IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2008 1067

FINDING INTO DEATH WITH INQUEST

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

Inquest into the Death of:	BAYDEN JOEL QUILKEY
Delivered On:	7 February 2014
Delivered At:	Level 11, 222 Exhibition Street Melbourne 3000
Hearing Dates:	21- 23 May 2012 28 May 2012
Findings of:	CORONER JACQUI HAWKINS
Representation:	Mr Ron Gipp appeared on behalf of Victoria Police instructed by VGSO Ms Sheehan appeared on behalf of NorthWestern Mental Health Service
Counsel Assisting the Coroner	Mr John Goetz appeared to assist the Coroner, instructed by Office of Public Prosecutions

I, JACQUI HAWKINS, Coroner having reviewed the investigation into the death of BAYDEN JOEL QUILKEY

AND the inquest[1] held by Coroner Hendtlass on 21-23 May 2012 and 28 May 2012 in relation to this death

at MELBOURNE

find that the identity of the deceased was BAYDEN JOEL QUILKEY

born on 24 January 1978

and the death occurred on 13 March 2008

on the nature strip outside 8 President Road, St Albans, Victoria

from:

1 (a) UNASCERTAINED

in the following circumstances:

SUMMARY OF CIRCUMSTANCES

1. Mr Bayden Quilkey[2] was 30 years old when he died on 13 March 2008 from unascertained causes in the context of an acute episode of a psychotic illness and whilst being detained by police in an attempt to provide treatment to his injuries.

2. In 2002 Bayden commenced a relationship with Stacey Velt and in 2003 they had a son together. Their relationship had experienced some instability over the years and they were separated at the time of Bayden's death.

3. Bayden's family, including his brother, mother and aunt, provided support in his time of crisis leading up to his death. In particular, his brother Adam Quilkey made a concerted effort to assist Bayden as he became progressively more unwell and sought to engage a support service to assist with his mental illness.

4. On 9 March 2008 Bayden moved from Queensland to live with Adam in Melbourne. Adam described Bayden's behaviour as unusual and he appeared to be paranoid. Adam sought assistance from Mid West Area Mental Health Service (Mental Health Service) triage team on 11 and 13 March 2008 because he was concerned for his brother's mental health.

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[1] This 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 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.

[2] For consistency, I have avoided formality and referred to Bayden Joel Quilkey as Bayden throughout the Finding.

5. On the morning of 13 March 2008, during Adam's second contact with the Mental Health Service triage team, Bayden became physically aggressive, attempting to take Adam's car keys and to flee the house. Adam ended the phone call and indicated that he would try to bring Bayden to their service.

6. Adam left the house shortly afterwards and when he returned, Bayden had cut his arms and legs and was covered in blood. Adam spoke with their mother, Yvonne Swenson, who was in Queensland. Adam asked her to contact emergency services so that Bayden would not be alarmed by overhearing him make the call. Ms Swenson was with her sister Wendy Strathearn when she spoke with Adam. Consequently, at 12.13pm Ms Strathearn contacted emergency services.

7. Ambulance Victoria agreed to attend and requested assistance from Victoria Police. Senior Constable John Midson and Constable Mark Kendall, operating under radio call sign Sunshine 307, arrived at Adam's house at approximately 12.25pm. On arrival at the scene, SC Midson and Constable Kendall spoke briefly with Adam to ascertain further information and formulate a planned response before entering the premises.

8. SC Midson and Const Kendall gained access to the house through the front door, with a key Adam had provided them. Bayden was standing in the hallway covered in blood. Although they could not see a knife, SC Midson and Const Kendall could not exclude the possibility that he was still carrying one.

9. SC Midson moved down the hallway towards Bayden. His behaviour was erratic and standoffish and he began to raise his voice in response to requests to attend the hospital. Bayden retreated into the bedroom at the end of the hallway.

10. Bayden then began to advance from the bedroom towards SC Midson who discharged a canister of Oleoresin Capsicum Spray (OC Spray) taken from his utility belt. Bayden did not appear to be affected by the OC Spray and ran past both police members, out of the premises, across Station Street, and down President Road. Const Kendall pursued Bayden on foot and SC Midson followed in the police vehicle.

11. After running up the driveway of 8 President Street, Bayden turned around and moved towards Const Kendall. Const Kendall requested him to stop and when he did not, sprayed him with OC Spray.

12. Const Kendall subsequently detained Bayden with the assistance of a passer-by until SC Midson arrived at the scene. Sergeant Chugg (Sunshine 251) arrived and assisted the other two police officers to handcuff Bayden.

13. Ambulance Victoria paramedics arrived at the scene at 12.48pm and decided to administer Bayden with a dose of Midazolam to sedate him for transport. However, before they could administer it, Bayden went into cardiac arrest.

14. Cardiopulmonary Resuscitation (CPR) commenced and his pulse was regained however subsequently lost for a second time. A second ambulance and a MICA paramedic arrived. The second resuscitation attempt was unsuccessful and CPR was ceased at approximately 1.12pm, and Bayden was pronounced deceased.

JURSIDICTION

15. This investigation proceeded by way of a mandatory inquest pursuant to section 52(2)(b) of the *Coroners Act* 2008 (Vic) (Coroners Act)[3] as Bayden was a person in the custody of a member of the police force at the time of his death.[4]

16. The Coroners Court of Victoria is an inquisitorial jurisdiction.[5] The role of a coroner in this State includes the independent investigation of deaths to contribute to a reduction in the number of preventable deaths, the promotion of public health and safety, and the administration of justice.

17. Section 67 of the Coroners Act provides that a coroner must find, if possible, the identity of the deceased, the cause of death and, in some cases, the circumstances in which the death occurred.

18. A coroner may comment on any matter connected with the death, may report to the Attorney-General and may make recommendations to any Minister, public statutory authority or entity,

[3] Section 52(2)(b) of the Coroners Act. An inquest must be held when the death of a person occurred whilst that person was immediately before death a person placed in custody or care.

[4] Section 3(j) of the Coroners Act defines *a person placed in custody or care* to mean "*a person who a member of the police force ...is attempting to take into custody or who is dying from injuries sustained when a member of the police force...attempted to take the person into custody*".

[5] Section 89(4) of the Coroners Act.

on any matter connected with the death, including recommendations relating to public health and safety or the administration of justice.[6]

ASSIGNMENT OF INQUEST FINDINGS

19. Coroner Jane Hendtlass retired on 31 December 2013 without completing the inquest findings in this investigation. The State Coroner of Victoria, His Honour Judge Ian Gray, assigned the completion of this Finding into Death with Inquest (Finding) to me pursuant to section 96 of the Coroners Act.

20. In writing this Finding, I have conducted a thorough forensic examination of the evidence including all the witness statements contained within the inquest brief, supplementary statements, exhibits and transcript of both directions hearings and the Inquest.

CORONIAL INVESTIGATION AND INQUEST

21. Coroner Jane Hendtlass commenced an investigation and held an inquest into the death of Bayden on 21-23 May and 28 May 2012.

Additional Statements obtained

22. Prior to and during the inquest the following additional statements were provided to the Court as part of the investigation:

    - Associate Professor Richard Newton, Consultant Psychiatrist, Medical Director of the Mental Health Clinical Service Unit, Austin Hospital[7]
    - Dr Lorelle Drew, Consultant Pyschiatrist, NorthWestern Mental Health Centralised Triage Service[8]
    - Eva Perez, Acting Assistant Director for the Mental Health Portfolio, Victoria Police[9]
    - Superintendent Michael Williams, Victoria Police[10]
    - William Barger, Manager Operational Quality & Improvement, Ambulance Victoria

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[6] Sections 72(1) and (2) of the Coroners Act.

[7] Exhibit 20, Statement of Associate Professor Richard Newton, Consultant Psychiatrist, Medical Director of the Mental Health Clinical Service Unit, Austin Hospital dated 18 May 2009.

[8] Exhibit 19, Statement of Dr Lorelle Drew, Consultant Psychiatrist, NorthWestern Mental Health Centralised Triage Services.

[9] Exhibit 17, Statement of Eva Perez, Acting Assistant Director for the Mental Health Portfolio, Victoria Police dated 6 March 2012.

[10] Statement of Superintendent Michael Williams, Victoria Police dated 9 March 2012.

- Bruce Hyatt, Manager – Quality Review, Ambulance Victoria
- Anthony Balm, Manager - Quality Review, Ambulance Victoria[11]
- Colin Grant, Manager – Professional Standards Ambulance Victoria[12].

