FORM 37

Rule 60(1)

FINDING INTO DEATH WITH INQUEST

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

Court reference: 4746/05

Inquest into the Death of ANGELO LOMBARDO

Place of death:	Werribee Mercy Hospital
Hearing Dates:	25-26 August 2008 & 27-28 October 2008
Representation:	Mr John Dickie, VGSO - Assisting the Coroner
	Mrs Maryanne Hartley of Counsel - on behalf of Werribee Mercy Hospital
	Mr John Constable of Counsel - on behalf of Dr Greg Kuriata
	Mr Bruce McTaggart of Counsel - on behalf of Dr Duncan Syme
Findings of:	AUDREY JAMIESON, Coroner
Delivered On:	7 June 2011
Delivered At:	Melbourne

FORM 37

Rule 60(1)

FINDING INTO DEATH WITH INQUEST[1]

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

Court reference: 4746/05

In the Coroners Court of Victoria at Melbourne

I, AUDREY JAMIESON, Coroner

having investigated the death of:

Details of deceased:

Surname: LOMBARDO
First name: ANGELO
Address: 5 Rankin Street, Altona, Victoria, 3018

AND having held an Inquest in relation to this death

on 25-26 August 2008 and 27-28 October 2008

at Coronial Services Centre, Southbank

find that the identity of the deceased was ANGELO LOMBARDO

and death occurred on 29 December 2005

at Werribee Mercy Hospital, Princes Highway, Werribee, Victoria 3030

from:

1a. CORONARY ARTERY ATHEROSCLEROSIS

in the following summary of circumstances:

Mr Angelo Lombardo was an involuntary psychiatric patient subject to a Community Treatment Order (CTO). On 29 December 2005, he was detained by Police under section 10 *Mental Health Act* 1986 and transported to the Emergency Department (ED) of Werribee Mercy Hospital. His CTO was revoked by the hospital and he was awaiting involuntary psychiatric inpatient admission. At the time of his death, Mr Lombardo had been in the Emergency Department for approximately 14 hours.

[1]The Finding does not purport to refer to all aspects of the evidence obtained in the course of the Investigation. The material relied upon included statements and documents tendered in evidence together with the Transcript of Proceedings and submissions of legal representatives/Counsel. The absence of reference to any particular aspect of the evidence, either obtained through a witness or tendered in evidence does not infer that it has not been considered.

Mr Lombardo's death was *reportable*[2] under the *Coroners Act* 1985 (the old Act).

Immediately before death, Mr Lombardo was a *person held in care*[3] as it is defined in the old Act.

An Inquest was held in accordance with section 17(1)[4] of the old Act.

JURISDICTION

At the time of Mr Lombardo's death, the *Coroners Act* 1985 (the old Act) applied. From 1 November 2009, the *Coroners Act* 2008 (the new Act) has applied to the finalisation of investigations into deaths which occurred prior to the new Act commencement.[5]

In the Preamble to the new Act the role of the coronial system in Victoria is stated to involve the independent investigation of deaths for the purpose of finding the causes of those deaths and to contribute to the reduction of the number of preventable deaths and the promotion of public health and safety and the administration of justice. Reference to preventable deaths and public health and safety are referred to in other sections of the new Act.

Section 67 of the new Act describes the ambit of the coroner's findings in relation to a death investigation. A coroner is required to find, if possible, the identity of the deceased, the cause of death and the circumstances in which the death occurred.[6] The 'cause of death' generally relates to the *medical cause of death* and the 'circumstances' relates to the *context* in which the death occurred.

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[2] "reportable death" means a death-
(a) where the body is in Victoria; or
(b) that occurred in Victoria; or
(c) the cause of which occurred in Victoria; or
(d) of a person who ordinarily resided in Victoria at the time of death-
being a death-
(e) that appears to have been **unexpected,** unnatural or violent or to have resulted, directly or indirectly, from accident or injury; or....
(i) **of a person who immediately before death was a person held in care**; or....

[3] "person held in care" means-
(a) a person under the control, care or custody of the Secretary to the Department of Human Services; or
(ab) a person-
(i) in the legal custody of the Secretary to the Department of Justice or the Chief Commissioner of Police; or
(ii) in the custody of a member of the police force; or
(iii) in the custody of a protective services officer appointed under the Police Regulation Act 1958; or
(b) a patient in an assessment or treatment centre under the Alcoholics and Drug-dependent Persons Act 1968; or
(c) a patient in an approved mental health service within the meaning of the Mental Health Act 1986;

[4] Section 17(1) A coroner who has jurisdiction to investigate a death **must** hold an inquest if the body is in Victoria or it appears to the coroner that the death, or the cause of death, occurred in Victoria and -
(a) the coroner suspects homicide; or
(b) the deceased was immediately before death a person held in care; or.....

[5] Section 119 and Schedule 1 - *Coroners Act* 2008

[6] Section 67(1) - *Coroners Act* 2008

A coroner may also comment on any matter connected with the death, including matters relating to public health and safety or the administration of justice.[7]

A coroner may also report to the Attorney General and may make recommendations to any Minister, public statutory authority or entity on any matter connected with a death which the coroner has investigated, including recommendations relating to public health and safety or the administration of justice.[8]

BACKGROUND CIRCUMSTANCES

Mr Angelo Lombardo was born on 16 May 1959. He was 45 years old at the time of his death. He lived at 5 Rankin Street, Altona with his parents, Santina and Rocco Lombardo and brother, Lorence Lombardo. His other brother, Dominic also lived at the Altona home from time to time. Angelo was a panel beater by trade but was unemployed at the time of his death and in receipt of a pension.

