IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: 4308/06

FINDING INTO DEATH WITH INQUEST

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

Inquest into the Death of JAMES KELLOCK BLOOMFIELD

Delivered On:	19 April 2012
Delivered At:	Coroners Court of Victoria Level 11, 222 Exhibition Street, Melbourne 3000
Hearing Dates:	25 to 29 May, 2009 at Sale Magistrates' Court 17 and 18 September, 2009 and 12 to 16 April, 2010 at Melbourne Magistrates' Court William Street, Melbourne 3000
Findings of:	JANE HENDTLASS
Representation:	Mr Goetz appeared to assist the Coroner Mr Gipp and Mr Lawrie appeared for the Chief Commissioner of Police Ms Gardner appeared for Latrobe Regional Hospital and Bairnsdale Regional Health Service Mr McAteer appeared for S/C Kronk, Sgt McWilliam, L/S/C Newton, D/S/C Billing, Constable Johnston and Constable Brooks

I, JANE HENDTLASS, Coroner having investigated the death of JAMES BLOOMFIELD

AND having held an inquest in relation to this death on 25 to 29 May, 2009 at Sale Magistrates' Court, 17 and 18 September, 2009 and 12 to 15 April, 2010 at Melbourne Magistrates' Court at Melbourne

find that the identity of the deceased was JAMES KELLOCK BLOOMFIELD

and the death occurred on 12 November, 2006

at Alfred Hospital

from:

1a SEVERE BURNS

in the following circumstances:

1. James Kellock Bloomfield was 53 years old when he died. He had lived alone in an on-site caravan at the Applegum Caravan Park at 610 Princess Highway in Bairnsdale for about eight months.

2. The Applegum Caravan Park is registered with the East Gippsland Shire Council for 69 powered sites and 15 unpowered camp sites.

3. The Applegum Caravan Park had been subject to routine inspection on 12 July 2006. Items requiring attention included provision of fire fighting equipment and installation of additional fire hydrants. On 17 July 2006, the Country Fire Authority had certified that these recommendations had been achieved to satisfactory standard.

4. On 6 November 2006, a major electrical fault occurred at the caravan park and a temporary generator was installed to provide electricity to the caravan park residents. The caravan park owner turned off the generator between midnight and 6am each night to reduce the noise.

5. Over the next four days, Mr Bloomfield became distressed about the dark in the caravan park when the replacement generator was turned off.

6. On 10 November 2006, Mr Bloomfield visited a number of agencies in Bairnsdale asking for assistance to fix the power problem. In the course of some of these visits, he threatened to set himself on fire if the power was not restored that night.

7. At 1.59pm on 10 November 2006, Mr Bloomfield refused to voluntarily accompany police to the Bairnsdale Hospital so Acting Sergeant Peta Billing and three other police officers apprehended him

under section 10 of the *Mental Health Act* 1986. They took him to the Accident & Emergency Department at Bairnsdale Regional Health Service (referred to from here as Bairnsdale Hospital).

8. At 3.00pm on 10 November 2006, Dr Manpreet Heer examined Mr Bloomfield and referred him to mental health triage for mental health assessment.

9. At about 4.45pm on 10 November 2006, Mr Bloomfield left the Bairnsdale Hospital without being assessed by a mental health practitioner.

10. At 1.30am on 11 November 2006, Mr Bloomfield presented at the Accident & Emergency Department again. He was holding an empty petrol can and he told the nurse on duty, Phillip Somerville, that the electricity at the Applegum Caravan Park had been turned off again so he was going to buy some accelerant and set himself on fire.

11. At about 1.50am on 11 November 2006, Mr Bloomfield spoke to Mr Somerville again. He had filled the can with accelerant and was going back to the Applegum Caravan Park to burn it. Mr Somerville rang 000. He told them about Mr Bloomfield's threat which he interpreted as a threat to burn the caravan park.

12. At 2.13am on 11 November 2006, Senior Constable Stacey Kronk and Constable Michael Brooks returned to the Appletree Caravan Park. In the light of their headlights they could see Mr Bloomfield near the telephone box. He was dripping with some sort of liquid and was flicking a cigarette lighter.

13. In an attempt to make Mr Bloomfield drop the cigarette lighter, Mr Kronk sprayed him with Beacon oleoresin capsicum ("O/C") spray. The spark from the cigarette lighter ignited the solvent and/or propellant in the O/C spray. This flame then ignited the accelerant on Mr Bloomfield.

14. Mr Bloomfield sustained partial and full thickness burns to 90% of his body and airway burns. He was treated at Bairnsdale Hospital and then was airlifted to Melbourne.