Viva Voce evidence at the Inquest

23. Twelve witnesses were called to give *viva voce* evidence at the Inquest. The witnesses were:

    - Adam Quilkey, Bayden's brother
    - Caterina Whyte, Psychiatric Nurse, Mental Health Service
    - Marie Elaine Bayliss, Senior Psychiatric Nurse, Mental Health Service
    - SC John Midson, Victoria Police
    - Const Mark Kendall, Victoria Police
    - Sergeant Helen Chugg, Victoria Police
    - Senior Sergeant Andrew Miles, Victoria Police
    - Douglas Sadler, Paramedic, Ambulance Victoria
    - Anthony Balm, Manager - Quality Review, Ambulance Victoria
    - Eva Perez, Acting Assistant Director – Mental Health Portfolio, Victoria Police
    - Dr Lorelle Drew, Consultant Psychiatrist – NorthWestern Mental Health Centralised Triage Service
    - Dr John Newton, Consultant Psychiatrist, Austin Hospital.

Submissions

24. Interested Parties were invited to provide written legal submissions at the conclusion of the Inquest. Counsel representing the Chief Commissioner of Victoria Police and NorthWestern Mental Health Service provided submissions, which I have considered for the purpose of this Finding.

Issues investigated

25. Section 67 of the Coroners Act requires me to find:

    a) the identity of the deceased

[11] Exhibit 16, Statement of Anthony Balm dated 22 May 2012.

[12] Exhibit 18, Statement of Colin Grant dated 25 May 2012.

b) the cause of death

c) the circumstances in which the death occurred. In so far as this Finding relates to the circumstances of Bayden's death I have considered the role and actions of the following agencies:

   i. Mid West Area Mental Health Service;

   ii. Victoria Police; and

   iii. Ambulance Victoria.

IDENTITY OF THE DECEASED

26. I find the identity of Bayden Joel Quilkey was without dispute and required no additional investigation.[13]

CAUSE OF DEATH

27. Dr Michael Burke, Senior Forensic Pathologist at the Victorian Institute of Forensic Medicine, conducted a post mortem examination on 13 March 2008. Dr Burke ascribed the cause of Bayden's death to 1a) UNASCERTAINED.[14]

28. In his summary, Dr Michael Burke states:

> Bayden died on a hot day after being restrained by police officers. He had sustained self-inflicted sharp force injuries. He was in an agitated state and he had not been able to be controlled by capsicum spray. There was no anatomical cause of death. From my reading of the three police statements the death occurred some time following the "active" restraint.
>
> Mr Quilkey's death is most probably due to a number of factors. The death occurred on a hot day, in the setting of blood loss from self-inflicted injuries, and agitated bizarre behaviour requiring police officers to restrain him. The physiological consequences could include raised circulating catecholamines, hyperthermia and hypoxia culminating in a cardiac arrhythmia.[15]

[13] Adam Quilkey, brother of Bayden Quilkey confirmed the identity of the deceased in a Statement of Identification dated 13 March 2008. Exhibit 21, Balance of the brief, p70.

[14] Exhibit 21, Balance of the brief, Autopsy Report of Dr Burke, p57.

[15] Exhibit 21, Balance of the brief, Autopsy Report of Dr Burke, p59.

29. The post mortem examination showed patterned intradermal bruises on Bayden's back consistent with the use of a police baton and as described by SC Midson in his statement. However, Dr Burke considered that the baton injuries did not contribute to the death.[16]

30. Restraint asphyxia was considered by Dr Burke as a possible cause of death due to the circumstances surrounding Bayden's death. Dr Burke commented that in restraint asphyxia cases, there is usually a history of an agitated individual who needs to be restrained by police, security staff or orderlies in hospitals, as the individual represents a danger to themselves and others. Often their arms and legs are pinned behind their backs until they are no longer noted to be struggling, which can compromise their medical state and on occasion require resuscitation. However, Dr Burke considered that this type of restraint was not indicated from the Victoria Police members' account of what occurred in relation to their attempts to restrain Bayden.

31. Dr Dimitri Gerostamoulos conducted a toxicological examination on blood samples taken from Bayden and detected no drugs or alcohol.[17]

32. Exsanguination[18] was investigated as a possible cause of death given the accounts of the Ambulance Victoria paramedics. Accordingly, Dr Burke provided a Supplementary Report dated 8 August 2012 considering this issue.

33. In discounting exsanguination as a cause of death, Dr Burke noted:

> One must accept that it is difficult to estimate a volume of blood from a simple inspection of a scene of death. In most instances an individual will overestimate a volume of blood given a particular scene. [...]
>
> I issued the cause of death as unascertained. As noted in my report I believe the death of Bayden was multi-factorial. Certainly the blood loss would have contributed to his death. Furthermore the hot day may well have contributed to hyperthermia and his agitated state would be expected to have contributed to his sudden collapse and death.[19]

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[16] Exhibit 21, Balance of the brief, Autopsy Report of Dr Burke, p58

[17] Exhibit 21, Balance of the brief, VIFM Toxicology Report, p261.

[18] Exsanguination means "extensive loss of blood due to haemorrhage". *Dorlands Illustrated Medical Dictionary* (30th Edition) 2003, W.B. Saunders Company.

[19] Supplementary Report of Dr Michael Burke dated 8 August 2012.

34. I accept that there were no drugs or alcohol detected, that the baton injuries did not contribute to the death and that restraint asphyxia was not supported as a cause of death. I am further satisfied that Bayden did not die due to exsanguination.

35. Accordingly, on the basis of all the available evidence, I am unable to determine with sufficient certainty the cause of death. I therefore find that Bayden Joel Quilkey died on 13 March 2008 of unascertained causes.

CIRCUMSTANCES IN WHICH THE DEATH OCCURRED

36. I do not propose to recount or summarise all of the evidence but rather refer to the parts that are necessary touching upon the relevant circumstances investigated as part of the inquest.

37. The issues explored at Inquest centred on the response provided by the Mental Health Service, Victoria Police, and Ambulance Victoria in relation to the circumstances engendered by Bayden's mental illness.

38. Bayden's medical history included the use of cannabis, amphetamines and crystal methamphetamine (Ice). He had previously expressed suicidal ideation and attempted suicide. Although there is some difference in the evidence about his mental health prior to 2007, there is consensus among friends and family that in late 2007 Bayden became increasingly paranoid with persecutory delusions, delusions of reference and possibly auditory hallucinations.[20] There is no evidence to indicate that Bayden had ever received clinical support for his mental ill-health.

39. Associate Professor Newton was asked to provide an opinion addressing the history, reasons for and consequences of Bayden's mental health deterioration. Associate Professor Newton opined that:

> ...[Bayden] is likely to have had a least six months of deteriorating function and a range of psychotic experiences in the likely absence of drug abuse, sufficient to justify a diagnosis of paranoid schizophrenia This was however most likely precipitated and may have been exacerbated and/or maintained by his amphetamine use.[21]

40. Prior to his arrival in Melbourne, Bayden had contact with the Queensland Ambulance Service and Queensland Police Service due to family concerns in relation his behaviour.

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[20] Exhibit 20, Statement of Professor Richard dated 18 March 2012, p2.

[21] Exhibit 20, Statement of Associate Professor Newton, p2.

These services considered there was insufficient evidence of mental illness to justify involuntary interventions.

41. On 9 March 2008, Bayden arrived in Melbourne to stay with his brother with no luggage and just the clothes he was wearing.[22] Adam described Bayden's behaviour as out of character and that he had never seen Bayden like this before.[23] Bayden exhibited a pattern of paranoid behaviours, including a regular routine whereby he checked doors and windows and asked Adam when 'they' were coming for him. He also appeared concerned for Adam's safety whenever he left the house.[24] Over the following two days, Adam became increasingly concerned about the state of Bayden's mental health.

Response by Mid West Area Mental Health Service

42. Adam made two phone calls to the Mental Health Service triage about his brother's mental health. One of the key issues explored at inquest was whether the Mental Health Service provided an appropriate response to these calls. Consideration of these issues is not intended to identify fault or attribute blame to any of the mental health practitioners involved in assisting Adam and Bayden but rather to ascertain areas that could improve their capacity to respond should another incident of this nature occur again.

First Contact with the Mental Health Service on 11 March 2008

43. As Adam had no previous contact or experience with mental health issues or services,[25] he used the internet to research information about mental illness and services available to help his brother. He found information about the Mental Health Service which was one of four services within the NorthWestern Mental Health Service (NWMHS).[26] The triage service operated within the Sunshine Psychiatric Unit. Their role was to determine an appropriate response to a person in the community who was experiencing mental health problems and in particular, the urgency of the response.

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[22] Exhibit 2, Statement of Adam Quilkey dated 14 March 2008, p2.

[23] Exhibit 2, Statement of Adam Quilkey dated 14 March 2008, p2.

[24] Exhibit 1, Statement of Adam Quilkey, dated 13 March 2008, p1.

[25] Transcript of evidence, p27.

[26] Transcript of evidence, pp28 & 41.