Mr Lombardo was diagnosed with schizophrenia in 1980's. He also had a history of violence and illicit drug use. He was Hepatitis C positive and had Type II diabetes, treated with oral hypoglycaemic medication but was poorly controlled. He had hypercholestraemia and a dependancy to cannabis.

Mr Lombardo was referred to Saltwater Clinic, Footscray in 1989. The clinic is a service of the Werribee Mercy Mental Health Program. He was also admitted to the Psychiatric Unit at Werribee Mercy Hospital in June 1999, December 2000, October 2002 and May 2005, during which he had spent periods of time in seclusion or the high dependency unit. Each admission was facilitated by the Police and necessitated the use of physical and chemical restraint.[9] Mr Lombardo had a history of violence and aggression towards staff resulting in a warning flag being placed on the Hospital's Client Management Interface (CMI) computer system.

Mr Lombardo was subject to a CTO under the supervision of Werribee Mercy Hospital at Saltwater Clinic. His case manager was Registered Psychiatric Nurse (RPN) Mark Mott. His medication included Modecate (fluphenazine) 62.5 mg intra-muscularly every 2 weeks and Seroquel (quetiapine) 300 mg twice daily.

SURROUNDING CIRCUMSTANCES

On 28 December 2005, RPN Mott visited Mr Lombardo at home to administer his depot medication, Modecate. Mr Lombardo admitted to hearing voices from the television, however Mr Mott stated that:

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[7] Section 67(3)

[8] Section 72 (1) & (2)

[9] Transcript of Proceedings @ p. 344 (Dr Matthew McArdle)

"Mr Lombardo was managing his mental illness within the community setting and had contingency plans to contact Triage, Case Manager or Crisis and Assessment Team if he was not coping. Mr Lombardo's family were aware of the required action if Mr Lombardo deteriorated."[10]

In the early hours of 29 December 2008, Mr Dominic Lombardo telephoned Werribee Mercy Crisis Assessment and Treatment Team (CAT Team) requesting attendance due to Angelo's behaviour. He spoke to Registered Nurse (RN) Deborah Brunning, psychiatric triage clinician. The CAT Team refused to attend in the absence of Police. Dominic rang the Police, requesting their attendance at the Rankin Street home. Dominic expressed concerns that Angelo was either going to hurt himself or hurt another member of the family.[11]

Acting Sergeant Cameron Scott, Senior Constable Barry Thorpe and Constable Jacinta Jenkins attended the Rankin Street home in response to the request. They were aware of Angelo Lombardo's past history of violence with Police and that there had been a previous occasion where Police had deployed oleoresin capsicum (O/C) spray to enable restraint. On arrival, at approximately 0340 hours the Police officers found Mr Lombardo to be extremely agitated and yelling abuse and threats. He failed to respond to the commands of Police and when attempts were made to handcuff him, he broke free, raising his fists in a threatening manner. Police deployed O/C foam with the desired effect resulting in the handcuffing and containment of Mr Lombardo. He was removed to the front lawn of the house and provided with aftercare.[12] Police detained Mr Lombardo under section 10 *Mental Health Act* 1986[13] and conveyed him to Werribee Mercy Hospital.

At approximately 0400 hours, Mr Lombardo was brought into the Ambulance bay of the Emergency Department (ED) of Werribee Mercy Hospital in the custody of the 3 Police Officers. He was still handcuffed. In the Ambulance bay, Mr Lombardo and the Police Officers were met by Dr Duncan Syme and RN Brunning. A Hospital Security Guard was also present. Dr Syme was on night duty in the ED. RN Brunning, was also on duty and had already provided Dr Syme with some background about Mr Lombardo's psychiatric history - information she obtained from the Hospital's Client Management Interface (CMI)/data base. RN Brunning was also aware that Mr Lombardo had a reputation for violence. Mr Lombardo was assessed as a high risk patient.

Mr Lombardo was placed on an emergency trolley, had his handcuffs removed and was immediately shackled to the trolley. He was told he was going to be sedated prior to being administered Clonazepam 6 mg (a sedative) and Olanzapine 20 mg (an antipsychotic) intramuscularly. The Police Officers departed the Hospital soon after.

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[10] Statement of Mark Mott - Exhibit 2

[11] Transcript of proceedings @ p. 55 (L/S/C Scott)

[12] The circumstances of the Police attendance were recorded in a Use of Force Form and an Incident Fact Sheet on 29/112/05 - Exhibit 4

[13] s.10 **Apprehension of mentally ill persons in certain circumstances**

(1) A member of the police force may apprehend a person who appears to be mentally ill if the member of the police force has reasonable grounds for believing that-

(a) the person has recently attempted suicide or attempted to cause serious bodily harm to herself or himself or to some other person; or

(b)the person is likely by act or neglect to attempt suicide or to cause serious bodily harm to herself or himself or to some other person.

At approximately 0420 hours Mr Lombardo was admitted to the ED because there was no bed available in the Psychiatric Unit. He was placed in Cubicle 9.