15. At 6.11am on 11 November 2006, Mr Bloomfield was admitted to The Alfred hospital. However, he was diagnosed with non-survivable injuries and his condition continued to deteriorate.

16. At 5.45pm on 11 November 2006, active treatment was withdrawn and palliative care was instituted.

17. At 4.45am on 12 November 2006, James Bloomfield died.

18. The forensic pathologist who performed the autopsy and read the police report of death formed the opinion that the cause of death was self immolation.

19. However, I have not formed the belief that Mr Bloomfield intended to die. Accordingly, I find that James Bloomfield died from severe burns.[1]

20. This Finding will discuss in further detail the following issues:

- Mr Bloomfield's medical history;
- Night light crisis;
- Police response; and
- O/C spray.

21. It will then comment and make recommendations which are intended to prevent other people dying for the reasons that Mr Bloomfield died.

Mr Bloomfield's Medical History

22. Mr Bloomfield's medical history included hypertension, diabetes mellitus, hypercholesterolaemia, chronic stomach ulcer, epilepsy, hepatitis C, coronary artery atherosclerosis, schizophrenia/psychosis, alcohol, cannabis and opiate abuse, generalised anxiety disorder and borderline personality disorder, acquired brain injury as well as attempted suicide.

23. In 2002, he had also suffered head injury when he fell off a bicycle after having a seizure secondary to alcohol withdrawal. Metal plates were fitted in his head and, since then, he had experienced chronic facial pain.

24. Dr Peter Worboys was Mr Bloomfield's general practitioner. He practised from 438 Main Street in Bairnsdale. Mr Worboys told the Court:

[1] Dr Michael Burke confirmed he had no objection to this change in cause of death in an email to Coroners Court dated 5 March 2012.

"James was a difficult character to deal with.... more often than not James was under the influence of alcohol when I saw him, and even if it hadn't been that morning, certainly the quantity of alcohol that he drank, he would have still been affected the following morning when he saw me."

25. Dr Worboys routinely prescribed six Panadeine Forte (codeine & paracetamol) a day for pain in Mr Bloomfield's face. This was dispensed for three days at a time.

26. At 12.26pm on 20 October 2006, Mr Bloomfield last consulted Dr Worboys. He was still drinking heavily and had already had five glasses of wine. He told Dr Worboys he sold some of his Panadiene Forte for 'grog' and had none left. Dr Worboys noted:

"Disappointed.... and doubt we are helping James much with his problems."

27. Dr Worboys continued his prescription for 180 x 500mg/30mg Panadiene Forte. Coastcare Pharmacy also dispensed Panadeine forte to Mr Bloomfield on 20 October 2006. He was away when Mr Bloomfield died.

28. In the second half of 2006, Mr Bloomfield also consulted two other general practitioners in Bairnsdale:

- On each of 18 July, 21 July, 24 July and 27 July 2006, Dr Bob Irungu prescribed 20 codeine & paracetamol.
- On 22 September 2006, Dr Tomasz Grabinski prescribed 20 codeine & paracetamol.

29. In addition, Mr Bloomfield was a client of the Gippsland and East Gippsland Aboriginal Cooperative Medical Centre at 37 Damahoy Street Bairnsale:

- His treating doctor was Dr Margaret Niemann. Mr Bloomfield consulted her once in 2006.
- On 27 September 2006, Dr Niemann referred him for detoxification at Bairnsdale Regional Health Service because he was booked to have a surgical procedure on his face at the Royal Melbourne Hospital on 9 October 2006.

30. Mr Bloomfield was also a patient at the Royal Melbourne Hospital:

- On 28 June 2006, Dr Worboys referred him back to Royal Melbourne Hospital outpatients because the steel plate in his face had begun to protrude through his gums into his mouth and he was suffering chronic left suborbital pain. Examination confirmed these diagnoses and he was referred for CT, further review by the Pain Control Clinic and surgery on 18 September 2006.

- On 30 July 2006, he presented to the Emergency Department requesting analgesia because he had left his in Bairnsdale and he was due for a CT scan next day. He was given a prescription for 10 Panadiene Forte to cover the next 24 hours.

- On 9 October 2006, he presented at the Pain Control Clinic at Royal Melbourne Hospital. He was drunk and abusive and threatening to sue the hospital. He also refused to see the anesthetist who was going to assess him for surgery. Mr Bloomfield was removed from outpatients by security because of abusing the staff there.

- He told Dr Anderson he was on a waiting list for surgery at the Royal Melbourne Hospital.

31. Mr Bloomfield was a client of Gippsland Centre Against Sexual Abuse:

- He saw them monthly until 28 August 2006 before a series of missed appointments.
- He was afraid of the dark because it brought back childhood memories and flash backs of being sexually assaulted by family members and in prison.
- He would overcome this fear by leaving the television on all night with the sound turned down.
- He had seen his father suffer severe burns when he had attempted suicide by throwing himself into a fire.