44. At about 11am on 11 March 2008, Adam rang the Mental Health Service Triage for advice about his brother. He spoke to Caterina Whyte, a registered psychiatric nurse of 24 years who had worked within the Crisis Assessment and Treatment Team (CAT Team) for 8 to 10 years. Adam said that Bayden had arrived at the house unannounced, was acting in an unusual manner, was paranoid and believed that someone was trying to kill him.[27] Adam advised Ms Whyte that it was unlikely that there was any basis for this fear.[28]

45. Ms Whyte stated that following her conversation with Adam, she did not have the impression that an urgent response was necessary. She noted that there was a lack of specific behaviours and no knowledge of recent medical history. Ms Whyte said that in her role as a triage clinician was important to speak to the affected person directly and obtain as much information about them as possible.[29] She felt it was difficult to assess a person's risk if they had not previously had contact with the service or if it was the first presentation of mental illness.[30]

46. She further stated that without speaking to Bayden she did not have enough information to proceed further.[31] She determined not to send a member of the CAT Team to attend his home and conduct an assessment in person. Ms Whyte stated that Adam was unsure of whether drugs were involved and informed Adam that he should enquire about that possibility and call back so that they could try to talk to Bayden.[32] Adam agreed to do this.

47. There were no discussions with Adam about what to do if Bayden did not agree to contact the Mental Health Service. She did not provide advice about the symptoms of mental illness, how best to assist Bayden, or what to do if things escalated.

48. Ms Whyte filled out a phone referral form and took handwritten notes of the conversation, including a phone number for Adam.[33] The notes she took were placed in a filing cabinet of recent contacts with the service.

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[27] Transcript of evidence, p46.

[28] Exhibit 4, Statement of Caterina Whyte dated 18 March 2008, p1.

[29] Transcript of evidence, p47.

[30] Transcript of evidence, pp 54-55.

[31] Transcript of evidence, p45.

[32] Transcript of evidence, p 46.

[33] Exhibit 5, Phone Referral form completed on 11 March 2008.

Second Contact with the Mental Health Service on 13 March 2008

49. By the morning of 13 March 2008, Bayden's mental health had declined significantly. At approximately 11am that morning, Adam rang the Mental Health Service Triage for a second time and asked to speak with Ms Whyte however, she was not working that day and he spoke to Marie Bayliss instead.[34] Ms Bayliss had been a registered psychiatric nurse with 22 years experience and had worked at the organisation since 2003.

50. Adam sought advice on how best to help his brother who he said suffered panic attacks and had not slept for 24 hours. As Adam provided Bayden's personal details to Ms Bayliss, Bayden became distressed and attempted to take Adam's car keys. Bayden then chased Adam and tried to prevent him from leaving the house.[35] In evidence, Adam stated that Bayden was severely panicked.[36]

51. Adam's evidence in relation to this phone call was that:

- He did not recall much about the conversation.
- Ms Bayliss said the Mental Health Service needed to see Bayden in person and asked if Adam could bring him to the clinic.
- There was no discussion about what to do if he could not bring him into the clinic.
- There was no discussion about sending a clinician to his house, however he agreed in evidence that this would have been of great assistance.[37]

52. The evidence of Ms Bayliss was as follows:

- Adam was quite distressed and the matter appeared to need urgent attention.
- She had no knowledge of Adam's prior contact except that he mentioned his phone call with Ms Whyte.
- She could not remember whether she was present at the team meeting when the initial contact was discussed.
- She did not speak with Ms Whyte after the telephone call probably because she was not on duty at that time. However, she would expect the notes to be in the information

[34] Exhibit 1, Statement of Adam Quilkey, p3.

[35] Exhibit 1, Statement of Adam Quilkey, p3.

[36] Transcript of evidence, p29.

[37] Transcript of evidence, p22.

folder where recent contacts were usually placed. She did not go to the folder to check, but could have.

- If she believed that there was an immediate risk, she would have told Adam to contact police and ambulance. She did not mobilise a CAT Team because she believed they had appointments.
- She determined that the most expedient response was to get Bayden into the clinic.
- She put Adam on hold while she went to check whether a doctor and bed were available, which they were. She arranged for Bayden to be seen by a CAT Team psychiatrist when he arrived.[38]
- She told Adam how to get there and provided Adam with the address.
- She believed that Adam would take his brother to the clinic and she presumed he would carry through with this.
- She was unaware that Bayden was present during the conversation and not aware of his reaction to the responses being provided by Adam. If she had known, she would have suggested Adam contact police and the ambulance because in the context of such a response, it was not safe for the CAT Team to attend without police.[39]

Issues identified

53. I was assisted in my understanding of the response by the Mental Health Service by Dr Lorelle Drew, a Consultant Psychiatrist with the NWMH Centralized Triage Service, and Associate Professor Newton, the Medical Director of Mental Health at the Austin Hospital.

54. Dr Drew and Associate Professor Newton both say that, in hindsight, there appear to have been opportunities to manage the interaction between Adam and the Mental Health Service Triage differently. In summary these opportunities for improvement include:
    - There could have been better guidance for triage clinicians with respect to obtaining further information from Adam and making decisions about the appropriate course of action to take.
    - A follow-up call either on the afternoon of 11 March 2008, or on 12 March 2008, might have averted the ultimate crisis by providing proactive and assertive treatment for Bayden's evident mental health issues.

[38] Exhibit 6, Statement of Marie Bayliss dated 14 March 2008, p1.

[39] Exhibit 6, Statement of Marie Bayliss dated 14 March 2008, p1.

- A better process could have been in place to ensure that the staff working subsequent shifts were aware of Adam's contact with the Mental Health Service, the information he had provided and the response that was given.
- A decision could have been made to mobilise a CAT Team on 13 March 2008.
- In the absence of the Mental Health Service having contact with Bayden, Adam could have been better supported in his request for assistance.

55. The following sections explore these issues further and discuss some of the areas in which the service could be strengthened to prevent similar deaths from occurring in the future.

Better guidance for obtaining information and for decision making

56. Ms Whyte obtained some preliminary information from Adam and took notes of that conversation.[40] Ultimately, she did not consider that the situation was urgent or that his behaviours warranted urgent clinical assessment but she was keen to see him in person to assess the situation further.

57. The information obtained by Ms Whyte was not sufficient to identify that Bayden's need for a CAT Team visit was high. Both Dr Drew and Associate Professor Newton agreed that the phone call on 11 March 2008 was a missed opportunity to gather further information to inform this decision. For example, Dr Drew said:

> I think CAT teams [...] would want to know more information than was provided on these occasions to make a decision about in what way they might attend.[41]

58. It appears that Ms Whyte was relying on information being provided to her rather than proactively asking questions that may assist her assessment. Dr Drew noted that in these circumstances:

> [...] it's important to actively engage the referrer in [...] obtaining information as they may not be familiar with the system or indeed the symptoms that are likely to be occurring and will need to be [...] supported in obtaining that information in detail. [42]

59. Ultimately, the acquisition of further information would have allowed for a more comprehensive assessment and may have resulted in a different course of action. The expert

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[40] Exhibit 5, Phone referral form completed at 1100hrs on 11 March 2008.

[41] Transcript of evidence, p212.

[42] Transcript of evidence, p210.

evidence was that not mobilising a CAT Team after the first call was a missed opportunity to get assistance for Bayden who was at that stage experiencing a psychiatric crisis[43] however was not yet in an emergency situation.[44] Importantly, it would have facilitated critical assertive treatment.[45]

60. Problematically, there were no guidelines available to Ms Whyte about what information to collect from concerned callers. Dr Drew noted that this led to inconsistencies in approach to triage and idiosyncrasies in the information obtained.[46]

61. There was also no standardised mechanism for categorising the nature or urgency of the mental health problem and there were no clearly articulated guidelines for the mobilisation of the CAT Team. The decision relied on individual non-standardised clinical judgement. Accordingly, there was opportunity for greater support to be provided to Ms Whyte by the Mental Health Service in responding appropriately to Adam's request for help.

Follow-up

62. In the absence of mobilising a CAT Team, Ms Whyte could have made a follow-up call to see how the situation had progressed. In the record of conversation with Adam, Ms Whyte interestingly notes "Await call back", thereby placing the onus on Adam to follow through.

63. Unfortunately, there were no processes in place for follow-up at the time and no one assumed responsibility to review Bayden's situation later that day and take further action if necessary. As such, Adam did not receive a follow-up call, either by Ms Whyte or any other member of the Mental Health Service staff. In retrospect, Ms Whyte believed that a follow-up call may have altered the outcome.[47]

64. Associate Professor Newton agreed that had this occurred, further information could have been obtained about the state of Bayden's health and a decision to mobilise the CAT Team may have been made. In the context of Adam's phone call, this would have been an important

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[43] The term 'psychiatric crisis' or 'mental health emergency' encompasses the escalation of a psychiatric condition or symptomology, which does not also occur in the context of an 'emergency situation'.

[44] In the current context, an 'emergency situation', or 'situational crisis' is used to denote an imminent and immediate threat to an individual's life or well-being. This can include circumstances in which an individual is affected by drugs and alcohol, violent, or threatening, or engaging in, self-harming behaviour.

[45] Transcript of evidence, pp 213-214 & 228.

[46] Transcript of evidence, pp205-206.