At 0510 hours Mr Lombardo's oxygen saturation was noted to have dropped 84%. On examination by Dr Syme, he was noted to be snoring heavily, had a brief episode of coughing and had a marked stridor. His Glasgow Coma Scale (GCS)[14] was 9/15. He was placed in the coma position and transferred to the resuscitation cubicle, which is in close proximity to the central nurse/doctor station. A guedels airway and intravenous cannula were inserted. He was administered 500mcg of Flumazenil[15] which temporarily improved his conscious state and breathing. A Flumazenil infusion was commenced resulting in an improvement in his conscious state - he spat out the guedels airway and was responding appropriately to questions. His oxygen saturation remained between 92% - 98%. The stridor disappeared although he continued to snore loudly when asleep.

At 0600 hours Dr Gregory Kuriata came on duty in the ED. His first contact with Mr Lombardo was at approximately 0800 hours after receiving a handover from Dr Syme. At or about the same time, Mr Lombardo was requesting to have a smoke and go to the toilet. Dr Kuriata was unable to perform a physical examination at that time or subsequently as Mr Lombardo was not co-operative. Each time Dr Kuriata tried to make contact with Mr Lombardo verbal and physical aggression was directed at him. From a distance, Dr Kuriata was able to assess Mr Lombardo's conscious state as he was speaking albeit in a slurred and threatening tone, and Dr Kuriata was able to visualise monitor recordings of pulse rate and oxygen saturation rates. Dr Kuriata reduced the dosage of Flumanzenil during the morning, ceasing the infusion at 1010 hours. It was recommenced at 1030 hours when Mr Lombardo was noted to be drowsy with reduced oxygen saturation.

At 1130 hours Mr Lombardo was noted to be tolerating sandwiches and orange juice. Around this time, Mr Lombardo had a telephone conversation with his mother and was moved from the resuscitation cubicle to cubicle 6. Flumazenil was ceased at 1200 hours. Throughout this time regular observations of Mr Lombardo were recorded. A number of enquiries about the availability of a psychiatrist/psychiatric registrar to perform an assessment of Mr Lombardo were made by RN Leonie Webb and Dr Kuriata.

At approximately 12:30pm, Mr Lombardo's oxygen saturation was noted to be 67% when asleep. Dr Kuriata directed the delivery of oxygen via a mask. Mr Lombardo awoke and was physically aggressive towards Registered Nurse (RN) Steven Webb who was attempting to place an oxygen mask on him.

At approximately 1300 hours the Psychiatric Registrar attended the ED but considered Mr Lombardo too drowsy to be interviewed. He noted that he would review him the following day. The plan was to transfer Mr Lombardo to the Psychiatric Unit when a bed became available.

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[14] Glasgow Coma Scale is a standarised system for assessing response to stimuli in a neurologically impaired patient; reactions are given a numerical value in three categories (eye opening, verbal responsiveness, and motor responsiveness), and the three scores are then added together. The lowest values are the worst clinical scores. (Source: *Dorland's Illustrated Medical Dictionary*, 30th Edition)

[15] Flumazenil is a benzodiazepine antagonist. Flumazenil is of benefit in patients who become excessively drowsy after benzodiazepines are used for either diagnostic or therapeutic procedures.

Throughout the day, Mr Lombardo intermittently slept with associated loud snoring and a drop in oxygen saturations. When awake, his oxygen saturation was normal. Mr Lombardo also got up to the toilet on 3-4 occasions - the last being at approximately 1600 hours when he jumped off the trolley requesting to go to the toilet. He was assisted by Clinical Nurse Specialist, Lucy Ng who observed Mr Lombardo to be *unsteady on his feet* and *quite agitated.* She then assisted him back to the trolley wherein he *almost immediately was asleep and began snoring loudly with sleep apnoea.*[16]

At some time during the day communication with Saltwater Clinic had occurred. Mr Mott personally received the notification of Mr Lombardo's admission to the ED at approximately 1700 hours on 29 December 2005, through a *duty reference.* He contacted the family to obtain additional information about the circumstances. It was his intention to visit Mr Lombardo on the following day.

At 1700 hours Mr Lombardo was seen to be sleeping in the left lateral position. He was snoring. At 1725 hours Mr Lombardo was located in the right lateral position by RN Trevor Weston. He was unresponsive, had no respirations or cardiac output. Cardio-pulmonary resuscitation (CPR) was commenced and he was transferred to Resuscitation Cubicle 2. Despite aggressive resuscitation attempts Mr Lombardo was not able to be revived.

At approximately 1745 hours Mr Lombardo was declared deceased.

INVESTIGATION

The identity of Mr Angelo Lombardo and the date and place of his death, were without dispute and required no additional formal coronial investigation.

The medical investigation

Dr Michael Burke, Forensic Pathologist at the Victorian Institute of Forensic Medicine, performed an autopsy. The post mortem examination revealed significant natural disease in the form of coronary atherosclerosis. Dr Burke commented:

> *Microscopic examination of coronary vessels showed foci of 75 to 80% stenosis by atheromatous plaque. This degree of heart disease is consistent with causing sudden death as result of a cardiac arrhythmia (heart attack). Risk factors for coronary artery atherosclerosis include smoking, hypertension, diabetes mellitus, hypercholesterolaemia and familial factors.*[17]

No evidence of injury was identified that could have led to or contributed to death.

