IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2007 1478

FINDING INTO DEATH WITH INQUEST

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

(Amended pursuant to s76 of the *Coroners Act 2008* on 13 March 2013 at 3.30pm)

Inquest into the Death of: ADAM WHITE

Delivered On:	13 March 2013
Delivered At:	Level 11, 222 Exhibition Street Melbourne 3000
Hearing Dates:	Between 31 January 2011 and 9 February 2011 20, 21 April 2011 Between 11 and 21 April 2011
Findings of:	PETER WHITE, CORONER
Representation:	Mr C. Morgan appeared on behalf of the Fraser family Mr N. Murdoch appeared on behalf of Peninsula Health Ms J. Nicholls appeared on behalf of Wilson Security Ms L. Close appeared on behalf of WorkSafe Mr J. Snowden appeared on behalf of Southern Health Ms Patane appeared on behalf of the White family
Police Coronial Support Unit	Senior Sergeant J. Brumby, assisting the Coroner

The discussion of evidence and findings particularly relevant to the investigation into the death of Adam White commence at page 29 of this finding.

I, PETER WHITE, Coroner having investigated the death of JUSTIN FRASER

AND having held an inquest in relation to this death between January 31 2011and February 9 2011 and April 20, 21 2011 (and again in conjunction with an inquest into the death of Adam White 1478 of 2007, held between April 11 and April 21 2011),

at MELBOURNE

find that the identity of the deceased was JUSTIN JOHN FRASER

born on 10 September 1971

and that death occurred on 26 October 2007

at the 2 West Adult Inpatient Psychiatry Ward at Frankston Hospital, 2 Hastings Road, Frankston 3199

in the following circumstances:

Background

1. Justin Fraser was born on September 10, 1971.

2. He married Sharon Fraser on July 10, 2005 and was the father of three children, now aged between 18 and 21, through a previous relationship.

3. According to Mrs Fraser, Mr Fraser had previously worked in the security industry himself, but had his license suspended for a period of 10 years in 2005/06 for an assault, which had resulted in a criminal court appearance. Following his suspension Justin Fraser left the security industry and obtained work as a furniture removalist, which she thought him to be well suited to because of his great physical strength.

4. Mrs Fraser further testified that during 2006 while he was working as a removalist, he began to drink heavily and later spoke of his depression for which he sought relief by use of the anti-depressant, Effexor. According to Mrs Fraser, her husband came from a family, which had a history of mental health issues and his bouts of depression became progressively worse until he stopped going to work altogether.

5. Again, from Mrs Fraser, from December 2006, her husband would be away from the home for periods of up to several weeks. He would return for a short time and then go away again. From this time, she was also aware that he had several dealings with the CAT team from Frankston Hospital. She states that,

   'she begged them to admit him but they would not.'

6. Mr Fraser was admitted to Frankston Hospital some nine days before his death and on 26 October 2007, the day of his passing, he was a voluntary patient at the Frankston Hospital psychiatric unit.[1]

7. During this period Mrs Fraser was able to recall that Mr Fraser was apparently aware of his illness and that a nurse, '*Nick,*' had commented to her that it was refreshing to have a patient who,

> '*knows that they are sick and wanted to get better.*'[2]

Issues

8. At a directions hearing in respect of the Fraser and White inquests, held on August 27 2010, the primary issue identified for examination in both matters had to do with the physical confrontations both Justin Fraser and Adam White engaged in, at or approximate to the time of their deaths and the relationship between those activities and those deaths.[3]

9. Also identified as an issue for review were questions concerning the relevant qualifications and training of persons employed in various capacities within both hospitals, this insofar as the issue related to psychiatric care at the two hospitals under consideration.

10. Accordingly, witnesses who would testify to these matters were identified and summonsed to attend.

11. On the first day of hearing, the Coroners Assistant, Senior Sergeant J Brumby amplified this matter.[4]

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[1] From the statement of the Clinical Director of Psychiatry at Frankston Hospital, Professor Wood, (brief page 20), we know that Mr Fraser was admitted on 17 October 2007, with a provisional diagnosis of "first episode psychosis", and a family history of psychosis. He was treated with the anti-depressant Olanzapine 20 mg per day, and a reducing regime of Benzodiazepine for his alcohol abuse withdrawal. It is also the case that his stay in the unit remained "uneventful" until the evening of the 25/26 October 2007.

[2] See exhibit 1 at page 2.

[3] As to the relevant background of Adam White and his stay at Dandenong Hospital, see below at page 36.

[4] Senior Sergeant Brumby in her opening further outlined the following issues arising from both investigations.

- What were the relevant hospital policies regarding the restraint of aggressive patients?

- Was the relevant policy sufficient to deal with the situation, which confronted staff in each case?

- Was the relevant hospital policy followed in each case?

- What training had the involved staff members received? Did this training adequately equip them to deal with the situation(s), which confronted them?

- What other alternative measures if any, were available to staff, to employ in response to the situations they faced?

The events of October 25 and 26 2007

12. Mrs Fraser further testified concerning her visit to the unit on the evening of October 25. Her testimony was that this visit occurred during his evening meal and that he reported he had been out of the unit that afternoon with a nurse,

    'Irene, who taught craft',

    and that they had shopped for the unit and then had lunch, which he had enjoyed. She had also observed him painting and that he seemed happy and was looking forward to coming out with her on the following Saturday to attend a family event. She left the Hospital at approximately 8.30pm.

13. Her further testimony was that shortly after 11.00pm she received a call from her husband requesting a phone number and that they were on the phone for less than a minute, at this time.

14. Later at around 3.00am she received a further call from the hospital informing her that Mr Fraser had died which, of course, came as a terrible shock. She contacted a friend and went to the unit where she was told that,

    'Justin had become agitated and that security had been called and he fought with security ... they said they thought he had a heart attack. (At her insistence she*) ... then went to the room where she believed Justin to be, and said her good-bye to him.'*

15. She was later informed that a nurse had found,

    'Justin in the early process of hanging himself with his belt. I just couldn't believe it and said Justin wouldn't do that.'[5]

16. I note here that it is now not in dispute that in the period immediately prior to his death, Mr Fraser attempted to hang himself and following discovery of this matter, behaved in a

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On the first day of hearing Mr Murdoch SC, for Frankston Hospital raised, (and was later granted leave to cross-examine and call opinion evidence concerning), his clients contention that the cause of death of Justin Fraser, set out in the Autopsy report prepared by the examining pathologist Dr Karen White, was partly in error. That submission was that Mr Fraser's cause of death or rather a contributing factor to the death, was a condition known as 'excited delirium', which addition should be made to Dr White's autopsy reported opinion that,

'death had occurred during restraint in an agitated obese man with coronary artery atherosclerosis.'

See discussion with the parties concerning this application, at Transcript page 5.

[5] See exhibit 1 at page 4.

threatening manner towards staff employed within the unit, with threats of violence to Special Nurse Fady Soural, and later the AMT staff, as well as harm to himself.

17. Evidence as to these events, was provided by a number of nursing staff, including Div 1 Psychiatric Nurse, Mary Hendrey.

The events prior to the arrival of security staff

- Nurse Hendrey

18. Nurse Hendrey had contact with Justin Fraser over the 9 days he had spent in the ward prior to the 25 and 26 October. During this period, she was on night duty at the Frankston Hospital Psychiatric unit. On the night of 25 October, she came on duty at 9.00pm. Her role was as Associate Nurse in Charge (acting), and working with her at that time were Nurses Katrina Geyer, a regular staffer in the unit, Michelle Woodcock, from the Peninsula Health Nurse Bank and male nurse Fady Soural, who was an agency nurse on duty in the unit for the first time. Katrina Geyer, Michelle Woodcock and Fady Soural, were all Div 2 trained psychiatric nurses. It is also relevant that Fady Soural was rostered to assist on that evening as a special nurse, with another patient in the unit, who at the time was exhibiting,

> *'high risk behaviours.'*[6]

19. According to Nurse Hendrey, the shift progressed unremarkably and the ward was closed down for the night at the regular time of 11.00pm.

20. At 11.15pm, Nurse Hendrey with Nurse Woodcock began an observation round, with Nurse Woodcock entering room 24/25, which we know to have been occupied by patients Justin Fraser and one other. Later Nurse Hendrey saw her colleague standing outside the room, which she considered unusual. She approached and was informed that Mr Fraser was not in his room. They then both went in to his room and heard noises coming from the bathroom. Nurse Hendrey then gained entry to the bathroom and found Mr Fraser standing in the shower cubicle beside a chair,

> *'... with a belt loosely tied around his neck and a (second) belt draped over the shower curtain rail, with a broken belt buckle on the floor.'*[7]

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[6] See exhibit 5 at page 1.

[7] See exhibit 5 at page 2.

21. Justin Fraser was upset at being found in these circumstances and quickly became agitated. He removed the remaining belt from his neck and went towards the window within the room proper and punched it saying,

> *'he was going through there.'*

22. He then made a further motion as if to run at the window. Nurse Woodcock blocked this movement as best she could while Nurse Hendrey attempted to

> *'talk him down.'*[8]

23. At this time, Nurse Woodcock pushed her duress alarm and Nurse Hendrey managed to get the attention of Nurse Geyer who was outside at the nurse's station several metres away. She directed her colleague to issue a,

> *'code grey, which is a general hospital alert that assistance was required where an aggressive incident cannot be defused. This occurred* at *11.18.'*[9]

24. Immediately thereafter, Nurse Fady Soural entered the room and Mr Fraser was verbally aggressive towards him telling him to,

> *'get out, don't come near me or I will hit you.'*

25. (According to Nurse Hendrey, Mr Fraser would have been aware that the security staff members were on their way at this time as he had previously been a witness to such a response, to a code grey hospital alert.)

26. Mr Fraser then changed out of one pair of jeans into another and put on his shoes,

> *'...and was bouncing around like a boxer...He refused to respond to any verbal attempts to settle him. He repeated to himself several times that I've had enough ... this has to end and its going to end tonight, this can't go on. I can't do it anymore...*
>
> *I'm going to die tonight and I want a good fight before I go. Come on lets go he said to security as they arrived at the door'*[10]

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[8] Ibid. The glass in question was double plated with a breach considered unlikely. See transcript page 197.

[9] See exhibit 5 at page 3.

[10] Ibid. Two security staff and four additional AMT staff arrived in the unit within several minutes of the calling of the code grey alert. The 4 AMT staff were male hospital personal care attendants, who for a minimal increase in salary, made them selves available and were rostered to attend to support security staff, when a code grey alert was called. The rostered Medical Officer also required to attend, did not in fact respond to the alert and arrived only at a later point, after the code blue was called.

The events following the arrival of security staff

27. Security staff were called by the code grey alert from Nurse Geyer, and attended the scene. The situation by this time was already,

> *'pretty escalated.'*[11]

28. Another patient remained in the room with Mr Fraser at this time apparently asleep in the bed closest to the rear wall and behind a dividing curtain.

29. It is not clear when security staff became aware of his presence.

30. The head of security (Trevor Murphy), asked Nurses Hendrey and Woodcock to leave the room. There was no debriefing.[12] Nurse Hendrey however initially remained within the room at the foot of the bed occupied by the second patient, referred to above.

31. It was in these circumstances that the two security staff Mr Murphy and Mr Botha (leading four AMT staff) determined to approach and tackle Mr Fraser, who then engaged in a significant struggle, which ultimately saw him restrained in a prone position with staff holding him on the floor, from above.