32. Mr Bloomfield was also well known to Bairnsdale Hospital. During 2006, he presented in the following circumstances:

- On 2 January, he presented at the Accident and Emergency Department for a Pandiene Forte script. This was provided.
- On 14 January, he presented at Accident and Emergency Department with suicidal thoughts running through his head. He was discharged home with clonazepam, temazepam and psychiatry services were to contact him in 1-2 days.
- On 28 March, he was admitted to Bairnsdale Hospital for four-day alcohol detoxification followed by community-based withdrawal through mental health and drug and alcohol services.
- On 3 April, he presented at the Accident & Emergency Department. He was discharged with advice for home-based detoxification.
- On 22 June, he presented at Accident & Emergency Department with psychiatric symptoms. He was discharged home.
- On 13 July, he presented with groin pain. He was diagnosed with a left inguinal hernia.
- On 25 July, he was admitted overnight for repair of an inguinal hernia.

- On 27 September, John Anderson from Alcohol & Drug Services reviewed Mr Bloomfield after Dr Niemann's referral.
- On 1 October, he discharged himself after four days of a five day detoxification programme to continue at home on Campral four a day and continuing Panadiene Forte. Dr Stuart Anderson prescribed 40 tablets of Panadiene Forte at six per day and referred him back to Dr Worboys.
- On 11 and 13 October, he was dispensed codeine & paracetamol and Campral prescribed by Dr Anderson.

33. Mr Bloomfield was also known to Gippsland Mental Health Services:

- On 4 October 2005, he was admitted as an involuntary patient to Flynn Unit at Traralgon Hospital. He was diagnosed with drug-induced psychosis and discharged as a voluntary patient on 21 October 2005. He was referred for short term case management and triage through Bairnsdale Community Mental Health.
- On 15 January 2006, the Accident & Emergency Department at Bairnsdale Hospital referred him to Bairnsdale Community Mental Health after he presented as suicidal. She assessed Mr Bloomfield no psychotic features or sustained depressive features and not requiring case management with their service at that time.
- On 25 January 2006, he was registered with Bairnsdale Community Mental Health. He was assessed as low to moderate risk, diagnosed with alcohol abuse and not accepted for service.
- On 27 March 2006, he was referred to Bairnsdale Community Mental Health. He was assessed as low risk, diagnosed with Alcohol & Drug service requirements and not accepted for service.
- On 31 March 2006, he requested assessment by Sue Mulkearns at Bairnsdale Community Mental Health because he felt he had psychiatric issues. He had no suicidal ideation and was referred for Team Review. Ms Mulkearns is a psychiatric nurse employed by Latrobe Regional Hospital at Bairnsdale Community Mental Health Service. Ms Mulkearns was also involved in Mr Bloomfield's management on 10 November 2006.
- On 3 April 2006, a Team Review at Bairnsdale determined his problem was primarily alcohol abuse and no Treatment Plan was completed.
- On 8 May 2006, Bairnsdale Community Mental Health Services told Gippsland Centre Against Sexual Assault that he did not meet the criteria for their services because he had an acquired brain injury. Therefore, no case manager had been allocated to him.

34. On 8 October 1992, Mr Bloomfield was convicted for criminal charges involving cannabis, burglary and theft and placed on a Community Based Order. Therefore, although he was known to Bairnsdale police as a resident of the Applegum Caravan Park, he had otherwise come to police attention

only as a victim of bicycle theft in 1999 and 2001 and of burglary in 1999. He had no history of violent offences.

Night light crisis

35. On 6 November 2006, a major electrical fault occurred at the caravan park. This fault involved a break in the electrical supply cable and a short between two phases of the power supply. This could only be remedied by digging up and replacing the underground cable.

36. While this work was being organised, a replacement generator was installed to provide electricity to the caravan park residents. The caravan park owner turned off the generator at midnight each night to reduce the noise.

37. Over the next four days, Mr Bloomfield became distressed about the lack of light between midnight and 6am when the replacement generator was turned off because he was unable to cope with the dark and it raised memories of his previous sexual assaults.

38. Mr Bloomfield complained to the Manager of the Applegum Caravan Park, Laurie Sansom. On or about 7 November 2006, Mr Sansom conveyed these complaints to Senior Constable Wayne Handley and said that Mr Bloomfield thought they were personally directed at him.

39. On or about 8 November 2010, Mr Bloomfield also complained to his friend, Ms Anne Cooper. Ms Cooper had known Mr Bloomfield for about 19 years. He visited her house nearly every day as an escape from the caravan park.