Toxicological analysis showed the presence of olanzapine at ~0.1 mg/L and 7-aminoclonazepam at ~0.05 mg/L.

Dr Burke attributed the cause of death to coronary artery atherosclerosis.

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[16] Statement of Lucy Ng, Clinical Nurse Specialist at Werribee Mercy - Inquest Brief

[17] Exhibit 19

The Police Investigation

The Inquest Brief was prepared by Acting Sergeant Brian Innes.

Clinical Liaison Service Investigation

The Clinical Liaison Service (CLS)[18] was requested to assist the Coroner in reviewing the medical management of Mr Lombardo in the Emergency Department of Werribee Mercy Hospital.

The investigation identified a number of issues which warranted further exploration in the public arena. These issues included:

- the treatment of Mr Lombardo by arresting Police
- procedures in place for dealing with psychiatric admissions at Werribee Mercy
- the relationship between the ED and the Psychiatric Unit
- the use of sedation and the level of monitoring of the sedated patient
- contributing factors to the cardiac event including whether patients on long term psychiatric medication should have cardiac investigations

The Inquest

Viva voce evidence was obtained from the following witnesses:

- Dominic LOMBARDO - brother of Angelo
- RPN Mark MOTT - Case Manager at Werribee Mercy and Saltwater Clinic
- Leading Senior Constable Cameron SCOTT- attended Mr Lombardo's home
- Dr Duncan SYME - on duty at Werribee Mercy
- Ms Frances DIVER, Director, Access and Metropolitan Performance, DHS
- Dr Greg KURIATA - 2nd shift doctor briefed by Dr Syme.
- RN Leonie WEBB - 2nd shift nurse.
- Dr Melanie PHILLIPS (nee SMITH) - 2nd shift - present during resuscitation.
- Dr Simon JUDKINS - provided Expert Opinion
- Dr Matthew McARDLE - Psychiatric Registrar at Saltwater Clinic.
- RN Steven WEBB - 2nd shift nurse.
- Dr Michael BURKE - Forensic Pathologist
- RN Trevor WESTON - 2nd shift nurse - found Mr Lombardo deceased.
- Dr Dean STEVENSON - Director of Clinical Services Mercy Mental Health
- RN Deborah BRUNNING - CAT Team Triage nurse, Werribee Mercy Hospital

[18] The role of the CLS was to assist the Coroner's investigation into the nature and extent of deaths which occurred during the provision of healthcare, and identify potential system factors in healthcare related deaths. CLS personnel comprised of practising Physicians and Clinical Research Nurses who drew on their medical, nursing and research experiences, skills and knowledge to independantly evaluate clinical evidence for the investigation of reportable healthcare deaths and to assist in identifying remediable factors that may have assisted in prevention and risk management in health services settings. (In 2010 CLS was replaced with the Health and Medical Investigation Team, a division of the Coroners Prevention Unit (CPU)).

FINDINGS, COMMENTS & RECOMMENDATIONS

Police involvement and the absence of a Crisis and Assessment Treatment Team (CATT)

Dr Dean Stevenson, Director of Clinical Services of Mercy Mental Health, had personal experience of Mr Lombardo's capacity for irritability and aggressive stance towards the mental health team. He stated that Mr Lombardo had been flagged as a patient at high risk of violence towards staff and that there had been some instances of aggression towards the CAT Team.[19] Dr Stevenson stated that it was his recollection that *the CAT team certainly did not go out and visit him at home because of the risk posed to clinicians.*[20]

The attendance of Police at the Rankin Street home was at the request of Dominic Lombardo for assistance. Dominic was concerned that Angelo was at risk to himself and to others. Angelo's behaviour was aggressive. Acting Sergeant Cameron Scott did not consider it prudent to contact the CAT Team on this occasion. When he arrived at the Rankin Street home and was led into the house he considered that Angelo's behaviour was such that immediate intervention was required - that there was no time to disengage for the purposes of contacting the CATT.[21]

I am satisfied that the precarious and volatile situation at the Rankin Street home was not one that the CAT Team could have contributed to resolving.

I find that the situation as presented to the Police was appropriately one for immediate Police management and not one that lent itself to delay or disengagement with Mr Lombardo while waiting for the CATT to arrive.

The use of capsicum foam by Police

Police have a range of aids available to them for the purposes of restraining or controlling behaviour. The utilisation of any of these aids will depend upon the assessment of the seriousness of the situation by attending officers. Handcuffs and capsicum foam were deemed appropriate to the situation presenting itself to the Police in the early hours of 29 December 2005. When Mr Lombardo resisted attempts by Acting Sergeant Scott to place him in handcuffs, capsicum foam was dispersed. Due to apparent resistance to the foam, it was dispersed a second time before Mr Lombardo was sufficiently subdued so that Police could confine and control him. Appropriate after care was provided and he did not demonstrate any acute adverse effects from the foam.