32. The sequence of events and the exact nature of the contact made by security and AMT officers with Mr Fraser, and indeed whether that contact caused or contributed to his loss of consciousness and/or his subsequent death, was a primary subject of inquiry.[13]

33. The following accounts are relevant.

- Nurse Hendrey

34. Nurse Hendrey testified that her understanding was that she remained in charge although,

> *'But also with Trevor it was not unusual for security to take the lead in an aggressive situation...the nurses often step back and the aggression management team takes over.'*[14]

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[11] See ibid at transcript page 160.

[12] This occurred with CSM Angela Aiello and Nurse Hendrey effectively handing responsibility for Justin Fraser to Mr Murphy. See further comment on this approach within finding below.

[13] See footnote 4.

[14] In answer to further questioning Nurse Hendrey testified that now under the 'code', there is a mental health clinician present whose duty it is to remain in control.

35. I note here however that her further evidence was to the effect that she deferred to Mr Murphy and her clinical senior, the Clinical Services Manager, (CSM) Angela Aiello and did not seek to make clear that she was in charge.

36. She further stated that once the security and AMT staff came into the room they approached Justin Fraser who took an aggressive stance.[15] (Soon) everyone was holding him and he crashed into the wall of the bedroom, causing damage to the wall. They, as a group, then fell through the bed curtain on to the nearby bed of the second patient, who was later removed from the room by herself.

37. Nurse Hendrey then went to the nurse's station to prepare to sedate Mr Fraser with a shot of Olanzapine 10mg, as permitted from his medication chart. When she returned to his room and after moving by CSM Aiello at the doorway, she found him restrained by security staff, face down on the floor. She administered the sedative in his upper gluteal region, and relevantly noticed that at the time he did not flinch when the needle broke flesh and that all struggle on his part had ceased.

38. She was concerned by this failure to react and general presentation and began DRABCDE[16].

39. She expected him to be breathing heavily from his earlier exertions. She found a pulse and slapped him on the face, which she stated was followed by an audible gasp and one breath, after which she anticipated but did not observe a normal breathing pattern (to) re-commence.[17]

40. She further noticed that one of his ears looked a little purple. His skin was warm and looked flushed, consistent with his exertions and she thought maybe the purple appearance of his ear stemmed from the fact that Nurse Fady near by at this time had pinched him on the ear when also trying to seek a response.

41. Nurse Hendrey was further questioned about her observations of the ongoing struggle to restrain following the initial contact. She was not a witness to these events, having left the room with the second patient.

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[15] See site floor plan diagram exhibit 5f.

[16] See exhibit 5 page 4 and transcript pages 172 and 200.

[17] At about this point she thought it possible that he was 'foxing' about whether he was breathing or not. The reason why she might have suspected such a course are unclear.

42. On her return to the room, she further confirmed that she saw CSM Nurse Aiello, in the doorway. At that point, she was unable to see into the room because of the persons obstructing her view. She believed he was restrained by this time however as the,

'banging and crashing had stopped.'

43. Similarly, she was not aware as to whether he was conscious or unconscious, as she re-entered.

44. Her further testimony was that when she approached, syringe in hand, she saw the position she described above.

45. There were four AMT and two security guards, on their knees, holding him down in a prone position from positions around him, with some appearing to hold him down on his back, and Nurse Fady situated at his head.[18]

46. At this point, she observed that Mr Fraser had ceased his resistance.

47. Later while apparently unconscious, Mr Fraser was carried face down by the same group of security and AMT staff, with nurses Hendrey and Fady in attendance, to a seclusion room. Again, there was no bodily movement observed by Nurse Hendrey as he was carried to the seclusion room and she further observed that he was not breathing during this some 30-second period. In these circumstances, she called a code blue during the transit.[19]

48. In the seclusion room an unsuccessful attempt at resuscitation took place. The responsible medical officer also arrived.[20]

- Nurse Fady Sourial (Fady)

49. Nurse Fady testified that on the evening in question he was called to attend the Frankston unit (for only the second time in his career) arriving after the shift handover, following a late request from his agency supervisor.[21]

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[18] At transcript page 168 the witness stated,

'There were six people, everyone was holding him, someone would have been holding him down in his back area.'

(At transcript page 168 the witness also stated, 'there was nobody on top of him.')

[19] See transcript pages 168, 177 and 213-15.

[20] See evidence of Nurse Hendrey at transcript page 174. Under the existing arrangements, a medical officer was required to attend immediately upon the calling of a code grey. This did not occur. The identity of the duty MO was not established in evidence.

[21] See his evidence as to the limits upon his knowledge of procedures within the unit, at transcript page 516.

50. He had been called in to provide special care for a particular patient, however this patient remained asleep during the relevant period and so he was able to step in to assist Nurse Hendrey with Justin Fraser.

51. Nurse Fady was present at the nurse's station at 11.00pm when Mr Fraser approached and was given access to his mobile phone to make a call, which on the evidence of Sharon Fraser, was received by herself.

52. Sometime later at approximately 11.40pm, he further observed that Mr Fraser had returned to the vicinity of the nurse's station and appeared to be engaged in an argument with an unidentified female patient. He approached together with Nurse Hendrey and separated the two adversaries, following which Nurse Fady remained with Mr Fraser, who mentioned that he had become upset when the female patient had intruded upon his call to his partner.[22]

53. They parted with Mr Fraser returning to his room.

54. At approximately 12.50am on 26 October, he heard a distress call coming from Mr Fraser's room. He entered the room and found Mr Fraser in a highly agitated state confronting Nurses Hendrey and Woodcock.[23]

55. Later two security and four PSA officers arrived. One of the security officers asked nursing staff to leave with Mary and him standing outside the door. From this position the witness saw and observed Mr Fraser commence this part of his confrontation with the words,

> *'Come on who is first,'*

(this while standing in a boxing position).

56. Staff then approached Mr Fraser from a distance of one to one and one half meters. There was something of a '*lull*' as he appeared to be calming down,

> *'...what triggered it...they tried to hold his hands or something like that...it turned to be a big struggle...and what caused that'*[24]

57. Thereafter he observed all staff attempt to grab Mr Fraser,

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[22] The phone call was also overheard by Nurse Fady and on his account, appeared to involve Mr Fraser trying to explain why he had not been in contact with the other party at an earlier time.

See transcript at page 516-19.

[23] See further description of early confrontation from page 3 of Nurse Fady statement, at exhibit 12.

[24] Transcript page 541.

'with all of them hitting the wall behind with force'.[25]

58. Then the group fell towards the second patients bed, so moving that bed with the patient waking and being taken away, (by Nurse Hendrey).

59. At this point, they fell to the floor into an area near the wall and where the second patient's bed had been (propelled) aside,

'they're over each other, they would fit in there'.

'Q: They didn't fall in an organised way?

A: No of course not.'[26]

60. Soon after Mr Fraser was on the floor,

'lying on his tummy...with one guy lying under the bottom half of John, with the other five firmly holding John, ... the other four were hands on'[27]

'...he was being held to the ground...a very random held if you like, was like everywhere.'

Q: Did you see people holding his torso his back area?

A: Um probably, Yes...I'm not 100% sure... there is a big chance that it is yes because there were a lot of them around him holding him...Everyone was holding him firmly.'[28]

61. The witness, now at Mr Fraser's head, was concerned to ensure that he was still breathing and could not at this point, discern if he was still resisting. His nose was near the ground and he was held,

'randomly'.

62. Later they,

'got more organized,'

with his legs held and his hands held to his sides. At some stage in the bedroom he was urinary incontinent.[29]

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[25] The two security officers led the approach to the middle of the room, talking to and *'then all of a sudden'* trying to hold Mr Fraser by his arms, one on each side, *'so that's what created the big struggle.'* See transcript at page 523.

[26] See transcript at page 525.

[27] Witness statement exhibit 12, at page 5.

[28] Transcript page 525-27. See also later evidence that he 'assumed' this to be the case at transcript page 546.

63. Nurse Fady could not detect breathing. He denied stating to fellow staff that Mr Fraser was breathing at this point.

64. A PSA was calling for, '*a bloody injection.*'

65. Nurse Fady further testified that he stated to Nurse Hendrey that,

> '*he is cyanosed.*'

66. Later the security were,

> '*rushing to try and carry him'.*

67. They moved him quickly, while still in a prone position. Mary was also at his head and said she had seen him,

> *'gasping.'*

68. Once in the seclusion room Mary said he was unconscious, a conclusion with which the witness and others agreed. CSM Angela Aiella, told her to call a code blue.

69. Later the resuscitation trolley arrived and the emergency team commenced CPR.

70. Nurse Fady's further opinion was that this confrontation and struggle was the most aggressive he had ever witnessed.[30]

71. His further evidence was that he did not observe Mr Fraser continue to struggle, when he was on the floor.[31]

72. Nurse Fady was aware of the risk that Mr Fraser might become a victim of positional asphyxia, which he described as, '*suffocation'*, but wasn't specifically concerned about that matter at the time, believing instead that Mr Fraser may have lost consciousness because of the level of violence which he had witnessed.

73. Nurse Fady was further questioned about his remark in his handwritten statement,

> '*..there were too many people on him holding his hands and legs and his face facing the ground. I told the guy who was holding his head to relieve his head so he can breathe*?'

74. His recollection was that,

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[29] Ibid page 6. Transcript page 528 and 549. According to the witness they held him in a disorganised way while trying to get the PSA out from underneath, for about one minute.

[30] See transcript page 536.

[31] See transcript page 537.

'... I remember making that adjustment...whether it was for his head or around that area, yes I remember that clearly.' [32]

- CSM Angela Aiello

75. CSM Aiello was on duty at Frankston Hospital from 10.30pm on the night of October 25, 2007. She responded to the code grey alert at 1.18am on the following morning. When she got there, she found Nurse Hendrey and the AMT together with two further nursing staff. Her expectation was that,

> *'the AMT would go in and talk to the patient and calm them down. I need to be present for a respond grey to make sure that the patient is all right and the staff are OK as well. In addition, I have to make sure that decisions made are correct. I act as a supervisor of all staff and as a patient advocate...*
>
> *When I got there the AMT "guys" gave me their phones and keys. I hadn't been briefed at this stage... We didn't have the luxury of being briefed on this occasion as the patient was yelling and the AMT were already in a position to respond.'* [33]

76. And later in testimony,

> *'the patient was screaming. I thought he was causing harm in the other room...I have people in security who are very good when they speak to a patient. Usually we do not have to detain a patient. Usually they talk them down. So I was not worried at that stage about anything.'* [34]
>
> *'I took the staff belongings and secured them in the nurse's station. I returned ... the boys were in the room and Trevor was speaking...Everything was quiet and the patient was co-operating. All of a sudden he started throwing punches... He was laughing ...I heard him say, "bring it on". As he was throwing punches (in a shadowboxing style according to her evidence and earlier evidence) the guys surrounded him. I didn't notice him connecting with his punches. I then left the room with the other patient.'*
>
> *'On return, the situation remained as before. He was laughing at this stage as he made his way forward...the CSM briefly turned her back.'*

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[32] See transcript page 542.

[33] Exhibit 8, page 1-4.

[34] See transcript page 277and 279.

'As I turned (back) around to face the group again the patient was on the floor. I don't know how it happened as I had my back to them when it happened. The patient was in a prone position with his head turned to the left which was facing towards the window.'