[47] Transcript of evidence, p42.

opportunity to review the information taken by Ms Whyte and may have resulted in the recognition of his heightened level of risk and consequently more assertive, proactive treatment of his mental health problems.[48] He did however further explain that the CAT Team take many calls and it was not inappropriate for them to have requested Adam to call back.

Handover

65. The handover of information relating to Adam's call was also not ideal. At 2.00pm on 11 March 2008, Ms Whyte discussed this contact with the multidisciplinary team. The plan was to await contact from Adam or Bayden himself. Ms Whyte's notes were placed in a filing cabinet of recent contacts.

66. Ms Bayliss was not sure whether she was present during the team meeting and did not read these notes when responding to Adam Quilkey's phone call on 13 March 2008. Accordingly, she did not have important information available to her about the previous contact.

Decision not to mobilise a CAT Team on 13 March 2008

67. On 13 March 2008, the Mental Health Service offered Bayden an immediate appointment with a psychiatrist and requested Adam to bring him to the clinic. Associate Professor Newton states that there does not appear to have been an assessment as to the likelihood of Adam being able to persuade his brother to attend. In fact, it appears from Adam's statement and evidence that it was highly unlikely he was ever going to get Bayden's consent and cooperation to do so.

68. Associate Professor Newton comments that, in hindsight, the triage plan of a clinic based assessment was not really appropriate and an urgent home-based CAT Team assessment would have been a more appropriate response. However, he does qualify this position by further stating that the crisis began during this phone call and even if the CAT Team had immediately attended the house, he does not think that it would have altered the outcome.[49]

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[48] Exhibit 20, Statement of Associate Professor Newton, p2.

[49] Exhibit 20, Statement of Associate Professor Newton, p2.

Assistance to Third Parties

69. Associate Professor Newton states that based on the evidence, the most likely diagnosis of Bayden would be paranoid schizophrenia.[50] One of the consequences of someone who is experiencing a first time psychosis is that they are likely to be very paranoid, suspicious and have little trust in the people who are trying to help[51] and are therefore extremely difficult to engage.

70. Part of the issue with the approach taken by the Mental Health Service was the focus placed on Bayden as the client. I understand that as a psychiatric service the person experiencing a mental illness must be the primary concern. However, in the absence of having contact with Bayden directly, Adam was the person requiring and able to receive assistance.

71. Dr Drew's statement referred to the Mental Health Triage program management circular which states:

> Mental health triage is provided for all potential consumers (or people seeking assistance on behalf of a person thought to have a mental illness) at the first point of contact with mental health services.
>
> Where it is considered that [Adult Mental Health Services] are not the most appropriate option for the person, he/she may be referred to another organisation or given other advice.
>
> Clinicians providing mental health triage should demonstrate a helpful, 'customer-focused' approach. Where it is determined that the Mental Health Service is not the most appropriate service, every effort should be made to link the consumer (or carer/referrer) with a more suitable service. Where appropriate, the clinician should make contact with this service on behalf of the person requesting assistance.[52]

72. Assisting Adam, as opposed to Bayden, would only require a slight shift in focus from one of clinical support to the provision of information. It is essential that concerned callers are empowered by receiving information and support with respect to the nature of mental illness, how to identify any deterioration, and how to engage in discussions with their loved one about seeking help.

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[50] Transcript of evidence, p227.

[51] Transcript of evidence, p222.

[52] Exhibit 20, Statement of Associate Professor Newton dated 18 May 2012, p2.

73. In evidence, Ms Whyte agreed that it would have been useful to have provided Adam with more information about the symptoms of mental illness and how Adam could best assist Bayden.

74. Associate Professor Newton explained the importance of providing information and support to third party callers, particularly when they are inexperienced in the area of mental illness:

> I think that when considering our responsibility as providers of mental health services to patients in need it's very important to provide people with services and responses that are realistic and likely to be helpful.[53]

75. Similarly, Dr Drew noted:

> I think it would have been a useful exercise to actually discuss in more detail with the referrer what psychotic symptoms are and why they occur as a way of exploring whether Bayden was experiencing those himself. ... it's very likely that this was I think Adam Quilkey's first experience with ringing a mental health service he would probably have very little idea as to, ... what to describe to clinicians as a way of getting help. And I think it's helpful to actually provide that information about .. the type of symptoms people can experience and how that can make them feel as a result, that is, very frightened or upset or angry.[54]

76. She further elaborated:

> ...it's often useful to go through, particularly with family members calling or carers, .. how they might introduce the idea of getting help to someone who is paranoid or feeling unwell in that way, that there are ways of describing services available that might be more... amenable to or less upset about if it's put in the right way. And that would have perhaps been helpful as well.[55]

Changes to practices at NWMHS

77. Dr Lorelle Drew commented that mental health services endeavour to work in the best way possible and towards the best possible outcomes. However, she agreed that there were opportunities to have managed the situation differently and gave evidence regarding changes and developments to the Mental Health Service that have occurred since Bayden's death.[56]

78. Specifically, in 2010 the Mental Health Service was one of four triage services across the NWMHS that were centralised.[57] Dr Drew said that this centralisation promotes a consistent

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[53] Transcript of evidence, p228-229.

[54] Transcript of evidence, p213.

[55] Transcript of evidence, p213-214.

[56] Exhibit 19, Statement of Dr Lorelle Drew dated 22 February 2012 p2.

[57] Exhibit 19, Statement of Dr Lorelle Drew dated 22 February 2012, p2.

and standardised approach to triage, in line with the Department of Health Statewide Mental Health Triage Guidelines (2010).[58]

79. Every contact is now categorised according to standardised criteria found in a triage scale, which guides decision-making and the outcome of calls. Dr Lorelle Drew explained the current triage assessment uses the A-G Code developed by the Chief Psychiatrists Group. The scale maps the assessment of information received to seven categories relating to the types of need, risk and urgency.[59]

80. In addition, the recording of, and access to, information about each contact to the service occurs in a centralised database. Although there is no template approach to the information gathered and clinical judgement is still expected, there is better training and clearer expectations including prompts with respect to the type of information to collect.[60]

81. Ms Whyte gave evidence that since the time of Bayden's death, a follow-up process has been implemented whereby if a caller does not make further contact within 18-24 hours as planned, staff members will proactively make contact.[61]

82. Under the new NWMHS triage service, a team approach is promoted. This includes a more thorough handover, in which referrals are discussed with personnel within the triage department and a plan is developed as to how they may proceed.[62] At the change of shifts, a complete handover of clinical information occurs. Ninety percent of contacts to the service are discussed at this time and the Triage Manager, Senior Psychiatric Registrar or Consultant Psychiatrist is present during discussions, which allows for a more dedicated and focussed appraisal.[63] In addition, all referrals to NWMHS are reviewed by the Psychiatric Registrar or Consultant Psychiatrist twice a week.[64]

[58] Exhibit 19, Statement of Dr Lorelle Drew dated 22 February 2012, p2.

[59] Exhibit 19, Statement of Dr Lorelle Drew dated 22 February 2012, p3.

[60] Transcript of evidence, p219.

[61] Transcript of evidence, p45.

[62] Transcript of evidence, p207.

[63] Exhibit 19, Statement of Dr Lorelle Drew dated 22 February 2012, p2.

[64] Exhibit 19, Statement of Dr Lorelle Drew dated 22 February 2012, p4.

Conclusions as to the appropriateness of the response by the Mental Health Service

83. I make no adverse comment in relation to the conduct of the Mental Health Service employees and believe those who had contact with Adam acted in accordance with their training at that time.

84. Having considered all of the evidence and having particular regard to the expert opinions of Associate Professor Newton and Dr Drew, I find there were opportunities for improvement to the Mental Health Service at the time of Bayden's crisis.

85. The evidence provided by Dr Drew was very informative and greatly assisted this investigation. I commend NWMHS for their commitment to improving mental health services to the community, including increasing access to information, and the implementation of standardised and consistent approaches to referrals and outcomes for users of the services.

86. While in theory these changes have strengthened the Mental Health Service response, the evidence does not allow me to conclude that they would have altered the outcome and prevented Bayden's death.

87. Finally, I have reached the conclusion that when a third-party caller such as Adam, makes contact with a mental health triage service, they should be considered the customer of the service until such time as the service is able to conduct a preliminary assessment of whether the person (with the indicators of mental health problems) is likely to have a mental illness or disorder, and the nature and urgency of the response required.[65]

88. As such, there would be an onus on the mental health triage service to support the caller, be it carer or other referrer, providing information, assistance and in some circumstances follow up in the manner described by Associate Professor Newton and Dr Drew. Accordingly, I recommended that the Mental Health Service consider adopting this approach (see Recommendation).

[65] Victorian Government, Department of Human Services, Mental Health Branch 2005 Mental Health Triage, Program Management Circular, p1. Accessed at: http://health.vic.gov.au/mentalhealth/pmc/index.htm

Response by Victoria Police

Background circumstances involving Victoria Police

89. The Emergency Services Telecommunication Authority (ESTA) notified Ambulance Victoria to attend this incident. Ambulance Victoria then advised that they required Victoria Police to assist them due to the circumstances of the incident.[66]

90. At 12.14pm, SC Midson and Const Kendall (Sunshine 307) responded to a request from Intergraph. They sought permission from their supervisor Sergeant Chugg (Sunshine 251), to divert from their previously allocated job, which she granted.