[19] Transcript of Proceedings @ p. 438 (Dr Dean Stevenson)

[20] ibid

[21] Transcript of Proceedings @ p.69 (L/S/C Scott - was an Acting Sergeant at the time)

I find that the use of capsicum foam to subdue Mr Lombardo was use of appropriate force in the circumstances and consistent with the powers of detention anticipated by section 10(2) *Mental Health Act* 1986.[22]

Mr Lombardo did not demonstrate any ongoing effects from the spray. Dr Simon Judkins, Emergency Physician and Deputy Director Emergency Department at Austin Health, stated *most of the effects of capsicum spray or foam will occur acutely*[23] and that he was unaware of any evidence of effects after such a prolonged period of time as being queried in Mr Lombardo's case.

And I further **find** that there is no evidence of a causal link between the use of capsicum foam and the cause of Mr Lombardo's death.

I find no causal link between the involvement of Police including the use of capsicum spray as a means of restraint, and Mr Lombardo's cause of death.

The use of medical restraint in the Emergency Department

There were inconsistent accounts about Mr Lombardo's demeanour at the time Police presented him at the ED at Werribee Mercy Hospital. On a background of Mr Lombardo's earlier violent and aggressive behaviour towards Police at his home, his demeanour on presentation at the hospital appeared almost *meek and mild, like a church mouse* - according to Leading Senior Constable (L/S/C)[24] Scott.[25] Nurse Brunning on the other hand, stated that Mr Lombardo was exhibiting signs of agitation, had a course tremor in his arm and was demonstrating hypervigilance to his surroundings.[26] She was also aware of Mr Lombardo's reputation for aggression. His "potential for violence" was flagged on the hospital's Client Management Interface (CMI) computer system.[27]

I accept that the Hospital staff had sufficient grounds to respond to the background circumstances for Mr Lombardo's presentment. The circumstances in which Mr Lombardo was detained under s.10 *Mental Health Act* and the flagged characteristics were sufficient grounds to treat Mr Lombardo as a high risk patient at the outset and provide him with sedation pending a psychiatric assessment. Providing the sedation in the Ambulance bay was deemed necessary at the time and although this is not a common practice, it may occur from time to time *if somebody does have a huge potential for creating a violent or disruption in the emergency department.*[28]

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[22] Section 10(2) For the purpose of apprehending a person under subsection (1) a member of the police force may with such assistance as is required-

(a) enter any premises; and

(b) use such force as may be reasonably necessary.

[23] Transcript of Proceedings @ p.340 (Dr Simon Judkins)

[24] rank at the time of giving evidence

[25] Transcript of Proceedings @ p.65 (Leading Senior Constable Cameron Scott)

[26] Transcript of Proceedings @ 377 (RN Deborah Brunning)

[27] Transcript of Proceedings @ pp 366-368 (RN Deborah Brunning)

[28] Transcript of Proceedings @ p. 373 (RN Deborah Brunning)

I accept that the decision to sedate Mr Lombardo on his arrival in the Ambulance bay was a considered clinical decision at the time.

The type of sedation used and the monitoring of its effects

I find that the use of sedation and an antipsychotic medication was appropriate in the circumstances.[29] However, the combinations of medications and the doses given to Mr Lombardo were not appropriate - they were very high doses.[30]

The rationale for the combination and dosage of Clonzepam and Olanzapine was not based on any Rapid Sedation Guidelines or advice from the Psychiatric Unit. Risk Management documents from the hospital also appear to have played little part in the overall management of Mr Lombardo or in particular, to the sedation given to him in the Ambulance bay. Similarly, the prescribing guidelines for either drug were not used[31] and the overall knowledge of the half life and the cyclical effects of clonzepam was little understood by Dr Syme and other medical staff in the ED.

Dr Syme stated that part of the rationale for giving this dose was the small number of staff on in the ED, the length of time before additional staff would come on duty and the availability of only one security guard for the whole of the hospital.[32] Dr Judkins was critical of the approach taken by Dr Syme. He stated that when looking after a patient who is agitated and needs emergent sedation it is his practice to:

> *...obtain IV access and administer a bolus of Midazolam 5 mg and then titrate to effect. I would subsequently introduce Olanzapine once I had control of the situation, but start with a low dose of 5 mg IM or oral. If I was unable to obtain IV access, I would use similar doses, but administer IM.*[33]

Dr Judkins was also critical of the subsequent approach taken to manage Mr Lombardo after he displayed signs of respiratory depression and hypoxia. Dr Judkins' criticism was not directed at the time taken to recognise and respond to the change in Mr Lombardo's condition but to the administration of Flumazenil which he stated was *fraught with danger* and *problematic* when used on psychiatric patients who may have been taking other medications such as benzodiazepines which are antagonised by Flumazenil and can lead to the development of seizures. Dr Judkins would have instead implemented more definitive airway control in response to Mr Lombardo's changed respiratory state and transferred him to an Intensive Care Unit (ICU) but he did however acknowledge that Flumazenil appears to have worked in Mr Lombardo's case and that his practice of managing patients on Flumazenil in a High Dependency Unit (HDU) or an ICU were not readily available options to the staff at Werribee Mercy Hospital. Although access to supportive resources is different between the Austin and Werribee Mercy hospitals, Dr Judkins commented that he would have expected

[29] Exhibit 13 - Dr Simon Judkins

[30] *ibid*

[31] Exhibit 13 - Dr Simon Judkins

[32] Exhibit 5 - Dr Duncan Syme

[33] Exhibit 13 - Dr Simon Judkins

his hospital to have managed Mr Lombardo in a number of different ways. He was critical of the lack of observations performed on Mr Lombardo, vital signs, oxygen saturation levels, ECG recordings or blood sugar levels.