77. And later,

'The boys were just holding him down to control him. At this stage he was quiet...He was breathing...Mary came in with a chemical restraint, which she injected in his buttock...I asked Mary to make sure...to make sure (he) was breathing...

Mary went to the head of the patient to make sure he was breathing.'

78. Then,

'I told them to move him to the seclusion section. Later when in the seclusion room, I had a look at the patient and he was still breathing, however I didn't like how difficult it was for him to breathe... I left the room and went to the nurses station and called a respond blue,'

- Security Officer Trevor Murphy

79. At the time of the events under examination, Mr Murphy testified that he was employed by Wilson Security, stationed for some four and a half years at Frankston Hospital, as the In Charge Security Officer.

80. He was a properly licensed holder of a private security license.

81. During his two-week training course in 2002, he saw a video concerned with '*positional asphyxia.*' Since that time he undertook a two day refresher course following the death of David Hooks (January, 2004), and an anger management course, and RiSCE Training Course which later course,

'all hospital staff must undertake'.

82. On the night in question, on hearing a respond grey alert, Mr Murphy understood that a situation threatening or displaying aggression had occurred at the designated location and that he was called as part of the AMT, to attend.

83. The AMT was comprised of the two security officers and usually four PSA's, who would check to see if they are so required and collect a pager, when they commence each shift.

84. He was the In Charge Security Officer on duty, with fellow officer, Hendrik Botha, with whom he had worked at the hospital over his period on the job. On hearing the code grey, they both went to the psychiatric unit.

85. He saw Mr Fraser in a boxing position within his room, while two nursing staff also remained in the room.

> *'He yelled at us to come into the room and fight...At this stage I instructed the nurses to leave the room for their safety.'*

86. The patient came towards them and was asked to come with them to the seclusion room. He continued to make threats to throw himself from the window, said he was a security guard and,

> *'knew our tricks and holds.'*

87. Mr Murphy further stated that he believed the threat was genuine and was concerned for the patient's safety. He confirmed with Hendrik and the AMT team, situated behind him, that,

> *'we needed to enter the room and physically restrain the patient...*
>
> *The CSM was present and agreed with this decision.'*[35]

88. As we approached, the patient had backed himself into a corner near the window.

89. Hendrik and I went to grab his upper arms, he started swinging punches... *'haymakers.'* I dodged and swung off balance. All six AMT members tried to grab him. A physical struggle ensued as we all bounced off the plaster near the window. At this point, I believe I held him by the wrist.

> *'Then we crashed into the bed. Then as a group we all fell heavily onto the floor.'*

90. He fell partially on top of me,... I pushed from under him. He was in a prone position. Hendrik and other AMT members positioned themselves around him securing his limbs while he continued to struggle. I still had to use a reasonable amount of force to secure his upper left leg. The charge nurse Mary said we needed to move him to the seclusion room. I said we need to medicate him and Mary left to get medication returning within one or two minutes.

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[35] Amended statement of Mr Trevor Murphy, Exhibit 9, dated 15/11/2007, pages 1-4.

91. When she medicated him, he did not flinch. He seemed not to be struggling any more. Certain AMT members said to check his airway. Mary checked and said, *'he has a pulse.'* Mary said he was breathing and needed to be taken to the seclusion room, 10-15 metres away. This was done.

92. Once inside he was placed face up on a mattress on the floor. His lips were blue and he had blood in his mouth. I heard someone say they were having trouble getting a pulse. The nursing staff called a code blue. [36]

- Security Officer Hendrick Botha

93. Mr Botha testified that he was 39 years of age at the time under consideration and that he was employed as a contract security officer by Wilsons Security from 2004 (at the Frankston Hospital) where he partnered Mr Murphy. He further testified that he was a licensed security officer and that he migrated to Australia in 2002 after a previous working history of 16 years spent as a prison officer in South Africa.[37]

94. Mr Botha had completed a RiSCE course at Frankston Hospital along with all other staff.[38] He stated that the course emphasized anger management training (AMT),

> *'but more about taking people down...., which related to stopping people hurting themselves and others.'* [39]

95. On 26 October, Mr Botha responded to a Code Grey alert just prior to 1.20am and followed Mr Murphy to the psychiatric ward at Frankston Hospital, Ward 2 West A. According to Mr Botha, they were directed into room 24 by one of the four AMT staff who were already present.[40] Thereafter, according to Mr Botha, he spoke with Mr Fraser,

96. I said, '*The staff want you to go to the seclusion room to calm down.*'

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[36] See statement at exhibit 9 page 6.

[37] See statement of Henry Botha at exhibit 10 page 1.

[38] Risk Identification Safety Containment Environment, (RISCE).

[39] See exhibit 10 page 2. In his testimony at transcript page 398-99 Mr Botha stated that the course was also about '*communication and negotiation.*'

See also his statement at exhibit 10 ibid where he estimated that of 1000 code greys per year at Frankston Hospital, 75% involve take downs, evidence from which he later resiled during testimony.

[40] The AMT staff were *'Peter, Tim, Andrew and Brett'*. In testimony, Mr Botha also confirmed that when they arrived outside room 24 no nursing staff (or nursing supervisor Aiella) were present and no one told them what to do. This he considered *'unusual'* transcript page 404 and 410, and that normally (at that time) the lack of direction was not usual and he would expect, '*more information.*'

97. He said, *'I just want to have my last fight before I die.'*

98. I said, '*It doesn't have to be like this.*'

99. He said, *'I don't care much about anyone. I used to be a security guard and I don't care much about all of this bullshit. I just want to die.*'[41]

100. Later, his colleague Trevor spoke much the same words. Thereafter the patient continued,

'bouncing around like a boxer,'

with fists clenched.[42]

101. They then sought instructions from the nursing supervisor (Ms Aiella) who said,

'If we feel like it we can go in and stop him and take control of the situation.''[43]

102. Mr Murphy and Mr Botha then approached the patient who was standing near a window threatening to jump through it. He was jumping up and down (shadow boxing like). There was then a,

'lull... At this moment it seemed like he had given in.'[44]

103. Mr Botha and Mr Murphy then went forward one on either side of the patient, each attempting to grab one arm.[45]

104. Following this,

'.....the patient was very strong and turned us both around his body with the parties landing first on a bed...'[46]

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[41] See exhibit 10 page 3.

[42] His subsequent testimony at transcript page 405 was that he spoke to Mr Fraser only after his colleague Mr Murphy had done so.

[43] Ibid page 4. His later testimony transcript 409-410, was that this wasn't her actual direction but rather that she said, *'If you feel comfortable you can do that you can do that.'*

He further testified that he felt Ms Aiella was '*unsure*' and '*frightened*' and that it would have '*been handy. . if the nurse in charge 'Ms Hendrey', had given direction.*'

[44] Ibid. The underlining is mine

I note here that the Room 24 window was known to be double-glazed and believed to be shatter proof.

[45] I further note that in a second statement, Mr Botha sought to emphasize that Mr Fraser was constantly aggressive while they were in room 24 and that security (Mr Murphy and himself), had only attempted to grab Mr Fraser after he had *'thrown punches.'* See exhibit 10(a) undated.

However Mr Botha also testified, transcript page 407, that the negotiating with Mr Fraser lasted '*five to eight minutes.*' And (contrary to his undated statement Exhibit 10(a)) that, *'yes (before he was grabbed) there was just a bit of calmness I would say.'*

105. The group fell from the bed on to the floor, with Mr Botha first crashing into the wall (then broken) and falling to the floor near the rear wall and window with Mr Fraser.

106. At this stage, Mr Fraser continued to struggle with Trevor Murphy finishing up underneath him. Trevor then struggled to get out. And then he and Trevor were on one side with Peter an AMT, on the other holding his arms down with the patient in a prone position, with Mr Fraser continuing to struggle, with a fair bit of force,

> '*not maximum force*',

used to hold him, with body weight being applied (to his arms and legs) from above to gain control and hold him .. [47]

107. Mr Botha further testified that he noticed that Mr Fraser's *'ears and lips were blue*' after the group had been on the floor for about '*30 seconds*', (with this occurring before medication was injected by Nurse Hendrey).[48]

> 'Q: *Fairly quickly?*
>
> A: *fairly quickly yes'*

108. Further, that there was insufficient space, for the AMT group (and Mr Fraser) to undertake the takedown.

109. Then Nurse Fady asked if he was still breathing. (Nurse Fady) checked the pulse and later stated that there was a pulse but he might be,

> '*unconscious.*'
>
> *'We kept holding him down for about ...90 seconds...At that stage I felt there was not much power or struggle in the patient anymore, Mary medicated him. She injected him in the bum. The patient immediately gave two gasps.'*

110. Mr Botha further testified that Mr Fraser spent a total of,

> '*a couple of minutes*'

held on the floor.[49]

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[46] Ibid.

[47] Transcript page 417-19.

[48] See transcript page 422, although I note here that he later testified under questioning by the Coroners Assistant, that he was mistaken as to both of these matters, See transcript page 424-25, (-which later version on a consideration of all of the evidence, I ultimately did not believe).

111. He was then carried to the seclusion room about 20 metres away.[50]

Physical restraint policies and staff training policies in situ at Frankston Hospital at the time of Justin Frasers death

112. Mrs Janette Child, the Executive Director for Mental Health, testified that at the time of Justin Fraser's death the relevant policy addressing restraint was the January 2007 version of the Risk Identification Safety Containment Environment (RiSCE) framework. [51]

113. I have now reviewed this material together with the evidence provided by security guards, Murphy and Botha and patient services assistants, Sutherland, Gibson, Thompson and Madeley. I have also considered the further evidence provided by nurses Hendrey, Woodcock, Sourial and Gayer and CSM Aiello.

The RiSCE framework

114. The framework is comprised of an introduction to risk management in four areas:

1) Occupational violence;

2) Restraint;

3) Seclusion;

4) Patient behaviours of concern.

115. Attachments to the policy outlined the need for adequate staff training and listed a number of training modules that might be appropriate and relevant. However, no specific training requirements were set out for staff who might have been required to undertake a physical restraint.

116. The RiSCE framework at exhibit 3 JC3[52] at attachment 2 sets out how restraint should be carried out.

117. Point 5 states that restraint is a clinical matter for the care team. Point 6 states that in an emergency situation restraint must be approved by the nurse in charge, and a senior medical officer.

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[49] Transcript page 429

[50] Ex 10 page 5, (Brief page 68).

[51] Mrs Child gave evidence and made several further statements about the protocols in place at Frankston at the time of Justin Fraser's death, and of changes introduced since that time. See exhibits 3-3E and transcript from pages 30-145.

[52] See the evidence of Mrs Child.

The RiSCE introduction and training

118. The overall goal of this policy and the procedures that accompany it was intended to facilitate a safe environment for staff, clients and visitors. Under the framework, the objective was to inform department heads, unit managers, supervisors and all employees of their duty to attend relevant RiSCE training and to comply with prevailing policies in their work.

119. As above, the policy did not include any specific training requirements.

120. Of security staff, the evidence suggests that both Mr Murphy and Mr Botha had attended the relevant RiSCE instruction.[53] The evidence concerning the training undertaken by nursing staff by this time was far less certain.[54]

121. AMT staff Sutherland, Gibson, Thompson and Madeley had attended Hospital administered courses in aggression management, although the content of these courses together with the times of their attendance, was also uncertain.