91. Sunshine 307 were told the subject was:

> a 30 year old male, paranoid, self harming. The caller's (sic) told ambulance that he's being restrained by his brother, he's been displaying some psyche behaviour over the last week or so, and it's escalated today. That's all we've got. [67]

92. On the way to the scene, Const Kendall liaised with Intergraph to determine whether anything further was known about the job, but Intergraph had limited information. In planning for their response, SC Midson and Const Kendall discussed how they would approach the scene.[68]

93. At approximately 12.25pm, SC Midson and Const Kendall arrived at 302 Station Road, St Albans and spoke to Adam outside the house.[69] Adam reported that Bayden was inside and was bleeding from cuts to his arms and legs. When asked about the extent of the cuts by SC Midson, Adam said that they were "pretty bad" and that he had a lot of blood on his trousers.[70]

94. In evidence, SC Midson recounted the information he received from Adam which included that Bayden:[71]

- had only moved to Victoria in the past two weeks from Queensland
- had recently been involved in a break-up where a child was involved

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[66] Exhibit 21, Balance of the brief, Intergraph transcript p286.

[67] Exhibit 21, Balance of the brief, Intergraph transcript p286.

[68] Exhibit 11, Statement of Constable Kendall, dated 13 March 2008, p2; Transcript of evidence, p83.

[69] Exhibit 11, Statement of Constable Kendall, dated 13 March 2008, p2.

[70] Exhibit 8, Statement of Senior Constable Midson dated 13 March 2008, p3.

[71] Exhibit 8, Statement of Senior Constable Midson dated 13 March 2008, p3-4.

- had some financial issues and possibly lost his house recently
- believed someone was trying to kill him
- was holding a kitchen knife when he last saw him, however no further information about the knife was obtained
- was not on any medication and as far as he was aware had not consumed any drugs recently
- was not violent, in his opinion, and had not threatened any other person
- was not mentally impaired and did not have any psychiatric issues.

95. SC Midson and Const Kendall conducted a risk assessment, discussed a plan which included the potential use of OC Spray, how they would manage the situation if Bayden had a knife, and the use of gloves to limit their exposure to Bayden's blood.

96. At approximately 12.40pm, after putting on ballistic vests and gloves, SC Midson went to the front door and attempted to engage in a discussion with Bayden, however, he was unable to convince him to come out or allow them to enter the house and talk.

97. SC Midson and Const Kendall obtained keys from Adam and entered the house. SC Midson walked along the hallway towards the bedroom. Const Kendall remained in the hallway, closer to the front door.[72]

98. SC Midson requested Bayden to come out of the bedroom at the end of the hallway so that they could see him. He emerged in a doorway at the end of the hallway covered in blood. SC Midson said that the lacerations on his forearms appeared to be quite deep.[73]

99. SC Midson looked into the bedroom at the end of the hall and told Bayden to turn around or he would use the OC Spray. Bayden turned around and started to walk with quickening paces towards SC Midson, at which time SC Midson deployed the OC Spray, without any apparent effect.[74] Bayden rushed past the two police officers and left the house through the front door.

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[72] Exhibit 8, Statement of Senior Constable Midson dated 13 March 2008, p6.

[73] Exhibit 8, Statement of Senior Constable Midson dated 13 March 2008, p5.

[74] Exhibit 8, Statement of Senior Constable Midson dated 13 March 2008, p6.

100. Const Kendall chased Bayden across Station Road and into President Road. Bayden was not paying attention to the road as he crossed and was narrowly missed by traffic.[75] SC Midson got into the police car and followed them.[76]

101. Bayden ran inside the fence line of the property at 8 President Road with Const Kendall following behind.[77] Bayden realised he had no path forward and turned to run back down the driveway.

102. Const Kendall was unsure what Bayden might do next and as Bayden advanced towards him, he deployed OC Spray to prevent any potential harm to himself and because he was concerned for Bayden's welfare.[78] Once again, the OC Spray did not appear to affect Bayden and he ran past Const Kendall and back onto the road.

103. SC Midson had by this stage arrived at their location and assisted Const Kendall to detain Bayden, who was strong and determined not to be detained.[79] Const Kendall noted:

> The male kept fighting, it was amazing how strong he was. It was also difficult for us to grab him because his arms were covered in blood and both my blue latex gloves and SC Midson's had ripped and we were trying to get the least amount of blood on us as possible.[80]

104. SC Midson and Const Kendall eventually managed to get Bayden face down on the ground, however he was still resisting, trying to get up on his hands and knees.

105. SC Midson struck Bayden twice with his baton, connecting with Bayden's ribs. Const Kendall attempted to kick out Bayden's left arm and leg so that he was unable to get back up.[81]

106. Although Bayden continued to resist attempts to restrain him, SC Midson managed to handcuff his right hand. Sergeant Chugg assisted with holding Bayden down and SC Midson put a foot on Bayden's right shoulder blade to prevent him from getting up. As a result, Const

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[75] Exhibit 11, Statement of Constable Kendall, dated 13 March 2008, p5.

[76] Exhibit 8, Statement of Senior Constable Midson dated 13 March 2008, p7.

[77] Exhibit 11, Statement of Constable Kendall, dated 13 March 2008, p5.

[78] Exhibit 11, Statement of Constable Kendall, dated 13 March 2008, p5.

[79] Exhibit 11, Statement of Constable Kendall, dated 13 March 2008, p5.

[80] Exhibit 11, Statement of Constable Kendall, dated 13 March 2008, p5.

[81] Exhibit 11, Statement of Constable Kendall, dated 13 March 2008, p5.

Kendall was able to use his own set of handcuffs to cuff his left hand, and the two sets of cuffs were joined.[82]

107. SC Midson continued to reassure Bayden that things were going to be alright and that they were going to help him. Bayden then started to calm down.[83]

Issues identified

108. I was assisted in my understanding of the response by Victoria Police by Superintendent Williams and Senior Sergeant Miles and Ms Perez, all of Victoria Police.

109. Over the course of the investigation a number of issues were considered including:

    a) Operational Safety Tactics Training (OSTT)

    b) The tactical decisions

        i. not to cordon and contain

        ii. to use OC Spray

    c) General operational decisions about the use of

        iii. mobile phones

        iv. gloves

    d) The restraint of Bayden.

110. I will now discuss these issues in turn to identify if there were any opportunities or areas of improvement to prevent similar deaths from occurring in the future.

OSTT Training

111. Senior Sergeant Miles gave evidence that both police officers were up to date with their OSTT training. SC Midson had last attended in October 2007 and Const Kendall had last attended in February 2008.[84]

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[82] Exhibit 11, Statement of Constable Kendall, dated 13 March 2008, p5.

[83] Exhibit 8, Statement of Senior Constable Midson dated 13 March 2008, p8.

[84] Exhibit 21, Balance of brief, pp268-269.

112. Const Kendall considered that the OSTT training he received in relation to mental health was appropriate.[85] SC Midson agreed that OSTT training covered all the basic things that were required to manage the situation.[86]

113. When asked about his response to this mental health issue, SC Midson stated that "each and every situation and critical incident that we go to is unique in its own right."[87] He also noted that these situations are hard to plan for and sometimes one can only do the best with the knowledge available to them at the time, and based on their training.[88]

114. I accept that police officers are not clinicians and when confronted with a situation such as this, it is extremely difficult to fully assess the person's mental health. In making an assessment of Bayden's situation, the operational members were guided by the mental health training they received as part of their OSTT. The evidence of Senior Sergeant Miles and Ms Perez establishes that police training, as part of the mental health strategy was appropriate in March 2008.

Tactical decisions not to cordon and contain

115. Sergeant Chugg instructed SC Midson and Const Kendall to attempt contact with Bayden and gain further insight into the situation.

116. It appears that cordon and contain was not considered a feasible option in these circumstances because SC Midson and Const Kendall were concerned about the nature of Bayden's injuries and believed he would bleed to death if they did not get him treatment.[89] To this end, they wanted to make contact with Bayden as soon as possible to create a safe environment for the attending paramedics to treat his injuries.[90]

117. In retrospect, Senior Sergeant Miles considered there might have been an opportunity to approach the situation differently by establishing a cordon and contain situation.[91] He notes that cordon and contain buys time and the creation of time provides an opportunity to garner

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[85] Transcript of evidence, p93.

[86] Transcript of evidence, p77.

[87] Transcript of evidence, p84.

[88] Transcript of evidence, p84.

[89] Transcript of evidence, p89.

[90] Transcript of evidence, p83.

[91] Transcript of evidence, p120.

more resources, obtain more information, possibly reduce the aggression and create a heightened chance of a successful situation.

