health's Enhanced Crisis Assessment Treatment Team. Finally, 92 patients (29.9% of the subset) had no formal mental health assessment or were found to be presenting with something other than a mental health issue.[78]

88. Dr Kelly gave evidence that patients who are drug or alcohol affected often recant from earlier statements of suicidality when examined.[79] I accept this to be Dr Kelly's experience, and I accept that it is likely to be a common reflection of events in emergency departments. Western Health submits that, "even if Joshua was questioned about his suicidality, he was unlikely to be forthcoming about any continued desires in that regard and would most likely have been discharged."[80] Expressed in this fashion, the speculation is over-stretched. Nonetheless, given Dr Samcewicz-Parham's impression of Joshua, I accept it is probable that he would have been released at some stage in the early hours of that morning (potentially with a plan for follow up), even if Dr Samcewicz-Parham had been aware of the suicidality statements. However, it is important to note that each deficit in the communication of information constitutes a missed opportunity to better inform the assessment of Joshua, and a missed opportunity for the assessment to have had a greater focus on his potential for suicide or self-harm.

Bail from Sunshine Police Station

89. At 2.30am, Haberecht and Trajkovski arrived with Joshua at the Sunshine Police Station. Senior Constable Mlodzik then prepared charges relating to the assault on Ferry and a single charge relating to the assault on Haberecht. Joshua entered an undertaking of bail to appear at the Sunshine Magistrates court on 4 May 2021.[81] At 3.15am, a family violence

78 A frequent presentation being "sad while intoxicated" – T252
79 T234-245
80 Western Health submissions at paragraph 23
81 CB781 and CB926 – Exhibit 19

safety notice was issued to Joshua which specified Sasha as a protected person.[82] Joshua was then released on bail and declined assistance to obtain alternative accommodation.[83] He left the police station at approximately 4.00am.

90. I am satisfied that the decision to bail Joshua and the process followed was unremarkable in the circumstances.

Events at 10 Kingsley Street, St Albans

91. Sergeant Reece and Senior Sergeant Justin Morley gave evidence concerning the police operation at Joshua's house which began shortly after the first police unit responded at 5.20am.[84] Natarsha had called 000 Emergency seven minutes earlier and reported that Joshua had returned to the premises, had taken gas[85] bottles with him to the shed, and was threatening to kill himself.

92. Joshua had used a welder to seal himself in the shed and the smell of gas was evident. The police response included the Critical Incident Response Team and the Dog Squad. Firefighters also attended and a cordon was placed around the premises. All attempts to establish communication with Joshua were unsuccessful.[86]

93. Senior Sergeant Justin Morley was the CIRT Duty Officer and he was notified of the situation at 5.41am. He monitored developments and remotely provided advice to the CIRT Tactical Commander (Sergeant Peter Jenkins) and the Forward Commander until his arrival at the scene at 6.49am. Senior Sergeant Morley provided a detailed statement describing the operation and gave oral evidence. I was also assisted by detailed statements from Sergeant Peter Jenkins and Inspector Lisa Prentice-Evans (among others).

94. I am satisfied that Joshua had created a "stronghold" which was not safe for police to breach by force until the explosive potential of the gas Joshua had released was eliminated.

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82 CB706-707 - – Exhibit 19
83 FC Haberecht, [CB082] – Exhibit 1
84 C Daniels [CB060] – Exhibit 19
85 LPG
86 SC Ramirez [CB242] – Exhibit 19

95. I am satisfied that the entry to the shed and the separate room within, which was achieved by police members between 7.23am and 7.30am, occurred as soon as possible after the risk of explosion had been eliminated.

96. There are no aspects of the police response at 10 Kingsley Street which attract concern. Joshua had effectively made himself unreachable while he hanged himself, and for some time thereafter.

Joshua's intent

97. I note the post-mortem toxicological analysis which reveals that Joshua had a blood alcohol concentration of 0.19% and had recently used cannabis.[87] Notwithstanding this degree of intoxication, it is apparent that Joshua engaged in a series of complex acts designed to keep others at bay while he hanged himself. In all the circumstances, and from at least approximately 5.20am on 5 September 2020, I am satisfied that Joshua acted with the intention of taking his own life.

COMMENTS

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

98. In evidence, Dr Kelly told of the paucity of research concerning how many section 351 (now section 232) transfers occur in Victoria and what are the outcomes, particularly for persons subject to multiple transfers. Dr Kelly explained that apart from her 2019 study of patients at Sunshine and Footscray Hospitals[88], an earlier study by her in 2014, and some work by a group at Swinburne University, there was no current research to better understand these matters.[89]

99. This was a surprising revelation. There is a clear need to understand, state-wide, the frequency of use of section 232 of the MHWA, as well as the types of presentation and the outcomes. I encourage the Victorian Department of Health to facilitate comprehensive information gathering and research concerning the use of section 232 so that future policy may be properly informed.

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87 CB0040 - Exhibit 19
88 AM1.2 - Exhibit 14
89 T277

RECOMMENDATIONS

I make the following recommendation(s) connected with the death under section 72(2) of the Act:

Recommendation 1

That the Victorian Department of Health (through its Mental Health and Wellbeing Branch[90], or other appropriate branch) and Victoria Police work in conjunction to develop a universal structured approach for the transmission of essential information upon handover from police of a person in their care and control pursuant to section 232 of the *Mental Health and Wellbeing Act 2022*.

Recommendation 2

That the Victorian Department of Health (through its Mental Health and Wellbeing Branch, or other appropriate branch) and Victoria Police work in conjunction to develop the necessary training and tools for police and medical staff to implement the practice of a structured approach for handover from police of a person in their care and control pursuant to section 232 of the *Mental Health and Wellbeing Act 2022* in all cases.

Recommendation 3

That Western Health and the Victorian Department of Health (through its Mental Health and Wellbeing Branch, or other appropriate branch) jointly review the practice of allowing only mental health clinicians access to the Mental Health Database with the aim of also permitting access by Emergency Department medical staff where necessary.

Recommendation 4

That the Victorian Department of Health (through its Mental Health and Wellbeing Branch, or other appropriate branch) review the practice of allowing only mental health clinicians access to the Mental Health Database, as it may apply for other Victorian health services, with the aim of also permitting access by Emergency Department medical staff where necessary.

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[90] 'Mental Health and Welling Branch' amended to 'Mental Health and Wellbeing Branch' pursuant to section 76(a) of the *Coroners Act 2008* (Vic) in this paragraph and subsequent paragraphs where appearing.

DIRECTIONS

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

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

Montserrat Molina, Senior Next of Kin

Manuel Gonzalez, Senior Next of Kin

Western Health

Ambulance Victoria

Chief Commissioner of Police

Victorian Department of Health

Safer Care Victoria

Detective Senior Sergeant Mark Ribbink, Coroner's Investigator

Signature:

Coroner Paul Lawrie

Date: 30 April 2025

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.