RiSCE Occupational violence procedure

122. "Occupational violence" was defined under the then policy as any incident where an employee is abused, threatened or assaulted in circumstances arising out of the course of their employment.

123. On the evidence when Mr Fraser came out of the bathroom and confronted Nurses Hendrey and Woodcock, I am not satisfied that he was engaging in such an act.

124. However, upon the arrival of Nurse Fady Soural, threats of violence were immediately made by Mr Fraser and from that point, "client initiated occupational violence" was in progress, in regard to all three nursing staff, then in the room.

125. The management protocol for client-initiated violence was said to depend on whether the violence was intended or unintended.

126. (While he was suffering from mental illness, I note here that it appears that Mr Fraser was not delusional at the relevant time, and that his response was a reaction to the discovery and interruption of his earlier suicide attempt).[55]

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[53] See exhibits 3F1-2.

[54] See Findings - general below.

[55] See discussion below under Findings - Cause of death.

127. I further observe that somewhat confusingly, the appropriate response to either intentional or unintentional activity constituting occupational violence, was not defined in the protocol.

128. Instead, the suggested response appears in another document, the "Internal Emergency Procedure Manual."[56]

129. The RiSCE procedure for Management of Client Initiated Violence sets out four steps.

    a. The identification and assessment of patient who like Mr Fraser had a history of violence.

    b. The consideration of physical environment, staffing and resource issues.

    c. Alerts for relevant staff that the patient is exhibiting signs of aggression.

    d. The 'staged' approaches for achieving acceptable behaviour.

RiSCE Restraint procedure

130. As stated in the introduction to the procedure, Peninsula Health promotes a policy of least restraint.

> *'Restraint should only be used to prevent the person from causing harm to themselves, other consumers the public staff property or from being at risk of harm through the intervention of the health service'.*

131. According to the policy it applied to Mr Fraser in the Unit but,

> *'It should be viewed as a temporary solution. Its use must be considered after a comprehensive assessment, use of preventative strategies and only after reasonable options have been exhausted'.*

Medical evidence as to the cause of death

Dr Katherine White

132. Dr White, a specialist in forensic pathology testified that she conducted an autopsy on Mr Fraser on 26 October 2007. Her report exhibit 19, set out her opinion as to the cause of death which was that Mr Fraser died suddenly during restraint, while agitated and suffering from coronary artery atherosclerosis. Her further view was that the earlier attempted hanging was not a significant factor contributing to death.

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[56] This manual reference was part of Mrs Childs' third statement, see exhibit 3 attachment JC3 at page 11.

133. She further opined that death in these circumstances can be multi-factorial and that restraint of an obese man in an prone position,

> *'can restrict the ability of the chest walls, and diaphragm to move adequately for respiration. Of note, when obese people are restrained in a prone position, their body habitus also contributes to restricted respiratory movement.'*

134. Her further opinion was that in a setting of prolonged physical exertion, agitation, possible psychosis and restricted ventilation can cause reduced oxygenation, a raised potassium level and an adrenaline surge, which factors are potentially fatal especially so when suffered by an obese man with coronary artery narrowing.[57]

Professor Johan Deflau[58]

135. Professor Deflau opined that this was a complex case which had been thoroughly investigated by Dr White, and that her conclusions,

> *'were entirely reasonable...but that the cause of death was inherently uncertain because of the general lack of absolute pathological changes and the presence of multiple potentially interacting processes'.*

136. He then raised four possibilities for consideration.

a) Asphyxia by hanging, or Positional Asphyxia;

b) Clinically unsuspected heart disease;

c) Mr Frasers medication; and

d) Excited delirium.

135. Professor Deflau then discussed each of these possibilities in detail setting out his further opinions in exhibit 18, and also in his evidence, stating his broad opinion that, the cause of death was likely to have been caused by a series of contributing events, one of which was the onset of excited delirium.

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[57] See exhibit 19 at pages 16 and 17.

[58] Professor Deflau was called by Peninsula Health and was given leave to give opinion evidence as an expert. His qualifications and experience are set out in his report at exhibit 18 page 1.

Professor Deflau did not examine Mr Fraser. The materials he considered before reaching an opinion as to the cause of death are set out at exhibit 18 pages 1-2. These materials describe the disorderly nature of the events leading to the patients loss of consciousness, which maters were amplified in later testimony.

Dr Linda Iles[59]

136. Dr Iles' report set out a broad description of the syndrome, known as excited delirium. She then detailed how it is of great forensic interest in the context of the examination of the cause of death of persons in custody who, immediately prior to the onset of symptoms of respiratory difficulty, have been the subject of restraint by law enforcement officers, or less commonly by medical staff. She further stated, agreeing with Dr White and Professor Deflau, that cases of excited delirium are usually non specific and do not point to an unequivocal cause of death.

'Common features observed are as follows:

- Acute psychotic behaviour
- Agitation
- Altered mental state and delirium
- Bizarre behaviour
- Profuse sweating
- Incoherent speech
- Extraordinary strength and endurance
- Lack of response to painful stimuli
- Extreme exertion and hyperactivity
- Hypothermia'

137. Dr Iles also testified as to the overlap between the condition and a number of other medical and psychiatric conditions. She further testified as to the two main settings in which the syndrome emerges.

- The most common setting being in the setting of stimulant abuse, predominantly cocaine.
- The second being in the context of psychotic illness, frequently in the setting of the abrupt cessation of antipsychotic medications.

[59] Forensic Pathologist Dr Iles, qualifications and experience was set out in her report exhibit 17, which report was sought at the direction of the Court with the request that she address the cause of death issue having particular regard to the opinions offered by Professor Deflau and Dr White. The materials reviewed by Dr Iles are set out at page 1 of her report.

138. She then referred to the Working Paper on Excited Delirium from the American College of Emergency Physicians and papers statement that,

> *'The minimum features for excited delirium to be considered include the presence of both delirium and an excited or agitated state'*

The underlining is mine.

139. She then went on to the definition of delirium as defined in DSM-IV-R[60] as

> *'disturbance of consciousness (ie reduced clarity of awareness of environment) with reduced ability to focus, sustain or shift attention.'*

140. Dr Iles then concluded that there was no evidence of disorientation or that he was not lucid or incoherent,

> *'i.e. there are no features suggestive of delirium'*

141. She further observed that there was no reference to body temperature before or after death and no reference to his being *'sweaty'*, from which hyperpyrexia,

> *'is an important clue to the diagnosis of excited delirium.'*

142. And that in all the circumstances she was reluctant to,

> *'ascribe excited delirium as a factor in the death..'*[61]

Findings - General

Having reviewed all of the evidence, and Counsels submissions, I make the following findings.

At approximately 12.50am on 26 October 2007, a highly agitated Justin Fraser was found by nurses Hendrey and Woodcock in the bathroom adjoining room 24/25, within the Frankston Hospital psychiatric care unit, having just made an unsuccessful attempt to commit suicide by hanging.

At the time Mr Fraser had a history of two suicide attempts and had been treated for,

> *'first stage'* psychosis, and was being,
>
> *'prepared for discharge.'*[62]

It is also relevant that Mr Fraser was an extremely strong person.

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[60] DSM stands for the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association .

[61] Exhibit 19 page 2.

[62] See exhibit 5 at page 1.

Following his discovery by the two staff members in circumstances, (which caused him to react emotionally, but which apparently had little or no impact upon his physical well being), Mr Fraser spoke aggressively to nurses Hendrey and Woodcock, and later threatened nurse Fady. As a result a code grey was called.

On arrival, security staff led by Trevor Murphy assumed control of the scene, and without a debriefing directed nursing staff out of the room. Security staff immediately followed by four additional AMT staff approached, and Mr Botha and Mr Murphy then briefly verbally engaged with Mr Fraser and soon after attempted to grab him.[63] Mr Fraser responded violently to the attempt to grab him, and was immediately engulfed by the group crashing first on to the wall behind and then forward on to the bed of the second patient, resident in that room.

Thereafter, the group fell to the floor with the AMT, including the two security officers then in disarray, all struggling to recover position.

I also find that on falling to the floor unidentified staff of uncertain number fell on top of each other and, unintentionally, on top of Mr Fraser who was in a prone position from which he was unable to escape.

Mr Murphy also fell under Mr Fraser's legs and lower torso.

Ultimately, after what had been a chaotic several minutes AMT staff took control with two staff members holding him separately at each of his arms and one at each leg, this with Mr Fraser still in a prone position. Staff applied weight and strength to Mr Fraser's arms and legs. Shortly later, Mr Botha noticed that Mr Fraser's lips were blue and that he had ceased or had significantly reduced his level of struggle.[64]

Further upon Nurse Hendrey's return and later re-entry, (after an absence of approximately two minutes, during which Mr Fraser was continually held mostly in a non orderly fashion), she found that he was restrained.[65]

An AMT staff was able to pull down his trousers on his left side. Nurse Hendrey approached and injected Mr Fraser with Olanzapine 10mg, in the gluten area, to which there was no physical reaction (to the infliction of associated pain). A concerned Nurse Hendrey and Nurse Fady, then

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[63] This occurred during a lull in activity, following a period in which Mr Fraser had verbally threatened staff while moving about in what was also a threatening manner.

[64] See the at times inconsistent evidence of Mr Botha, and the evidence of Nurse Fady Sourial set out above, concerning this sequence of events.

[65] See transcript at page 165.

approached Mr Fraser's head and both attempted to ascertain whether he had lost consciousness. During that examination, Nurse Hendrey believed she witnessed Mr Fraser taking one breath, (which was all she believed she saw).[66]

While this was taking place the AMT, following the direction of Mr Murphy, picked Mr Fraser up carrying him then to a nearby seclusion room.

Thereafter, the nurse's suspicion of his earlier loss of consciousness was confirmed by further examination.

The responsible medical officer, evidently following his own sense of priorities, also then arrived.

Later, concerted attempts at resuscitation were not successful.

Findings - Cause of Death

Concerning cause of death, I have now reviewed all of the pathology evidence and the factual evidence underpinning the reports and evidence referred to above. I have also reviewed the medical notes concerning Mr Fraser's '*uneventful*' stay in the Unit, up until the night of his death.

Specifically concerning Professor Deflau's opinion concerning the attempted hanging, I note here that his subsequent behaviour suggests that this event had little or no impact upon the bodily well-being of Mr Fraser, or his subsequent level of physicality.

Concerning his opinion on the possibility that excited delirium contributed to death I note his view that,

> *'In summary, restraint, even involving relatively minor force, can result in significant deterioration in a person's physiological function, especially if there are additional factors in play, and can result in sudden and often unanticipated death during the restraint. In such cases, the autopsy findings are non-specific, and a diagnosis is made predominantly on the circumstances presented.'*[67]

I also note that his opinion concerning excited delirium was in part based upon a view that,

> *'the deceased was placed in a face down position,'*

and that the restraint in a prone position was,

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[66] See transcript page 214.

[67] Exhibit 18 page 8-9.

'predominantly by the limbs. [68].

As above, I find however that the bringing down of Mr Fraser was quite chaotic and that there was pressure applied to Mr Fraser's back and body generally as the group of six AMT fell randomly and unintentionally, around, on top of and under Mr Fraser, while he continued to struggle. I further find that Mr Fraser's presentation, his distress, the cyanosis and his reducing ability to continue to struggle, were first observed very shortly after the AMT regained control, in what were confined surroundings, and that AMT members had only then began to hold him with his limbs at his sides. It is also relevant that these initial observations were made before the return of Nurse Hendrey, and the injection of sedating medication.