118. The approach planned by SC Midson and Const Kendall and the decision not to cordon and contain was influenced to varying extents by a number factors, including:

- Bayden's state of mind
- The possibility Bayden had a knife
- The unavailability of the Critical Incident Response Team (CIRT)

Bayden's state of mind

119. One of the factors influencing a decision to cordon and contain is the urgency of the response required by virtue of the individual's state of mind. For example, in some circumstances, if an individual is believed to be self-harming, as opposed to intent on dying, it may warrant a slower and more cautious approach.

120. SC Midson and Const Kendall were presented with conflicting evidence about his state of mind. For example, Ms Strathearn indicated to ESTA that Bayden was self-harming with a knife.[92] She further conveyed that she did not believe it to be a suicide attempt but rather that he was experiencing psychotic symptoms.[93] However, Adam informed them Bayden was not mentally ill and did not have any psychiatric issues.[94]

121. Ultimately, SC Midson and Const Kendall appear to have concluded that Bayden was suicidal rather than self-harming. SC Midson made the comment that "the extent of the injuries made it fairly clear in my mind, it was extremely evident that he was suicidal with those type of injuries." [95] This meant that entering the house became more urgent.[96]

122. Const Kendall noted that the job came across as self-harm and although Adam did not say Bayden was suicidal, Const Kendall presumed he was.[97] This was strongly influenced by the

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[92] Exhibit 15, Statement of Douglas Sadler 30 March 2008, p1.

[93] Exhibit 20, Balance of the brief, Recorded conversation between Ambulance Operator and Wendy Strathearn also Police, p316.

[94] Exhibit 8, Statement of Senior Constable Midson dated 13 March 2008, p3.

[95] Transcript of evidence, p91

[96] Transcript of evidence pp112-114.

[97] Transcript of evidence, p100.

amount of blood on Bayden and at the scene. However, in these circumstances, whether Bayden was intending to self-harm or take his life, was of peripheral relevance. The nature and extent of his injuries meant that he needed them assessed and treated as soon as possible.

123. Indeed, SC Kendall said it probably would not have made a difference to the plan they formulated and they would have treated the situation the same either way.[98]

The possibility Bayden had a knife

124. Senior Sergeant Miles indicated that when the operational officers had determined that Bayden was unarmed[99] they could have considered establishing a cordon and contain.

125. However, SC Midson stated that their "utmost concern was for the safety and welfare of Bayden."[100] Seeing the amount of blood and the extent of his injuries made the members very concerned[101] and increased the urgency of having him seen by ambulance officers as quickly as possible.

126. SC Midson further stated:

> I think the fact that he didn't have the knife created the best opportunity in my mind that we would have got that day to help Bayden and communicate with him and facilitate a successful outcome.[102]

Unavailability of Critical Incident Response Team (CIRT)

127. There was some discussion at the inquest about whether the CIRT should have been contacted. CIRT have specialist resources including trained negotiators and access to specialist equipment that is not available to general duty members including Tasers, different types of chemical munitions and more sophisticated firearms.[103]

128. CIRT do more mental health training and their primary strength is that they are negotiators. As such, a trained negotiator may have understood the subtleties associated with a first

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[98] Transcript of evidence, p100.

[99] Transcript of evidence, p120.

[100] Transcript of evidence, p83.

[101] Transcript of evidence, p86.

[102] Transcript of evidence, p90.

[103] Transcript of evidence, pp141-142.

presentation mental illness and may have been able to respond to Bayden in a manner likely to cause less panic, given his evident paranoia.

129. Senior Sergeant Miles commented that the involvement of the CIRT team in incidents greatly heightens opportunity for a more successful outcome.[104]

130. On the day of Bayden's death, there was an assumption that if a CIRT unit was around, they would have come up on the radio to indicate this and because they did not, a CIRT unit was not requested.[105] This created (real or perceived) pressure to deal with the situation themselves and influenced their decision not to cordon and contain.

Conclusions as to tactical decisions not to cordon and contain

131. Although he believed things could have been done differently, Senior Sergeant Miles ultimately concluded that, SC Midson and Const Kendall had done their risk assessment and determined that they needed to enter the house for the welfare of Bayden.[106]

132. Ms Eva Perez gave evidence at the inquest and did not criticise their conduct. In fact, Ms Perez commented that this incident was a striking example of the dynamic and complex mental health issues faced by police on a daily basis.[107] Further, Ms Perez stated that there is universal agreement that police are not clinicians and are not exercising any of that sort of judgement.[108]

133. I acknowledge that these situations are dynamic and I accept the conclusion of Senior Sergeant Miles and Ms Perez. No two occasions will present with the same facts and circumstances. Police have to think quickly on their feet, using the practical skills they have learned on the job and draw on their training.

134. I accept the circumstances involving Bayden were not clear-cut. On the one hand he may have only wanted to self harm, but on the other hand due to the injuries and the amount of blood it was reasonable to have concluded that it was a suicide attempt.

[104] Transcript of evidence, p119.

[105] Transcript of evidence, p84.

[106] Transcript of evidence, p120.

[107] Transcript of evidence, pp185-186.

[108] Transcript of evidence, p194.

135. I accept that it is not feasible to request assistance from mental health experts such as CIRT every time there is a notification of someone with possible mental health issues. Although I am of the opinion that these circumstances warranted at least a discussion about the appropriateness of making this contact, I am unable to conclude that it would have resulted in CIRT attending or that in any event, CIRT attendance would have altered the ultimate outcome.

136. Ultimately, what was clear was that Bayden needed assistance with his injuries and his mental health and I find that the operational police should not be criticised for the decision to enter the premises or the manner in which they engaged Bayden. Their response to this crisis indicated to me that they made their best efforts to assist Bayden's welfare. Therefore, I am satisfied and I find that it was reasonable to enter the house and not cordon and contain.

Tactical decisions about the use of OC Spray

137. The use of OC Spray appeared to escalate the situation and was the catalyst for a pursuit on foot. However, the plan formulated by the officers to use OC Spray was more consistent with reasonable force and the promotion of harm-minimisation rather than other options available to them, such as firearms.

138. The Victoria Police Manual provides that OC spray can be used in the following circumstances:

- In situations of violent and serious physical confrontation
- In situations where a member believes on reasonable grounds a violent and serious physical confrontation is imminent
- Where a person is involved in violent or other physical conduct likely to seriously injury themselves or result in suicide.[109]

139. In evidence, Const Kendall stated that he feared he would be assaulted by Bayden.[110] SC Midson also stated that he used the OC spray because he was acting in self-defence and believed that Bayden was intent on attacking him.[111]

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[109] Victoria Police Manual, 101-3 [7.2].

[110] Exhibit 11, Statement of Constable Kendall, dated 13 March 2008, p6.

[111] Transcript of evidence, p108; Exhibit 8, Statement of Senior Constable Midson dated 13 March 2008, p6.

140. Accordingly, I find that both deployments of the OC Spray were in compliance with the relevant procedures in the Victoria Police Manual as the officers believed, based on the information available to them and their observations that a serious confrontation was imminent.

General operational issues

Use of mobile phones

141. After Sunshine 307 had accepted the job, Sergeant Chugg asked Intergraph whether they were in a position to call her on her mobile.[112] Accordingly, Const Kendall contacted Sergeant Chugg on the mobile phone and she advised them to attempt contact with Bayden and determine the severity of his injuries.[113]

142. There is no Victoria Police policy recommending against the use of mobile phones in these circumstances and the evidence given was that this can be a useful, less stilted manner of communication than through Intergraph. In addition, it frees the airway up for other communications.[114]

143. Const Kendall commented that Intergraph can be busy at times and it is difficult to have a conversation with a supervising officer. Comments have to be short and it is sometimes easier to speak by phone.[115] Const Kendall commented that the use of mobile phones is accepted practice within Victoria Police and is why they are issued with one.[116] Sergeant Chugg agreed.[117]

144. Senior Sergeant Miles commented that the use of mobile phones by police is unavoidable.[118] However, during an incident such as this, a senior sergeant usually supervises communications and if they are not privy to what is said to operational members, it is difficult

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[112] Exhibit 21, Balance of the brief, Intergraph transcript p293.

[113] Exhibit 11, Statement of Constable Kendall, dated 13 March 2008, p3.

[114] Transcript of evidence, p123.

[115] Transcript of evidence, p95.

[116] Transcript of evidence, p95.

[117] Transcript of evidence, p106.

[118] Transcript of evidence, p124.

for them to appreciate what decisions are being made and why and to consider other resources that may be required.[119]

145. In addition, none of the communications via the mobile phones are recorded and my ability to fully evaluate the decision to enter the premises, as opposed to cordon and contain, was hampered by a lack of access to recordings of those communications.

Use of gloves

146. The amount and extent of blood on Bayden's body and involved at the scene was a significant concern for SC Midson and Const Kendall both in terms of what this meant for Bayden's wellbeing and how they would modify their response tactics to prevent contact with the blood.