In his *viva voce* evidence, Dr Judkins modified his criticism somewhat as he contemplated and had the benefit of considering the differences in resources between his own facility and that of Werribee Mercy Hospital. He conceded that he was *not envious of the circumstances they were in when they were making this decision.*[34]

Nevertheless, on any interpretation of the evidence, Mr Lombardo was over-sedated. **I find** that the combination of the administration of Clonazepam 6mg and Olanzapine 20mgs IM in the Ambulance bay was excessive or at best a "relatively high" dose[35] and not within a range of accepted clinical practice or within the prescribing guidelines.

Dr Syme ultimately bears the responsibility for the decision for the administration of these drugs. I acknowledge that the consequences of an adverse finding or adverse background comment may have grave consequences for the professional[36] however, the weight given to this particular adverse finding should not be interpreted in isolation but be measured against the totality of my findings in respect of Mr Lombardo's management at Werribee Mercy Hospital.

I also find that the medical management in response to Mr Lombardo's over sedation was reasonable and appropriate in the circumstances. Dr Syme had limited options to this emergent situation. **I find** that his decision to administer the Flumazenil infusion in response, the correct one in the circumstances.

And I **further find** that there is no evidence of a direct relationship between the over sedation of Mr Lombardo and the cause of his death. Dr Burke said there was no evidence the drugs contributed to Mr Lombardo's death. Professor Drummer was unable to say the drugs contributed to death and in his report to the Court, Dr Judkins stated that despite the identified shortcomings in the provision of health care management:

> *I can't say whether this would have changed the outcome in this case, as it could not be determined if any of the apparent differences in management would have prevented Mr Lombardo's death.*[37]

Security and the management of potentially violent patients in the ED

Dr Syme's rationale for the type and dose of sedation used included *the fact there was only one security officer on duty who had to cover the whole hospital.*[38]

The potential for violence within an ED is well known. Escalating behaviours occur with injury, pain and fear, in patients affected by drug and/or alcohol and in patients that are psychiatrically

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[34] Transcript of Proceedings @ p. 330 (Dr Simon Judkins)

[35] Expert Opinion Report - Professor Olaf Drummer dated 20 August 2008 @ p.3

[36] *Briginshaw v Briginshaw* (1938) 60 CLR 336

[37] *ibid*

[38] Exhibit 5 - Dr Duncan Syme

unwell. ED staff must manage violence and the potential for violence whilst attempting to deliver health care whilst maintaining safety for themselves and their other, and often many, patients. Access to, and the presence of, sufficient security staff to provide support to medical and nursing staff in the ED is essential for the delivery of reasonable and appropriate care. The lack of available support to provide security in the ED should not need to be a part of the rationale for adopting a particular course of action in the scheme of a patient's management. But this is what did occur in Mr Lombardo's case.

The overall management of Mr Lombardo in the ED was derived from an anticipation of violence in the knowledge of a lack of availability of a physical presence of security personnel and the lack of communication about when admission to the psychiatric unit would occur. Also missing at Werribee Mercy ED was the option or "luxury" of placing Mr Lombardo in a seclusion room. The options for effective management are immediately restricted which in turn invites a practice reliance on sedation only.

I find that the level of security provided by the Werribee Mercy Hospital were inadequate to assist ED staff with any potential violent patient. Dr Syme was right to be concerned for the health and safety of the staff and other patients by the arrival of Mr Lombardo. He was right, in the circumstances, to include this as part of his rationale for sedation *per se.*

I recommend that Werribee Mercy Hospital review all aspects of its security arrangements including the provision of adequate numbers of security personnel and seclusion rooms commensurate to the "better practice"[39] of Austin Health as referred to in Dr Judkins' evidence. Such a review should by necessity identify what impact, if any, improvements in security will have on resource allocation to other areas of the delivery of health services by the hospital.

I make further comment about the provision of adequate security later in the Finding.

Length of time in the Emergency Department

The length of time Mr Lombardo spent in the ED was less than satisfactory. His condition necessitated his involuntary admission which of itself should have prompted a timely assessment by a Psychiatrist or Psychiatric Registrar along with a timely transfer to the Psychiatric Unit for specialist treatment and monitoring of his mental ill health. An ED is not the appropriate place to effectively care for and manage a patient such as Mr Lombardo - a patient who had only hours earlier displayed acute symptoms and who was continuing to have outbursts of violence towards staff.

The length of time Mr Lombardo spent in the ED denied him the opportunity for appropriate psychiatric care and placed ED staff in an invidious position. They could not discharge him, transfer him, do anything to alter or improve his treatment and at times some staff members could not approach him due to outbursts of aggression. This was an unsatisfactory situation for Mr Lombardo and the ED staff.