From these findings and having reviewed the opinions offered by all three experts, plus the evidence of his history in the Unit, I conclude that both the manner of restraint of Justin Fraser, together with his underlying heart disease, contributed to the respiratory distress later observed by different witnesses.

I further find that I can safely accept the opinion of Dr White set out in her autopsy report that Mr Fraser died from,

1(a) Sudden death during restraint in an agitated obese man with coronary artery atherosclerosis,

and while there can be no absolute certainty about this matter, that the evidence in this case does not support the contention that the syndrome known as Excited Delirium was a contributing factor to Mr Fraser's death.

COMMENT

1. I remind myself that it is easy to be wise while sitting apart from the threat of imminent physical violence.
2. Being so reminded, I find that after the arrival of CSM Ms Aiello and the AMT, made up of the two named security officers and the additional four PSA's, that Ms Aiello as the senior clinician at the scene should have sought a briefing from Nurse Hendrey before commencing to debrief Mr Murphy. She should also have then continued with her supervision.[69]

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[68] See exhibit 18, paragraph 13 at page 6.

[69] I note from transcript pages 178-186 that Nurse Hendrey gave the clear impression that she remained unaware of any training received by her about restraint related protocols. Nurse Fady had not read and was not otherwise familiar with the same protocols.

3. In so finding I do not accept Ms Aiello's claim that the urgency of the situation did not permit her the opportunity to engage in that level of involvement, and to plan how best to proceed.[70]

4. I also find that following such a briefing, conversation at the scene with Mr Fraser should also have been led by Ms Aiello, as the senior clinician present.

5. It is also relevant that the security officer's initial brief attempt to mediate led to a *'lull'* in Mr Fraser's level of aggression and that Mr Murphy who had assumed control, evidently saw this as an opportunity to seek to physically impose himself and Mr Botha in a manner which was intended to take Mr Fraser by surprise.

6. I find however that during this *'lull'*, which occurred prior to the attempt by the two security officers to grab him by each arm, that actual fighting was still avoidable.

7. In these circumstances, I further consider that the initial objective, (ideally to be achieved through mediation by the senior clinician present), should have been to have Mr Fraser move at least as far as the corridor and leave the confines of his room where at the time another patient apparently slept behind a soft curtain room divider. This did not occur.[71]

8. I further find that AMT including security staff, at this point and before did not seek to comply with the sometimes uncertain requirements of the RiSCE Occupational Violence procedure, the Internal Emergency manual or the RiSCE Restraint procedure, allowing for a clinical leadership role as discussed above. Instead, it is clear that upon their arrival and without any information from the CSM about Mr Fraser's medical condition, or the background to his behaviour that both security staff acted prematurely when they initiated actual physical contact (without knowing anything about the patient) and without planning a strategy.

9. I further find myself satisfied that Mr Fraser's death was preventable.

10. In this regard, I find that (instead of acting in a more conservative mode as suggested above), I am satisfied that the manner of the tackling by security and other AMT staff in that space

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See transcript at page 516.

[70] Instead, the situation, because it was so volatile, required the full engagement of a senior clinician and in the absence of the duty Medical Officer that responsibility fell to the CSM.

[71] As above, I consider that failing mediation by a senior clinician, (which position had not then been reached), that in preparation for a pre-emptive take down, an attempt should have been made to lure Mr Fraser into the corridor or possibly to the recovery room itself, before that take down action began.

against an aggressive and heavily built patient of unknown physical capacity and mental health impairment, significantly (and unnecessarily) increased the possibility of injury, for all of those present.[72]

11. This together with the failure to follow protocols concerning patient evaluation, initial debriefing, team control, and the seeming acceptance by the CSM of Mr Murphy's assumption of authority, plus the late arrival of the duty medical officer and his/her consequent non-involvement, all contributed to increase the likelihood that tragedy would result.[73]

ADAM WHITE CASE NO. 1478 of 2007

1. Having investigated the death of Adam White in an inquest held at the Coroners Court Exhibition Street, Melbourne between the 11th and 21st of April 2011, (in conjunction with an inquest held into the death of Justin Fraser), I find that the identity of the deceased was Adam White and that he died at the Dandenong Hospital Banksia Ward Psychiatric unit on the 20th of April 2007,

   from, 1(a) Restraint asphyxia in a man with heart disease

In the following circumstances:

Background

2. Adam White was at the time of his death, thirty-one years of age, with a ten-year history of schizophrenia, together with intermittent alcohol and substance abuse.

3. On 17 April 2007, he was admitted to the Maroondah Hospital Emergency Department with symptoms of psychosis, agitation, impulsivity and delusional beliefs that, he was saving the world.

4. He had been serving a Community Treatment Order, which was subsequently revoked and was kept at Maroondah Emergency Department, awaiting a bed. While waiting he was medicated

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[72] It is also relevant that unbeknown to the CSM (who had not herself sought any meaningful background briefing from Nurse Hendrey), that Mr Fraser had earlier demonstrated no insight or judgement concerning his condition and behaviour at that time.

[73] The CSM arrived following the code blue alert and was present at the scene during the events, which followed, (transcript 532).

On all of the evidence I am not satisfied that the nursing staff including the CSM, were fully aware of the applicable RiSCE protocols or had received training in them.

In this vacuum and in the absence of direction Mr Murphy and Mr Botha did as they saw fit and with little regard to existing RiSCE protocols, exercised sub optimal judgement concerning the choices which then remained available.

with 300mg Largeatil, 6mg Clonazepam, 10mg Droperidol and 35 mg Midazolam, over an 18 hour period.[74]

5. On 19 April, 2007 Adam White was transferred by ambulance and finally admitted as an involuntary patient, at the Banksia Ward of Dandenong Hospital. The nightshift at Banksia commenced their shift at 9.00pm. At about this time Mr White was observed wondering around the ward pacing up and down. At about 11.15pm he was seen attempting to jump a security fence at the perimeter of the unit. He was approached by a psychiatric nurse, and security officer, and informed them that,

'I am trying to pull the fence down'

6. In response, he was asked to return inside, which he did. Thereafter, he was observed behaving in a,

'passive aggressive,'

manner, and he finally went to sleep at around midnight.

Events unfolding from 4.00am

- Nurse Elena Margineanu (Elena)

7. Nurse Elena, a psychiatric nurse at Banksia Ward, testified that Adam White was obese and unkept and had been aggressive to other patients following his admission to Banksia on 18 April, for Schizophrenia.

8. She was on nightshift duty on the 19th/20th of April, together with Nurses Betty George and Irene Wilson.

9. During her shift Adam White was,

'agitated, paranoid and delusional. By this, I mean he called me a cunt and a faggot and asked me if I was male or female. He also asked for two cups of milk and then started to

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[74] See evidence of Dr Mohamad from transcript page 475 and exhibit 11, to the effect that the drugs were suitable and Mr White was not over administered, given his size and weight and his ongoing high level of agitation.

(Dr Mohamad was the psychiatrist on call at Banksia ward on the occasion under consideration. He was called to the scene following Mr White's collapse. He did not psychiatrically examine the patient).

He further testified that from his examination of the notes Mr White was still agitated on his arrival at Banksia and could only be medicated by intra muscular injection.

His further opinion was that Mr White's low level of oxygen saturation (91%) on his arrival at Dandenong Hospital, may have indicated pulmonary disease, lung disease, emphysema, asthma or acute heart disease, which observation I note is consistent with the later findings of the examining pathologist.

sing in the corridor. I would say he had a thought disorder and would have forgotten about calling me names.'

10. She saw him wandering around and pacing the corridors, and later trying to jump over the seclusion fence of the courtyard outside.[75]

11. At around 4.00am Adam came to the nurse's station and spoke and sang to Nurse Elena and Betty George in an inappropriate manner. Nurse Elena then offered a coffee to which Nurse George responded that he was required to fast for later blood specimen taking, as a sample was required for testing. There was then further discussion with Adam White about taking the sample immediately, but that, security staff had to be called, if that was to occur.

12. Adam White said,

'Call the faggots, because I can take them down one by one.'[76]

13. Nurse Elena then called the Security officers Duncan and Dean. She later found that a blood sample was unnecessary, as a test had already been completed on the 19th of April. She so informed Adam White who continued to be loud and request another blood test.

14. By the time they arrived a few minutes later, Mr White had calmed down and agreed to go to the seclusion room. He then walked in the direction of the seclusion room with Duncan and Dean following him and Nurse Elena following Duncan and Dean. At the end of the corridor, she told Adam to turn right towards the seclusion room. He then turned around to face Duncan and Dean and shouted angrily at them. In response, they tried to calm him with one saying,

'Go back to your room mate.'[77]

15. The security officers then tried to redirect him towards the security room and Nurse Elena walked past them and went to prepare the security room, about 20 metres past where Adam was standing at this time.

16. Thereafter,

'I returned in less than a minute to later see Duncan and Dean struggling with Adam on the floor. Adam had his legs and tummy on the floor and his upper was off the floor, because he has a big belly.

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[75] See statement exhibit 4, page 1-2.

[76] Ibid.

[77] Ibid page 3.

17. The underlining is mine.

> *Duncan was on Adam's left side and trying to hold him down. Dean had a knee on Adam's bottom and the other on the base of his back. Adam was kicking out violently with his legs. Adam was continually swearing, saying, "fuck you" and "cunts". Duncan was saying to Adam "just settle mate. There's no need for this. Relax your fist. Just calm down." I approached and pushed down on Adam's left calf muscle behind his ankle. I found it very hard to hold his calf and I realise I couldn't hold it much longer. Duncan yelled at me,*
>
> *"Get the cops. We cannot restrain him any longer. We need them. Get the other wards too."*
>
> *I ran to the nurses stations and called the Dandenong Police Station. I told the other nurses to call the other wards and a doctor. I (was) concentrating on the phone and cannot remember hearing anything that was happening.*
>
> *I return(ed) to the scene approximately 2-3 minutes later. When I rang the police I told them, we needed them urgently.*
>
> *When I got back to the scene, I saw Adam was not fighting anymore. He was laying on his right side with his head facing up. Duncan asked me to assess the patient. I asked them to turn him over. Dean released Adam. I pushed his chest for Adam to face me. I did not feel any resistance. I started to call his name and Adam started to pass out. His eyes were open and when I rolled him more on to his side he had difficulty breathing. He was pale and he passed out. His lips were turning blue and he was deteriorating very quickly'.*

18. Nurse Elena then called a code blue from the nurse's station. She returned to Adam and on examination could not feel a pulse. Later, she and Betty started oxygen to Adam and a '*resuscitation trolley*' arrived at the same time. Thereafter, ICU staff arrived.

> *'Duncan and Dean were physically exhausted and removed themselves from the scene. I saw Duncan sitting on the floor in the corridor and Dean was almost passing out...They tried to resuscitate Adam for 40-45 minutes and zapped him six times'.*

19. The attempt was unsuccessful.[78]

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[78] Ibid page 3-5.

ANUM, Nurse Betty George

20. Nurse Elena's version of these events, was largely supported by Nurse Betty George (to the extent that she witnessed the incidents under review). She stated that at the relevant time she was the Associate Nurse Unit manager, the in-charge on duty in Banksia ward. At the time, she was a Div 1 Grade 2 Year 9 (RN).