147. Prior to arriving at the scene, both members agreed to wear police issue gloves as a barrier against contact. Both members gave evidence that there was an extensive amount of blood at the scene and that Const Kendall's gloves tore during their struggle with Bayden.[120]

148. At Inquest, Senior Sergeant Miles gave evidence of the difficulties presented by blood and the use of gloves particularly finding a balance between a glove that provides adequate protection and one that still allows the officer to properly discharge their functions, including with respect to firearms.[121]

149. I have considered the use of gloves as an issue and note that their use is important to protect police officers from contamination of someone else's blood. However, the evidence of Senior Sergeant Miles is that it can also impede an officer's ability to operate a firearm and this has the potential to create even more risk to an officer's safety.

150. Consequently, I consider this issue becomes a matter of common sense for operational members when faced with an event such as this. Operational members are best placed to assess the risk of contamination versus the potential risk of not being able to use their firearm. Each situation is completely different to the last and there should be no hard and fast rule.

[119] Transcript of evidence, p124.

[120] Exhibit 11, Statement of Constable Kendall, dated 13 March 2008, p95.

[121] Transcript of evidence, p122.

Restraint of Bayden

151. The evidence is that Bayden had a psychotic illness and laceration injuries to his body and those injuries and his illness needed urgent medical treatment. The evidence is also that Bayden was strongly resisting the efforts of police to assist him, including running away from them and not being affected by the OC spray. Consequently some physical force was required which included being hit with a baton and having a foot placed on his back to place him in a safe position on the ground, so that he would be able to receive medical treatment.

152. Ambulance Officer Douglas Sadler said from "a medical point of view I was completely satisfied that the male was being cared for in an appropriate manner given the circumstances of him being restrained."[122]

153. Associate Professor Newton commented that this restraint by the police appeared to have been conducted without obvious excessive force given the intensity of the physical struggle and commented that the officers conducted themselves appropriately.[123]

154. Based on the evidence I am satisfied that SC Midson and Const Kendall were concerned for Bayden's welfare and intent on trying to get him medical attention. I find that the physical force used by the police members to restrain Bayden was not excessive and was reasonable in the circumstances.

Changes to practices at Victoria Police

155. Victoria Police provided evidence with respect to the approach taken by the organisation at the time of the Inquest and organisational changes that have occurred since Bayden's death.

Training

156. Superintendent Michael Williams advised that "training for managing incidents involving vulnerable persons continues to be an organisational priority for Victoria Police."[124] The

[122] Exhibit 15, Statement of Douglas Sadler 30 March 2008, p2.

[123] Exhibit 20, Statement of Associate Professor Newton dated 18 May 2012, p4.

[124] Statement of Superintendent Michael Williams, Victoria Police dated 9 March 2012, page 4.

evidence of Ms Perez was in accordance with this and she provided the court with a copy of the Victoria Police - Mental Health Strategy.[125]

157. Ms Perez indicated that police training has been updated and improved with a move away from training members on defensive tactics and firearms training and replacing it with incident management, communications and conflict resolution.[126]

158. Senior Sergeant Miles commented that it was sometimes a challenge to present the information in a way that maintains the members' interest. He noted that sometimes the attitude was: "Not again - I've heard this …last time and the time before. So our challenge is to try and change it around and try and change the way that we present it."[127]

Critical Incident Response Teams

159. The evidence given at Inquest was that if this incident occurred today, there would likely be better use of CIRT units, which have been expanded significantly since 2004.[128]

OC Spray

160. At the time of Bayden's death, OC Spray was available to all officers trained in its use. However, OC Foam has a longer reach so that officers do not have to get as close to the person, was only available to senior sergeants and to members of CIRT.[129] I note that OC Spray is no longer in production and OC Foam is now available more broadly to uniformed officers.[130]

Cordon and Contain

161. Senior Sergeant Miles indicated that the understanding of Victoria Police with respect to the benefits of cordoning and containing has changed since 2008. At Inquest Senior Sergeant

[125] Exhibit 17, Statement of Eva Perez, Acting Assistant Director for the Mental Health Portfolio, Victoria Police dated 6 March 2012, Appendix A.

[126] Exhibit 17, Statement of Eva Perez, Acting Assistant Director for the Mental Health Portfolio, Victoria Police dated 6 March 2012, pp6-7.

[127] Transcript of evidence, pp 138-139.

[128] Transcript of evidence, p119.

[129] Transcript of evidence, p125.

[130] Transcript of evidence, p125-126.

Miles commented that: "...we've got evidence now that creation of time gives you a greater level or heightened chance of a successful outcome at the end of the incident."[131]

Conclusions as to the appropriateness of the response by Victoria Police

162. I am grateful for the evidence of Superintendent Michael Williams, Senior Sergeant Miles,[132] and Ms Eva Perez[133] who assisted me in understanding and assessing the response by Victoria Police.

163. Whilst I did not have the benefit of witnessing SC Midson and Const Kendall's evidence, I have studied the transcript and consider their evidence to be wholly honest and reliable. It conveyed to me their level of concern for the welfare of Bayden.

164. I find their actions to have been appropriate in the circumstances. Their actions required a delicate act of balancing perceived risks of harm to Bayden, themselves, and the general public. The weight of the evidence suggests that safety was always their highest priority and that they were primarily concerned about Bayden's welfare and getting treatment for his injuries.

165. Nevertheless, the circumstances of Bayden's death provide a good opportunity to reflect on the protocols, guidelines and training for front-line members of Victoria Police responding to individuals in mental health crises.

166. In reviewing the circumstances of Bayden's death, I recognise that the work of first responders is dynamic, stressful, highly pressured and the information on which decisions are based can be imperfect.

167. I am also conscious of the fact that members of Victoria Police are not trained mental health practitioners and are expected to observe behaviours, rather than make clinical decisions. However, because they have many and varied contacts with people who are mentally ill, and the situations in which they are required to respond can be difficult and confronting, the mental health training for Victoria Police must continue to be prioritised and strengthened.

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[131] Transcript of evidence, p133.

[132] Senior Sergeant Andrew Miles is in Charge of the OSTT Unit within Victoria Police.

[133] Ms Perez manages the Mental Health Strategy Project within the Operations Coordination Department of Victoria Police.

168. I accept Victoria Police has recognised mental health training as important and has conducted a number of reviews in recent times that consider the effectiveness of both their training and operational models.

169. The evidence indicates that the training is an ever-evolving process and I commend Victoria Police for their commitment to ensuring that members are equipped with knowledge, information, practical suggestions and resources to provide them the best chance of resolving a difficult situation such as this.

170. If there is limited time available in the OSTT course and if members are already resistant to the concept of more training, concerted effort must be made to ensure that the training that is provided is effective, relevant and interesting.

Response by Ambulance Victoria

Background circumstances involving Ambulance Victoria

171. Ambulance Victoria received a call from ESTA at 12.11pm. The information received was that there was a 30 year old male, experiencing abnormal or suicidal behaviour. He was reported to be violent, although it was unknown whether he had a weapon. The caller indicated that the male had attempted suicide by laceration.

172. The call was coded as a Code 2, as it was not considered immediately life threatening which resulted in an ambulance being sent as soon as possible without use of emergency warning devices including lights and sirens. As a result, two ambulances were diverted from attending because of higher priority situations which were allocated a Code 1.

173. At 12.34pm police were instructed to advise when it was safe for an ambulance to approach the scene. At 12.45pm police notified Ambulance Victoria that it was.

174. At approximately 12.48pm, an ambulance containing Ambulance Officers Doug Sadler and Shannan Thomas, arrived at Dover Street, Albanvale, however, they were not able to locate the patient or police as they had been given an incorrect address. Upon further inspection, they noticed two police cars around the corner in President Street and they moved to that location.[134]

[134] Exhibit 15, Statement of Douglas Sadler dated 30 March 2008, p1; Exhibit 21, Balance of the brief, Statement of Shannan Thomas dated 14 May 2008, p153.

175. Upon their arrival, Douglas Sadler noted that a male police officer was kneeling beside Bayden, with no pressure being applied to him other than his wrists. Bayden's "head was to the side and he was breathing. He did not appear to be in respiratory distress."[135] Bayden was noted to have a Glasgow Coma Scale ("GSC") of 15, was orientated and obeyed commands but remained aggressive.[136]

176. The ambulance officers determined that he would need to be transported to the nearest hospital and that it was necessary to give him Midazolam to calm him down.[137] As they were preparing the sedative for injection, Bayden became limp and his GCS dropped to 6.

177. The ambulance officers asked the police to roll Bayden on to his back and the handcuffs were removed.[138] Mr Thomas inserted an oropharyngeal airway and applied assisted ventilations with 100% oxygen while Mr Sadler applied the monitor.[139] Bayden was pulseless and at 12.56pm, CPR commenced.

178. At 12.57pm, Intergraph was notified that Bayden had arrested and they required MICA attendance if possible and at 12.58pm, MICA was dispatched. At 12.59pm, spontaneous circulation returned and Bayden was moved to the back of the ambulance.