I accept that Mr Lombardo would have been admitted directly to the psychiatric ward if a bed had been available.[40] The delay in attendance for assessment by the Psychiatric Registrar was unsatisfactory in the circumstances. Similarly the decision by the Psychiatric Registrar not to

[39] As per submisions of Mr Constable - Transcript of Proceedings @ p.571

[40] Transcript of Proceedings @ p. 372 (RN Deborah Brunning)

assess Mr Lombardo on the grounds that he was too sedated appears to have been hastily made given the number of times Mr Lombardo was also awake and up to toilet, eating and at one stage telephoning his mother. A greater degree of support and assistance could have been proffered to the ED by the Psychiatry Registrar and psychiatric services *per se*. The ED staff appear to have adopted a generally passive approach in waiting for the psychiatric assessment and availability of a bed although RN Leonie Webb and Dr Kuriata did make enquiries with the Psychiatric Registrar. Escalation of the ED's concerns of a delay to the after hours Psychiatrist or Consultant Psychiatrist could have occurred however there was little in the way of guidelines to assist the ED staff. The lack of any certainty about when the psychiatric assessment and transfer would occur compounded the overall lack of ability of the ED to manage Mr Lombardo.

However, there is no evidence to attribute a causal link between Mr Lombardo's cause of death and the excessive time he spent in the ED. The medical cause of death has been attributed to coronary artery atherosclerosis with the precipitating event likely to have been a cardiac arrhythmia. He had no known history of cardiac disease and made no complaints of chest pain or demonstrated other typical signs or symptoms in ED which may have prompted the performance of an ECG or other cardiac investigations.

Given the level of coronary artery disease identified by Dr Burke, a fatal arrhythmia could have occurred at anytime - at home or in the psychiatric ward if he had been admitted there, as he should have been. His opportunity for resuscitation would have been no greater in either of these locations and in all probability to the contrary as Emergency Departments in general, are better resourced for such an event.

Dr Stevenson adequately addressed changes at Werribee ED since Mr Lombardo's death although he stated that they did not necessarily arise from his death. There have been improvements to psychiatric services at the facility and improvement in the relationship between psychiatric services/the psychiatric ward and the ED and attempts have been made to reduce the need for psychiatric patients to be dealt with in the ED. The hospital have adopted Guidelines[41] which if in place at the time of Mr Lombardo's admission would have in all probability, significantly altered the way he was managed. Dr Stevenson indicated that the Guidelines are working satisfactorily which Counsel for the hospital, Ms Hartley, submitted assumes that they are guiding practice without constraining good practice by over prescribing the type of treatment that ought to be given in a particular circumstance.[42]

I accept that the changes implemented by the hospital are intended to improve patient care and I commend the hospital in this regard. Since the Inquest I understand that further work has been undertaken facilitated by DHS for the adoption of a consistent Statewide approach to Rapid Sedation Guidelines not dissimilar to the Guidelines for Management of Acute Behavioural Disturbance implemented by Werribee Mercy Mental Health. I support the adoption of a Statewide approach to the management of patients presenting with acute behavioural disturbance and **recommend** Werribee Mercy Mental Health review its current guidelines to ensure consistency with other Victorian mental health facilities.

[41] Guidelines for the Management of Acute Behavioural Disturbance - Werribee Mercy Mental Health Program (undated)

[42] Transcript of Proceedings @ p. 590

Absence of a previous diagnosis of cardiac disease

Mr Lombardo was not known to have cardiovascular disease. The family questioned why there had been a failure to diagnose and treat him for this condition given that he had been interacting with the medical profession for a period in excess of 20 years. In addition, Mr Lombardo had obvious risk factors. He was overweight and according to Dominic, ate a lot of fatty foods.[43] Other risk factors included diabetes, anxiety and he was also a smoker.[44] He had also been prescribed antipsychotic medications which are associated with an increased risk of sudden cardiac death in persons with cardiovascular disease.[45] Mr Lombardo never complained of any overt symptoms of cardiovascular disease such as chest pain, palpitations or shortness of breath. His mental health team were aware of his risk factors and wanted to have him undergo medical investigations but Mr Lombardo always refused to participate in any form of medical examination or investigation including an annual physical examination, blood tests and ECG - clinical tests which are expected to be performed on a client on antipsychotic medication and with multiple risk factors. In short, Mr Lombardo never engaged with his treaters and did not heed their advice.

Dr McArdle stated that the plan was to get Mr Lombardo on a better dose of oral antipsychotic so that he would engage with them and co-operate with investigations but at the time of Mr Lombardo's death, they were still a long way from achieving that.[46]

I accept that Mr Lombardo was at all times a patient/client that lacked incite into his own illness to such an extent that he refused to engage with, and take the advice of, his mental healthcare team. The opportunity to perform investigations against his consent could only ever have been contemplated during an involuntary admission to the Psychiatric Unit. In the absence of any symptoms it seems unlikely that any such investigations would have amounted to a full cardiac workup. In the event that a diagnosis of cardiovascular disease had been made it remains difficult to envisage what preventative precautions/treatment could have been imposed on him, given his history of non-compliance with his known medical conditions such as his diabetes and his mental ill health. Furthermore, a pre-existing diagnosis of cardiovascular disease would not of itself altered the manner in which he was managed in the ED on 29 December 2005, prevented the onset of a sudden adverse cardiac event or affected the response to it or the outcome.

Dr McArdle has highlighted the desirability of investigations to determine cardiovascular status in the patient/client on long term antipsychotic medication and with other identifiable risk factors, however, I make no adverse comment about the lack of a diagnosis of cardiovascular disease in this case.