> *'I ran down the corridor. I found them outside the male four, bedroom. Mr White was on the floor and appeared "blue" and was unresponsive to RN Margenenu's calls to him...I ran to get the oxygen ... The Code Blue team attended and managed the arrest system...I returned to the main communal areas and with Nurse Wilson maintained the safety of the other patients several of whom had woken.'*[79]

The underlining is mine.

Security Officer Duncan Jones,

21. At approximately 4.30am on the 20 February 2007, Duncan Jones was in the security office at Dandenong Hospital when Nurse Elena at Banksia Ward, called him out. He attended at the ward with partner Dean Tucker.

22. Adam (White) was obviously elevated. Adam was being loud and physically expressive but was not aggressive...At the request of the nurses he walked with us to a treatment room and (we) sat him in a chair where blood was usually taken.

23. Later, he walked out to the kitchen...

> *'his level of agitation had gone up'.*

24. He was being very loud and

> *'obnoxious, swearing and yelling...We spoke to Elena about what to do with patients. She said that he should be placed in seclusion..., which is a room with a bed, a window, and door. Adam had been in one of these rooms before.'*[80]

25. Initially Adam co-operated as they commenced to walk to the security room...

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[79] See statement at exhibit 18, page 1.

[80] Ibid page 2.

26. As they walked past Adam's room, he moved to walk in. Dean Tucker then took steps to block his way and Adam was told that he could not go in there. He then became a *'bit'* agitated.

> *'This went on for about one minute. All of a sudden Adam just snapped. He did not say anything but I could see in his eyes that he meant me harm. He raised his right hand behind his head with a clenched fist, and his left hand was raised to chin level, in a fist. Almost like a boxing stance.*
>
> *I moved in towards Adam and grabbed his right arm so that he couldn't hit me. I got as close in as I could and wrapped my right leg, and put him on the floor. Dean had a hold of Adam as well, which meant that Adam went to the floor quite slowly. My hands were on the floor between his head and the floor, so he wasn't hurt at all'.*[81]

27. As soon as he was on the floor, he started,

> *'thrashing about kicking, punching and hitting.'*

28. He was 6 feet tall and weighed over 140kg. He was extremely strong and the two of them struggled to restrain him. Eventually they were able to restrain in a crucifix position in a corner of the corridor and where there was little space to move. They called for assistance as Adam continued to struggle and Duncan believed they would not be able to hold him for long.

> *'While the nurses were organising police, Adam continued to struggle. He'd put his arms under himself and then Dean and I would manage to pull them out again.'*

29. After a couple of minutes Duncan noticed that Adam and stopped struggling and that he had started snoring…We turned him on his side.

> *'I couldn't see if he was breathing because his hair was across his face, and his breath was moving his hair. For our safety we still had both his arms behind his back.'*

30. Mr Tucker and Mr Jones then started yelling for help.

31. Mr Jones suffered superficial injuries to his body arms and legs.

32. And later,

> *'I don't know how long the whole incident took, but I was completely exhausted by the end of it. ... I have since heard that Adam has passed away. This news has devastated*

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[81] As above.

me, because I feel that Dean and I acted completely within our training and did nothing wrong.'[82]

Security Officer Dean Tucker

33. Dean Tucker gave evidence, which supported that given by fellow security officer Duncan Jones.[83]

34. According to Mr Tucker, as they approached Adams bedroom he indicated that he needed to get his toothbrush, but was told by Elena and Duncan, that he couldn't have a tooth brush in the seclusion room...[84] He was enraged by this and had

'*gone at*' Duncan Jones. [85]

35. He then grabbed at Adam and perhaps unwittingly assisted Mr Jones to bring him to the floor.

36. Initially, Mr Jones may have been under him,

' but then ... he was grabbing and wrestling against us. He had been kicking against us ... I moved so I was kneeling on the back of his legs.

All I can remember is that I saw him move his left hand, which was clenched in a fist, out from underneath near his face onto the floor next to his head. He had his fist pushed down into the floor as if he was trying to get up. I remember thinking that if he got that arm free we would be in trouble, so I lent over and was trying to grab his left hand, I wanted to get it behind his back. Because I was concentrating on that left fist, I cannot say what Duncan was doing at that time.

This went on for some time.[86] *I cannot say how long...I heard what sounded like (his) snoring,* (with Mr White then noted to be unresponsive and both security officers exhausted) *and relaxed my grip.*

...To the best of my knowledge we acted within guidelines and I am devastated this man has died, despite me thinking that we have done absolutely nothing wrong' [87]

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[82] Ibid page 3.

[83] See transcript from page 341.

[84] See transcript from page 359.

[85] See evidence from page 361, where further description of the attempted take down and 'crashing to the floor...with Mr Tucker on top of Mr White' was given.

[86] In evidence at page 366, Mr Tucker testified somewhat uncertainly, that the struggle 'may' have lasted two minutes.

37. The underlining is mine.

Hospital Nursing Coordinator Registered Nurse Jenny Blanch

38. Nurse Blanch was the senior hospital nurse on duty on the night of 19/20 April. At 4.45am she was called to Banksia Ward and attended on Adam White.

39. At the time of her arrival, an attempted resuscitation was in progress. Adam was connected to the cardiac monitor by the 'Code Blue' team, with the system indicating either a fine fibrillation or asystole. CPR had commenced but the Doctors were not trained in intubation and had not been able to establish a secure airway to administer medication by this route.

40. The anaesthetist Dr Osborne arrived some time later stating that he was unfamiliar with the location of the Banksia Ward and had been unable to find it. He was then able to intubate Adam.

41. Cardiac resuscitation continued throughout however cardiac compressions were very difficult to perform, possibly due to Adam White's large size and build.

42. Later,

> *'The ICU Registrar, Medical Registrar and I discussed whether we had any further options available to us. Nothing more could be done...Mr White was pronounced dead at 5.26 am on the 20th April 2007'.*[88]

Medical evidence as to cause of death

Senior Forensic Pathologist Michael Burke

43. Dr Burke conducted an autopsy on Mr Fraser on the day of his death.

44. It was noted that Mr White was an obese Caucasian male of 182 cm and weighed 135kg (BMI 40.8). He had two petechial haemorrhages found in the right eye. Bruising to the lip and blood around the nostrils and on the right side of the face were also observed. Further superficial injuries to the right and left arms and to both hands and left wrist were also observed. Similar injuries were found on both legs and on his back.

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[87] See statement of Dean Tucker at exhibit 8 page 2-4 and evidence at page 364 where Mr Tucker confirms that he was trying to pull Mr White who was struggling on the floor in a prone position, while lying over Mr Jones.

[88] See Brief, Exhibit 19 at page 18.

45. Coronary arteries were in normal condition save that the mid portion of the left anterior coronary artery showed atherosclerosis. Mr White was found to have a large heart with focal artery atherosclerosis (50%) and intra mural coronary artery and chronic asthma.

46. Dr Burke's further opinion was,

(Having, regard to the circumstances, being that Mr White was a patient, admitted to Banksia Ward concerning an acute exacerbation of schizophrenia...having been involved in an incident with two security guards who had tried to restrain him by forcing him to the floor. The circumstances indicate that one security guard was kneeling on the back of the deceased's legs and attempting to restrain his left arm. A second guard was leaning on his right side...),

as follows,

47. The post mortem examination showed no injury which would have led directly to death;

48. The circumstances of death with marked congestion of his face and rare petechial haemorrhage is consistent with the diagnosis of restraint asphyxia;

49. Whilst this is normally seen in association with agitated delirium associated with the use of cocaine and amphetamines, restraint asphyxia may also occur in non-drug affected individuals;[89]

50. The deaths appear more common in somewhat obese individuals who are restrained face down (as here), resulting in a splinting of the ribcage and diaphragm. The respiratory compromise leads to relative hypoxia and in the setting of increased blood levels of adrenaline, which occur in such circumstances, death is due to a sudden cardiac arrhythmia.[90]

51. After a review of the clinical history Dr Bourke's further opinion was that Mr White had died of restraint asphyxia with his underlying cardiac abnormalities, possibly also contributing.

Management protocols then in place at Banksia Ward

Banksia Ward Psychiatric Nurse Unit Manager (NUM) Theresa Meiklem[91]

52. NUM Meiklem testified that a new building was soon to be opened which would replace Banksia Ward.

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[89] See discussion at transcript page 466 and the toxicology reports obtained in respect of Mr White, leading to Dr Burke's view that the use of illicit drugs and 'agitated' delirium', was not a factor in Mr White's death.

[90] See post mortem report at exhibit 10, pages 9-11.

[91] As at April 2007 Nurse Meiklem was one of five associate Nurse Unit Managers (ANUM) on the ward. She is now holds the senior position of Nurse Unit Manager. She was not directly involved in care provided to Mr White.

53. She also testified as to the change in nursing staff culture, which had occurred on the ward, some more disturbing aspects of which, to do with the bullying of nursing staff, are discussed at transcript page 523. The underlining is mine.

54. Her further testimony was that as at April 2007, conditions at Banksia Ward were such that on any one shift there was a call in sick rate of between 13% and 17%, now improved to between 2% and 5%,

'so we have gone from the highest in the mental health range to the lowest.'

55. As a result, most shifts at the time had to rely on Bank and Agency staff, which need has not,

'arisen over the last two years',

with full time staff now willing and able to work overtime as required. [92]

56. Further evidence was given as to significant clinical changes, which had been introduced from this time.

57. These related to the previous use of seclusion rooms, a practise which led to the overuse of security staff,

'and there wasn't one person controlling things.'

58. Under a new approach, there is now consultation with the patient,

'What does the patient want, what can you do, do you offer medication. Then you tell the nurse in charge and make sure the nurse in charge is aware of what is happening... The nurse in charge takes over...de-escalating and recognizing that the patient has needs...' [93]

59. According to the witness, nursing staff are now much more pro-active with patient's needs and medication issues under constant supervision.

'I am (now) very proud of the staff.' [94]

60. NUM Meiklem further testified that at the relevant time Mr White's seclusion room might have been intended to be left with the door ajar.

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[92] Transcript page 522-23.

[93] See Exhibit 12 Banksia Ward De-escalation Checklist.

[94] Transcript page 531.

61. I note here however that his level of agitation appears to have been finally triggered by the refusal to allow him to enter his own room to get a toothbrush, rather than because of the intention to place him in a so-called seclusion room.[95] Significantly, it is also the case that all of the evidence tends to establish that the management system then in place left Nurse Elena, to her own resolution of the matter, and did not discourage the early engagement of security staff.'[96]

62. In regard to the medication offered to Mr White, NUM Meiklem further testified that staff could have further provided sedative PRN medication, had they chosen to do so. Stilnox, Olanzapine and Diazepam could have been used, but were not offered.[97] Her further view was that,

> *'enforcing that nurses are proactive rather than, waiting for things to happen,'*

was a factor in the improved performance of the unit.[98]

63. Concerning the trigger, which led to the outbreak of violent contact, Ms Meiklem stated that in the case of schizoaffective disorder, it could be anything.

64. Further evidence was given concerning a seclusion audit detailing seclusion incidents, which had occurred in the ward at night, and of the failure to report seclusions around the time the subject of this inquiry.[99]

65. The experience suggested that early release from seclusion was now proving helpful in the management of the ward, with assaults on staff members in Banksia unit falling from a maximum of sixteen incidents per month, down to zero.