179. As another ambulance arrived, Bayden lost his pulse for a second time.[140] The MICA paramedic was due to arrive on the scene so the ambulance officers waited until he arrived to make a decision about ceasing CPR. When MICA paramedic Stewart Carroll arrived and formed a view of the current state of the patient, including that he was unconscious, there was no pulse, he was not breathing, his skin was pale and the cardiac monitor showed the rhythm to be asystole.[141] After this assessment, a joint decision was made to cease CPR.

180. Bayden was pronounced deceased at 1.12pm.[142]

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[135] Exhibit 15, Statement of Douglas Sadler dated 30 March 2008, p2.

[136] Exhibit 21, Balance of the brief, Statement of Shannan Thomas dated 14 May 2008, p153.

[137] Exhibit 15, Statement of Douglas Sadler dated 30 March 2008, p2.

[138] Exhibit 15, Statement of Douglas Sadler dated 30 March 2008, p2.

[139] Exhibit 15, Statement of Douglas Sadler dated 30 March 2008, p3.

[140] Exhibit 21, Balance of the brief, Statement of James Coates 19 March 2008, p149.

[141] Exhibit 21, Balance of the brief, Statement of Stewart Carroll, p160.

[142] Exhibit 15, Statement of Douglas Sadler dated 30 March 2008, p3.

Issues identified

181. The issues associated with the Ambulance Victoria response that were identified as part of this investigation were:

- the coding of the original call
- the delay of the ambulance response
- whether the attendance at the incorrect address had an impact on the outcome
- the decision to terminate resuscitation efforts.

182. Ambulance Victoria conducted an internal review and provided three additional statements[143] to assist with the investigation.

Coding of the original call

183. Mr Anthony Balm conducted a quality review of the incident. He commented that the call was coded based on the initial information received from Ambulance Victoria as "25B6V – 25 – PSYCH, B6 – UNKNOWN STATUS (3rd party caller), V - Violent".

184. When a call is received by ESTA, a response code is allocated on the basis of the urgency of the situation and using the Ambulance Victoria Clinical Resource Assignment Table to determine the appropriate ambulance response. This call was categorised as a Code 2[144], which resulted in an ambulance being sent without the use of the emergency warning devices including lights and sirens. This is primarily to ensure that police control the violent scene and weapon prior to arrival by ambulance paramedics.[145] Mr Balm was satisfied that the matter was correctly coded.[146]

Delay of the ambulance response

185. There was some delay in an ambulance attending the scene. This delay was investigated by Mr Hyatt and Mr Balm who both found that three ambulances had been diverted to higher priority jobs or because there was a closer ambulance. The first ambulance dispatched was diverted to a cardiac arrest, the second ambulance was diverted to an unconscious patient and

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[143] Statement of Bruce Hyatt dated 6 January 2009, Two statements of William Barger dated 8 May 2012 and 15 May 2012 and Exhibit 16, Statement of Anthony Balm dated 22 May 2012.

[144] Code 2 means for non-life threatening but urgent responses, non lights and sirens. As described in Exhibit 16 - Statement of Anthony Balm dated 22 May 2012, p.2.

[145] Statement of Bruce Hyatt dated 6 January 2009, p1.

[146] Exhibit 16, Statement of Anthony Balm dated 22 May 2012, p2.

the third ambulance was withdrawn because there was another ambulance available closer to the scene.[147] I find that there was a short delay but this was explained due to the fact that the allocated ambulances were diverted to other higher priority jobs, as they awaited notification from Victoria Police that it was safe to approach the scene.

Attending at the incorrect address

186. There is evidence that the first ambulance that attended was provided with the incorrect address. This occurred because of a miscommunication by Sergeant Chugg. However, I find that it did not negatively impact the overall response as the ambulance was quickly able to identify the error and attend the correct address.

Decision to cease resuscitation

187. When MICA paramedic Stewart Carroll arrived, the ambulance paramedics made a joint decision to cease resuscitation. James Coates stated that Stewart Carroll saw no prospect for the patient's survival and a joint decision was made to cease resuscitation.

188. In relation to this decision Stewart Carroll noted in his statement:

> I gained a history of the patient from the staff and formed a view of the current state of the patient. The patient was unconscious, there was no pulse and he was not breathing. His skin was very pale. The cardiac monitor showed the rhythm to be asystole.
>
> [...] I formed the view that this was most likely a traumatic cardiac arrest given the apparent stab wound to the epigastric region.
>
> Given that [...] patients suffering cardiac arrest secondary to penetrating truncal trauma can only be saved if in close proximity to a trauma centre, I considered further resuscitative attempts futile.[148]

189. This evidence is consistent with the other four paramedics present at the scene. I accept that it was a joint decision made by all the paramedics and based on the medical presentation of Bayden.

190. I find that based on the weight of the evidence that the decision to terminate resuscitation was reasonable and within acceptable practice.

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[147] Transcript of evidence, p76; Statement of Bruce Hyatt dated 6 January 2009.

[148] Exhibit 21, Balance of the brief, Statement of Stewart Carroll, p160.

<u>Conclusions as to the appropriateness of the response by Ambulance Victoria</u>

191. Based upon all the evidence, I find that Ambulance Victoria correctly coded the initial call, attended in a timely manner and the decision to cease CPR was appropriate in the circumstances.

FINDINGS

192. I find that Bayden Joel Quilkey died on 13 March 2008 from unascertained causes in the context of an acute episode of a psychotic illness and whilst being detained by police in St Albans.

193. I make no criticism of Mid West Area Mental Health Services and I find the personnel involved in the two telephone contacts with Adam Quilkey acted appropriately and in accordance with their knowledge, training and procedures at the time. I accept that NWMHS have implemented and developed many changes to their service since this incident, namely centralising their program and the provision of more consistent and standardised services to their clients. They should be commended for their continuous improvements.

194. I find that Victoria Police members SC Midson and Const Kendall were predominantly concerned with the welfare of Bayden and intent on helping him receive medical treatment. I accept that police officers have an unenviable task of being confronted with these types of issues on a daily basis and agree with Ms Perez that it is a dynamic, stressful and, at times, very difficult job. I accept that they drew upon their training and their experiences as front line police officers.

195. I find that police officers SC Midson and Const Kendall acted appropriately and without excessive force.

196. I find that Ambulance Victoria's response including the coding of the event, the attendance at the scene and the decision to terminate resuscitation efforts was appropriate in the circumstances.

COMMENTS

Pursuant to section 67(3) of the **Coroners Act 2008**, I make the following comment(s) connected with the death:

197. The actions of Adam in seeking assistance for the decline in his brother's mental health were admirable. To witness such an event is undoubtedly distressing and heartbreaking. I commend Adam on his devoted actions in trying to obtain assistance and medical support for his brother. I acknowledge the devastation experienced by the loss of a family member in tragic circumstances such as this.

198. Often a person suffering a psychotic episode, particularly for the first time, is the hardest to engage with due to their paranoid state. I acknowledge that in some circumstances it may not even be possible to engage with that person. Therefore it is crucial that organisations such as NorthWestern Mental Health support the ones that love them the most - their family and friends - in a time of crisis such as this. To this end, I have made a recommendation in line with this comment.

199. I acknowledge the work that Victoria Police has done in terms of improving their OSTT training, particularly in relation to dealing with vulnerable people with mental health issues. The circumstances of Bayden's death provide a good opportunity for Victoria Police to reflect on the protocols, guidelines and training for operational members responding to mental health crises and I urge them to continue with further developments and improvements, particularly in relation to keeping members interested enough to take on board the lessons required.

200. I would suggest that Victoria Police provide some clarity to operational members and consider issuing guidelines on the use of mobile phones whilst attending an incident. I acknowledge that in some cases it is appropriate to speak to supervising officers away from the traffic of Intergraph, however the value of hearing these conversations by supervising officers cannot be underestimated. Specifically, I consider that any decisions made by operational members during, or on the basis of, a mobile phone call should then be communicated and transmitted over the radio.

RECOMMENDATION

Pursuant to section 72(2) of the **Coroners Act 2008**, I make the following recommendation connected with the death:

> I recommend that NorthWestern Mental Health consider implementing a policy, procedure or guideline in relation to dealing with third party referrers as quasi customers or clients. The policy, procedure or guideline should require the triage clinician to provide information about mental health including possible symptoms and how to engage with the affected person, particularly when they are resistant to receiving help. It should also require the clinician to establish a clear action plan for the third party referrer, if the affected person's mental health deteriorates.

Pursuant to section 73(1) of the **Coroners Act 2008**, I order that the finding be published on the internet.

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

Adam Quilkey

Yvonne Swenson

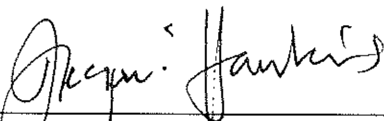
NorthWestern Mental Health Service

Ambulance Victoria

Chief Commission of Victoria Police

Inspector Harrington

Signature:



JACQUI HAWKINS
CORONER
Date: 7 February 2014