I find that the lack of an antemortem diagnosis of cardiovascular disease is explicable in Mr Lombardo's circumstances.

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[43] Transcript of Proceedings @ p.23 (Dominic Lombardo)

[44] ibid @ pp23-25

[45] Statement of Professor Olaf Drummer dated 20/8/08

[46] Transcript of Proceedings @ p.350 (Dr Matthew McArdle)

Possible assault on Mr Lombardo in the ED

Mr Dominic Lombardo raised concern that his brother had been assaulted in the ED. The concern was based on his mother's observation of a white plastic sheet on his abdomen and the loosely formed perception of Dominic that his brother may have made remarks to staff that would prompt revenge.

There is no evidence to support this concern. There is no evidence that Mr Lombardo was "manhandled" or assaulted in any way by nursing, medical or security staff. Dr Burke found no evidence of an injury to the abdomen on external examination and no evidence of injury *per se* that could have contributed to or led to death.[47] The white plastic sheet or the like was in all probability, related to materials used in the resuscitation attempts.[48]

CONCLUDING COMMENTS & FINDINGS:

Mr Lombardo was a difficult and complex challenge to his treating team. According to Dr McArdle, Mr Lombardo was severely and chronically ill. He had the severest category of schizophrenia that does not respond well to medication.[49] He had a history of being verbally abusive and threatening to his family and hospital staff - violent behaviour which in part could be explained as anger towards his psychotic thoughts and experiences.[50] His non-compliance and continued substance abuse exacerbated his mental ill health and limited meaningful engagement with his treating team and with ED staff on his admission on 29 December 2005. Ultimately it is this background to which I have attached greater weight over and above some inconsistencies in respect to Mr Lombardo's history as a patient, his propensity for violence and his demeanour on his arrival at the ED. Furthermore, his actual behaviour after admission was at the very least, unpredictable and was at times volatile and this in turn, compromised the delivery of his health care.

In these particular circumstances, the death of Angelo Lombardo I am not however able to find that his compromised health care caused or contributed to his death. The manner of the delivery of his health care was less than acceptable in that there should have been other options open to the hospital staff, particularly in respect of sedation and admission to the psychiatric ward, however, the mechanism of his death, from coronary artery atherosclerosis, prevents me from finding that his death was preventable.

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[47] Exhibit 19 @ p.2 & p.7

[48] Transcript of Proceedings @ pp234-235 (Dr Melanie Phillips)

[49] Transcript of Proceedings @ p.344 (Dr Matthew McArdle)

[50] ibid @ pp345-346

Having regard to issues of public health and safety and the promotion of the same, I had intended to recommend a more general review of how hospitals, and in particular emergency departments, manage violent patients but I note the recent[51] announcement of a Parliamentary Enquiry into Violence and Security Arrangements in Victorian Hospitals with particular reference to emergency departments.[52] A desirable outcome of this enquiry would be an enhancement to the provision of public health and safety to patients and staff in Victorian hospitals and in respect of Werribee Mercy Hospital, compliment improvements already implemented.

The investigation into the death of Angelo Lombardo has highlighted how the absence of adequate security arrangements can create compromises to patient care and potentially jeopardise the safety of staff and other patients. Pending the outcome of the Parliamentary Enquiry it remains the responsibility of the hospital to ensure its medical and nursing staff can deliver care to their patients in a safe and secure environment.

In conclusion, I accept and adopt the medical cause of death as identified by Dr Michael Burke, Forensic Pathologist, and **I find** that Angelo Lombardo died of natural causes being coronary artery atherosclerosis.

And **I further find** that although the investigation identified shortcomings in his medical/psychiatric management at Werribee Mercy Hospital, there is no causative relationship between any aspect of his admission to the ED on 29 December 2005 and Angelo Lombardo's death.

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[51] Received from the Legislative Assembly on 05 May 2011

[52] The Terms of Reference of the Inquiry state:

That under s.33 the Parliamentary Committees Act 2003, an inquiry into violence and security arrangements in Victorian hospitals and, in particular, emergency departments, be referred to the Drugs and Crime Prevention Committee for consideration and report no later than 30 September 2011, including:
(a) the incidence, prevalence, severity and impact of violence in Victorian hospitals and, in particular, emergency departments;
(b) the effectiveness of current security arrangements to protect against violence in Victorian hospitals and, in particular, emergency departments;
(c) an examination of current and proposed security arrangements in Australia and internationally to prevent violence in hospitals and, in particular, emergency departments, including the appropriateness of Victoria Police Protective Services Officers in Victorian hospital emergency departments;
(d) a recommendation of initiatives to enhance the overall security arrangements and safety in Victorian hospitals, particularly emergency departments, to ensure appropriate levels of safety for health professionals and the general public without compromising patient care.

Pursuant to 73(1) *Coroners Act* 2008 this Finding will be published on the Internet in accordance with the Rules.

Signature:

AUDREY JAMIESON
CORONER
Date: 7 June 2011

DISTRIBUTION OF FINDINGS:

Mr Dominic Lombardo - on behalf of the family
Dr Dean Stevenson, Director of Clinical Services, Werribee Mercy Mental Health
Mr John Dickie, Victorian Bar
Ms Rebecca Kovacs, DLA Phillips Fox
John Ball & Sons
Office of the Chief Psychiatrist
Minister for Health