66. Further, evidence in regard to assaults on staff, to the effect that there were at the time two nursing staff who would,

> *'goad patients and try and restrain them in order to support work cover claims,'*

provided additional illustration indicating a level of management malaise within the unit at this time.[100]

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[95] On the previous evening, Mr White had slept in an open seclusion area, without incident.

[96] See exhibit 12 – Banksia Ward De-escalation Check list.

[97] Transcript page 532.

[98] See also the witnesses discussion of Nurse Elana's evidence as to the incidence of assaults on staff at the time, from transcript page 542.

[99] See exhibit 12 c and discussion at pages 538-40..

Restraint policy then in place at Banksia ward

Patient Restraint protocol[101]

68. The Patient restraint protocol appears to have applied in the case of Mr White, given that its purpose included,

'The use of non mechanical restraints by medical or security personnel, should be considered when it has become apparent that medical or security personnel are unable to safely manage or cope with the physical demands of a given situation.'

69. Relevantly a further purpose states,

'Restraint activities are to be co-ordinated by medical and nursing staff. Officers are only to act under their specific instructions.'

70. The underlining is mine.

71. I also note however that the protocol appears to be mainly directed towards administering treatment and does not specifically deal with the situation where violence is threatened against a member of staff.

Management of Occupational Violence and Emergency Response protocol (MOVE)

72. The Dandenong Hospital's patient restraint protocol (MOVE), in place at the time of the death of Adam White, had been introduced from July 2004.[102] According to the protocol its purpose was to govern,

'The use of non-mechanical restraints by Medical or security personnel should be considered when it has become apparent that medical and or security personnel are unable to safely manage or cope with the physical demands of a given situation'

73. (Certainly, following the arrival of security staff, and the confrontation outside Mr Fraser's bedroom, this criteria had been met.)

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[100] See transcript at page 543.

[101] The patient restraint protocol was introduced from Jan 2002, and revised in August 2005.

[102] See discussion of Management of Occupational Violence and Emergency Response (MOVE) in evidence of Dr Huppert and in his statement at exhibit 2.

74. I also note that the protocol dictates that the restraint and 'continued engagement' is to be monitored, and that the emergency response is to be initiated by a senior clinician.

75. The protocol further states in regard to emergency response that,

Step1 All staff or those designated as the Emergency Response Team ...will proceed promptly to the local designated area for instructions... and

Step2 Identify as quickly as possible the situation (eg who is involved in the incident, if anyone present knows the consumer,details of violence etc

Step3 Implement the emergency response as directed by the Controller

Step4 The senior clinician initiates the emergency response

These rules then require that a senior clinician takes charge of the situation and directs the activity of all others involved. It is also the case however that the protocol appears to have been primarily designed for use to deliver medication and again does not specifically address the need for restraint to protect patients and staff from the threat of physical harm.

76. Again, the Restraint methods suggested in this protocol are mostly relevant to patients lying on a couch or bed and do not appear to be especially helpful to those called to deal with the situation presented by Adam White.

Minimization of Restraints protocol

77. This protocol was also in place at the relevant time. It sets up a number of steps to be undertaken consecutively when determining whether to undertake a restraint. The protocol requires a careful examination of all risk factors, and a consideration of alternatives to restraint, and a careful monitoring during restraint by a clinician.

78. I note however that again this particular protocol also appears somewhat limited in its usefulness, as it requires extensive direction to staff, to refer to and to complete forms around the decision of how to restrain, and contains no detailed direction as to how staff should undertake restraint, in such a situation.

Training

79. The Minimization of Restraints protocol also deals with training for Southern Health employed Security Officers. The evidence of Mr Jones and Mr Tucker suggests that they both undertook training provided by their employer although the methods of training (like the relevant protocols) appear to demonstrate only minor relevance to the restraint of a potentially violent patient at large, in the hospitals Banksia Ward.

Findings

I accept the evidence of Dr Burke and having regard to his evidence and to all of the rest of the evidence, I find that the cause of Adam White's death was

1(a) Restraint Asphyxia in a man with heart disease

1(b) Acute exacerbation of schizophrenia

2 Chronic Schizophrenia

I further find that officers, Jones and Tucker, who were called upon to manage Adam White on the night of his death, were seriously undermanned and could not cope with the strength exerted by Mr White, as he fought to be released from their grasp.

I find that the training provided by the Hospital to both security officers as well as other staff likely to be concerned with the resolution of such conflicts, was sub-optimal.[103]

It is also the case that neither the nursing manager, Mr White's duty nurse, or unwittingly the two security officers concerned, adhered to the general direction concerning clinical management of

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[103] Both the Management of Occupational Violence Emergency response protocol (MOVE)* revised August 2005 and the Minimisation of Restraints protocol dated Oct 2006 were in place at the time of Mr Whites death. As set out above both protocols appear to have had certain shortcomings the former policy (though not the latter) appears to deal primarily with patients needing medical restraint, and was only indicative and of limited assistance, to the nursing staff and two security officers concerned in the events leading to Mr White's death.

The Hospital through the evidence of Leanne Satherley, quite properly conceded that the programme (MOVE) as it then operated, did not sufficiently direct staff how to deal with high levels of aggression.

I further find that the security guard and Security crowd control licenses relevant to Mr Tucker and Mr Jones, also did not specifically qualify them for dealing with the challenges of violent conduct, in a hospital psychiatric ward setting.

restraint, contained in the Occupational Violence and Emergency Response, the Minimization of Restraint and the Patient Restraint protocols then in force.[104]

I further find that this general failure was consistent with the problematic working culture then in place, as described by NUM Meiklem and others, and was further complicated by the absence of clear direction in the protocols about how to manage a mentally ill patient, who like Mr White presented in a threatening manner.

In these circumstances, the two security officers were left with little choice but to engage with Adam White at a time when his level of psychiatric illness and resulting incapacity, not to mention his physical strength, made such a course inherently perilous.[105]

I further find that in these most difficult and challenging of circumstances, that the manner of his restraint, with an out of control Mr White in a prone position being inadvertently pressed from above, as the officers fought to take him into control, contributed to his death and that he asphyxiated under restraint.

For the reasons given above, I do not attach blame for this tragedy, to the two officers concerned.

Comment

I note here my view that had the management system, together with the Management Restraint protocol, (plus the MOVE protocol) then in place successfully encouraged both the on duty ANUM, and/or the duty nurse, or other more senior clinician, to manage the conflict in its early stages in a proactive manner (with appropriate inquiry and reasoned response), that the loss of Mr White was avoidable.

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[104] As above, I note that the MOVE response protocol does not appear to target restraint in emergency situations, although the protocol does suggest the importance of clinical supervision. Similarly the Minimization of restraint protocol talks of clinical supervision but is otherwise limited.

[105] Having regard to the protocols and the evidence of NUM Meiklem I consider that the decision by Nurse Elena to call security and send Mr White to a seclusion room was premature, and in a best case should not have been hers to make. Further, it is also clear that such a decision would now be much more closely examined, by a more senior clinician.

I also find that the failure of nursing staff to engage Mr White on the question of his plan to take a toothbrush from his room, and the failure of the ANUM on duty to engage with him on any of these matters, was not in his or the Hospitals best interests, especially given his likely confusion over the earlier proposed blood testing. (See the evidence of security Dean Tucker concerning Mr White's unauthorised venture into a medical treatment room, from transcript page 353 and at 355).

Instead, (absent an appropriate level of clinical management), the fact is that at the time Mr Tucker and Mr Jones were called upon to attend and then physically engage Mr White (outside his bedroom), that opportunity had passed. [106]

COMMENTS ARISING OUT OF BOTH MATTERS

1. The evidence given in these two matters suggests that a good deal has now been achieved at both hospitals to improve performance during security emergencies, within their respective psychiatric units.[107]

2. This has occurred by the establishment of apparently workable protocols, and the provision of improved training for Nursing, PSA and Security staff alike. Considerable effort has gone into achieving these outcomes and I respectfully congratulate those responsible for such an achievement.

3. It is relevant to note however that during my investigation it has become apparent that different approaches have over many years, been taken within different hospitals and that these differing approaches have a significant potential to confuse. This had led to what I would describe as a 'fusion' approach to security with a general blurring of understanding among clinical staff and security staff, (including AMT staff at Frankston), concerning their respective individual duties and responsibilities.

4. I further observe that the danger of such a fusion is particularly pronounced in situations when agency and bank nursing staff may be called upon to work casually at short notice in different psychiatric units, and when security and PSA staff may, for similar reasons, be new to the protocols and practises current within any particular unit.

5. This also emerges because of the necessary requirement that non-nursing security staff in both hospitals are engaged to carry out duties, which are hospital wide and not simply limited to the security needs of the psychiatric unit.

6. It is also relevant that my inquiry has revealed that the Australia wide standards of training and experience requirements, within the security industry as they apply to Hospital care, are

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[106] The opportunity being for inquiry and appropriate reasoned response by management staff.

[107] See exhibit 3B the fourth statement plus attachments, and the evidence of Mrs Child reference Frankston Hospital, and the evidence of NUM Meiklem reference Dandenong Hospital, as set out above.

themselves inconsistent, often depending on where within Australia the security officer was initially recruited and licensed.

7. It is appropriate to note here that an overview of these matters was raised, (in the context of this investigation), at a meeting held with the then Chief Psychiatrist, Dr Ruth Vine, in late 2010, i.e. before the taking of evidence commenced.[108] This meeting was also attended by the Director, Public Sector and Community Services Division, WorkSafe, Ms M Williams, together with staff from the Coroners Prevention Unit and Coroners Assistant, Senior Sergeant J Brumby,

8. Among other initiatives underway by this time, the meeting was informed of the progression of Government plans to introduce a new Mental Health Act.

9. At this time and as the inquest progressed, further consideration turned to the possibility that the introduction of a new Act may provide an opportunity to regulate in the area of physical restraint, within Hospital Psychiatric units.

10. Allowing for this possibility the Coroners Prevention Unit[109] at my direction, undertook a comparative inquiry concerning possibly appropriate protocols for the management of restraint within such units, the relevant parts of which I attach to this finding.[110]

RECOMMENDATIONS

I have now again reviewed the evidence before me. Having regard to all of this material, together with review materials prepared by the CPU, I make the following recommendations:

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[108] See minutes of meeting available to interested parties on application with cause.

[109] The Coroners Prevention Unit is a specialist service for coroners created to strengthen their prevention role and provide them with professional assistance on issues pertaining to public heath and safety.

[110] See attachment A

I further note here that in a recently published Department of Health paper

titled A new Mental Health Act for Victoria-Summary of proposed reforms,

the Department deals with these matters under the heading Restrictive innovations,

where it is noted,

'Restraint and seclusion are highly intrusive practices that tragically have been linked to patient deaths...

The legislation will introduce regulation of physical restraint in addition to the existing regulation of mechanical restraint and seclusion. It will improve the safety of restraint and seclusion by increased oversight of and accountability for these restrictive practices.

In addition the legislation will specify that restrictive interventions must only be used as a last resort after all other less restrictive options reasonably available have been tried or considered and found unsuitable in the circumstances.'

Recommendation 1

That the current review of the Mental Health Act considers the inclusion of regulation, which endorses the following seven principles for safe physical restraint, with a view to reducing the possibility that death or serious injury may result from psychiatric patient restraint.

General approach to psychiatric patient restraint

1) Physical restraint is only to be employed after a consideration of all available options and as a last resort, to prevent immediate harm to the patient or others.

Training

2) Approved physical restraint techniques should not include the putting of any pressure at all on the trunk of the patient's body; that is the taking of a patient to the floor in a prone position, or the pressing of his or her abdomen from above, while a patient is on the floor.[111]

3) All staff members who could potentially be involved in restraining a patient, including clinical staff, security staff and patient services assistants, should be trained insofar as is practicable together, by Hospital contracted personnel (in approved restraint techniques).

4) All such staff training to include specific direction concerning the dangers of positional asphyxia during physical restraint, how to recognise the condition and what to do if a patient appears to be succumbing to the condition, or to any related condition or syndrome.

Management

5) Aggression management in an inpatient unit is a clinical issue, and as such, a senior clinical staff member should always lead any physical restraint.

6) While a patient is being physically restrained, a clinical staff member must be and remain present to manage the staff engaged in the restraint, while also monitoring the patient's breathing and general well being, this for the duration of the physical restraint.

7) As per principle 2 above, an approved physical restraint should not involve the taking of the patient to the floor, unless such a course is unavoidable. In the event that it is

[111] Instead, techniques should focus on the securing of the limbs and head of the patient, both because such an approach reduces the possibility of restraint asphyxia and because these are parts of the body, which can moved in a manner which may inflict injury upon staff, so involved.

determined prior to the restraint, that a patient must be taken to the floor, or where a patient is unintentionally forced to the floor during restraint, this should only be permitted to continue for the minimum amount of time required to achieve restraint, and concurrently, only while the patient's respiratory condition remains uncompromised. Determination of these matters, both before and during restraint, is the exclusive responsibility and is to remain at all times under the control and direction of the senior clinician present.

Recommendation 2

Following a review of all relevant practise and having regard to existing contractual obligations, a practise guideline should also issue from the Office of the Chief Psychiatrist, which guideline should broadly direct the adoption of a single manner of physical restraint guideline, for the consideration of respective hospitals and their training managers.[112]

Of those now in place at Dandenong and Frankston Hospitals and those additionally reviewed below in Attachment 1, it appears to this Coroner that the MOVAIT Techniques Manual, deserves particular consideration.

CONCLUSION

I wish to thank the Coroners Assistant, Senior Sergeant Brumby, and appearing Counsel and instructing solicitors, together with all witnesses and those who made written submissions, for their assistance in the conduct of this joint inquest. Finally, I wish to place on record my appreciation of the particularly open and forthright manner in which Dandenong Hospital and its agents assisted my inquiry into the circumstances of the death of Adam White.

[112] The security issues, which arise at atypical intuitions such as for instance the Thomas Embling Hospital, require a separate consideration, which is beyond the jurisdiction of this inquest.

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

The Family of Justin Fraser

The Family of Adam White

The Victorian Minister for Health.

The Secretary, Victorian Department of Health.

The Chief Executive Dandenong Hospital

The Chief Executive Frankston Hospital

WorkSafe.

The Australian Nursing Federation.

The Health and Community Services Union.

Executive Director, Mental Health, Drugs and Regions Division, Victorian Department of Health.

The Royal Australian and New Zealand College of Psychiatrists.

The College of Mental Health Nurses.

The Chief Executive of Wilson Security, the provider of security services at Frankston Hospital.

Psychiatric Nurse, Mary Hendrey

Nurse Fady Sourial

Security Officer Trevor Murphy

Security Hendrick Botha

Dr Katherine White

Professor Johan Deflau

Dr Linda Iles

Nurse Elena Margineanu

ANUM, Nurse Betty George

Security Officer Duncan Jones

Security Officer Dean Tucker

Hospital Nursing Coordinator Registered Nurse Jenny Blanch

Tessa Maguire, Victorian Institute of Forensic Mental Health (Forensicare)

Lina Wilson, St Vincent's Hospital

Mark Parigi, Barwon Health

The Manager, Coroners Prevention Unit (Attention Mary Hyland and Jeremy Dwyer).

Signature:

PETER WHITE
CORONER
Date: 13 March 2013

ATTACHMENT A

Background

The Coroners Prevention Unit (CPU) prepared this report at the request of Coroner Peter White to provide assistance for his investigation into the deaths of Mr Adam White and Mr Justin Fraser, two inpatients in Victorian psychiatric units who died at or about the time they were being physically restrained by health services staff.

Coroner White requested that the CPU review the guidelines for physical restraint of adult psychiatric inpatients that are used in three health services: (1) Barwon Health, (2) Forensicare, and (3) St Vincent's Mental Health.

1 Barwon Health guidelines

Barwon Health's aggression management program is called Management of Violence and Aggression International Training (MOVAIT). The MOVAIT program was originally developed in England and is used by Barwon Health under licence. Neil Tonkin, the Occupational Health and Safety Manager at Barwon Health, provided the CPU with four MOVAIT documents that address aggression management and physical restraint guidelines at Barwon Health:

- *MOVAIT Level Two Three-Day Course Information*, dated 2011.
- *Restraint Techniques in MOVAIT*, dated 25 October 2010.
- *MOVAIT Techniques Manual*, dated 2007.
- *MOVAIT Course Package*, which is undated.

The *Restraint Techniques in MOVAIT* document explains the rationale behind the restraint techniques taught at Barwon Health and how they protect client and staff wellbeing. Particular issues identified that inform the restraint techniques include:

- Touching or restricting the torso of the person being restrained must be avoided. Reasons include that (a) the client's respiratory capacity may be unknown, (b) any weight or restriction placed on the torso may result in respiratory distress, and (c) the torso area cannot be 'used' by the client to inflict injury to self or others.

- Restraint techniques instead focus on securing the limbs and the head of the client, because these are the parts of the body that can inflict injury.

The *MOVAIT Level Two Three-Day Course Information* outlines the topics and themes taught in the course. One of the themes is Restraint Techniques and Teamwork (see p.7), which is described as follows:

> The restraint techniques are designed to assist the participant to control and immobilise the attacker.
>
> The management of the aggressor's limbs involves, using the natural joint movement, which minimises the risk of injury and preserves the dignity of all involved.
>
> The unit offers opportunities to develop manoeuvring skills, supportive holds, escorting techniques, negotiating obstacles, entering and exiting rooms, interchanging team members, building team awareness, and co-ordination. These techniques have a strong focus on the safety of the client ensuring optimal care in regards to positional asphyxia, maintenance of airway, also head and neck management.

The *MOVAIT Techniques Manual* covers in dot point form the various authorised techniques for responding to aggression and violence that might be taught to Barwon Health staff. Of particular interest are the techniques numbered 41 and onwards under the title "Restraint and Escort Techniques" (pages 10-17). These techniques, which are designed to protect the safety of both patient and staff, have a number of commonalities:

- Three staff are required to apply the restraint techniques.
- Monitoring the patient is a key requirement at all times, with in most cases a staff member dedicated to this task.
- Restraint is applied to limbs, never the torso.
- In dealing with violent behaviour the staff should take the patient to his or her knees, not to the ground.

The *MOVAIT Course Package* outlines the principles taught to Barwon Health staff on how to respond to aggression and violence. It does not contain material directly addressing physical restraint guidelines.

2 Forensicare Guidelines

Ms Tessa Ginders, M4 Coordinator at the Victorian Institute of Forensic Mental Health (Forensicare), provided to the CPU the *M4 Participant Manual* currently used at Thomas Embling Hospital. M4 is the name of the Thomas Embling Hospital's aggression management training program.[113] The manual is undated but includes reference to training schedules for 2010.

The relevant section of the manual for the purposes of this review is titled "Passive Holds and Restraint Techniques", and spans pages 19-27. The principles set out in this section include:

- All restraint techniques require a four-person team.
- In any situation requiring aggression management, there is a single person designated the 'head person' who manages the situation. The head person is the only team member who should talk. The head person is responsible for ensuring the patient is safely restrained and the patient's airway is safe. (p.21)
- When an aggressive person is restrained, the person must be taken to the floor in a controlled manner with the head protected. The head person monitors patient wellbeing at all times while other team members secure the arms and legs using techniques outlined in the manual. (pp.21-22)
- None of the restraint techniques described in the manual involve putting pressure on the patient's trunk.

3. St Vincent's Mental Health Guidelines

Clinical Nurse Educator Ms Lina Wilson provided to the CPU the *Therapeutic Response to Aggression Management* document used by St Vincent's Mental Health. The document is dated 2008.

The relevant section of the manual for the purposes of this review is titled "Module 7 - Personal Safety and Compassionate Control", and spans pages 59-60. In this section it is stated that staff are taught team restraint techniques including a "two person take down" and "ground restraint and control". In an accompanying email, Lina Wilson explained that the training has been updated to

[113] M4 stands for "Management of the patient, and Management of the environment, and Management of the team, for the Management of aggression".

address "five person take down", "physical monitoring of patient whilst restrained" and "ground restraint and control including leg restraint".

There is a detailed discussion in the section about awareness of positional asphyxia, which covers the following points:

- To comply with St Vincent's duty of care, all staff must have an understanding of positional asphyxia and how to avoid the risk of positional asphyxia when physically restraining a patient. (p.59)

- Positional asphyxia is where a person is placed in a position such that his or her ability to breathe (both inhalation and exhalation) is compromised. The general cause is pressure on the ribcage from the chest or back, or upward pressure on the diaphragm that prevents adequate lung expansion. (p.60)

- Scenarios that might cause positional asphyxia include applying pressure to a standing person's chest and back simultaneously, applying pressure to the upper section of a lying person's torso (such as lying or kneeling on the back or chest), and placing an overweight person on the ground where the pressure of body weight can compromise breathing. (p.60)

In concluding this section, readers are reminded that "physical restraint of persons, especially those resisting, should be undertaken only when absolutely necessary, and then only with extreme care" (p.60).

The *Therapeutic Response to Aggression Management* document does not describe the physical restraint techniques themselves, which are taught to St Vincent's Mental Health staff by the training providers International Security Training Academy (ISTA). With Lina Wilson's permission, the CPU contacted ISTA Managing Director Tim Sell and obtained the *Code Grey Training TRAM Emergency Response* document (which is undated) that is currently used to train St Vincent's Mental Health staff in restraint techniques for inpatients.

*The *Code Grey Training TRAM Emergency Response* document contains a wealth of material on safe patient restraint. The following material is particularly relevant:

- Avoiding positional asphyxia is part of the duty of care of a security officer. Those at heightened risk of positional asphyxia include overweight people, intoxicated people and people with medical problems (p.18). To prevent positional asphyxia when a patient is on the

ground, an officer should never keep the patient in this position for a prolonged period, nor apply pressure to the back or head. Instead, the officer should keep the back and head free of physical pressure, continue to maintain communication with the patient, monitor the patient's vital signs, and roll the patient into the recovery (coma) position if there are any failures in vital signs (p.18).

- In responding to patient aggression or other potentially challenging patient behaviour, a number of stages must be followed before using force. For example, the security guard should greet the patient, ask about his or her concerns, request the patient to follow instructions, and explain the consequences of non-compliance (p.19). "The escalation of physical force should only come after you have exhausted all verbal and negotiation options" (p.27).

- The non-compliant patient can be asked to kneel (p.33). The prone position should only be used for totally non-compliant patients. A variety of techniques are described that involve wrist locks rather than pressure (p.34), or immobilisation of arms and legs (p.42).

- All self-defence and restraint techniques described in the *Code Grey Training TRAM Emergency Response* document involve controlling limbs.