40. In that week, Mr Bloomfield also went to the Accident & Emergency Department. He was agitated and he was concerned about not having light and he complained about the lack of power at the Applegum Caravan Park. He spoke to Nurse Evan Jenkins. Mr Jenkins knew Mr Bloomfield from previous presentations at Bairnsdale Hospital.

41. Mr Jenkins had no reason to believe that Mr Bloomfield had a mental health issue. He told the Court:

> *"I believe that if we had a mental health patient that we thought needed to be assessed we would call (mental health triage). We would call. I think that the senior staff in the department have worked there long enough now to be able to make that call"*

Rather, Mr Jenkins advised Mr Bloomfield to speak to the special housing accommodation people to see if there was anything that they could do for him. Mr Jenkins gave Mr Bloomfield $40 to buy a lantern.

42. At 1.00am on 10 November 2006, Mr Bloomfield returned to the Accident & Emergency Department at Bairnsdale Hospital. Nurse Phillip Somerville was on duty. Mr Bloomfield was distressed and anxious because of the dark. He also told Mr Somerville:

"What do I have to do to get attention? Do I have to set fire to myself?".

Mr Somerville did not know Mr Bloomfield. Mr Somerville gave him batteries for his torch.

43. Mr Somerville did not record Mr Bloomfield's presentation early on 10 November 2006 because Mr Bloomfield did not need a medical assessment or a psychiatric assessment. If there was no admission form required, there was nowhere to write about people who came in for a cup of coffee or batteries. Mr Somerville explained to the Court:

".... the first time that James attended he wasn't triaged or clerically processed .... if I don't clerically admit them I haven't got anything to write on."

44. At 8.30am on 10 November 2006, Mr Bloomfield visited Anne Coopers' house at 55 Davies Street in Bairnsdale for a cup of coffee. He stayed about 45 minutes. Ms Cooper said Mr Bloomfield was:

"Very angry and frustrated and didn't like the idea of being in the dark, and that I couldn't fathom why he went back up there. I said to him, "You can come and stay here with us and that way then you've got the light on".

45. Mr Bloomfield left on Mrs Cooper's daughter's bicycle.

46. On 10 November 2006, Mr Bloomfield also visited a number of agencies asking for assistance to fix the power problem:

- At 11.00am, Mr Bloomfield spoke to Heather Flukes at the Gippsland Lakes Community Health Centre for about 50 minutes. He was upset and angry about the power being turned off at the caravan park. He threatened to set himself on fire if the power was turned off again at midnight.
- At 12.20pm, Mr Bloomfield made these threats to Anne Hiscock at the Department of Human Services and Elizabeth Noone at Community Housing Victoria Ltd. He also told them he had been sexually abused as a child and explained this was one reason he could not be left I the dark.
- At 12.32pm, Ms Noone contacted the manager of the Applegum Caravan Park. At 12.36pm, she contacted the Rick Lightowler at Bairnsdale Hospital. At 12.40pm, she contacted the mental health triage at Latrobe Hospital. At 12.42pm, she contacted the Bairnsdale Police Station.

- At 12.51pm, Ms Flukes also contacted the Bairnsdale Police Station. At 12.58pm, Ms Flukes rang police to say Mr Bloomfield was back and she would keep him there.
- At about 1.40pm, the Department of Human Services contacted the Bairnsdale Police Station to say that Mr Bloomfield had been at their office 20 to 30 minutes earlier saying he was going to set himself alight.

Police Response

47. At 12.36pm, 12.51pm and 12.58pm on 10 November 2006, Acting Sergeant Peta Billing took the phone calls from Ms Noone and Ms Fluke reporting that Mr Bloomfield had been to the Accident & Emergency Department on the previous night and that he intended to set himself on fire tonight. At 1.40pm, Leading Senior Constable Bryce Dilley also took the phone call from the Department of Human Services.

48. Ms Billing contacted the Accident & Emergency Department at Bairnsdale Hospital and the Bairnsdale Community Mental Health Service to obtain information:

- At 12.21pm, she spoke to Loy Jubb who was associate unit manager of the morning shift at the Accident & Emergency Department at Bairnsdale Hospital asking for information about a person who claimed to have been at the hospital on the previous night and had been given torch batteries. Ms Billing told Ms Lubb that the person was threatening to 'torch himself' and it was likely that the police would come to the hospital later with this person.

- At 1.03pm, she contacted Ms Kerr at the Bairnsdale Community Mental Health Service. Ms Kerr was also performing the role of receptionist at the Bairnsdale Community Mental Health Service. In the course of this brief telephone conversation, Ms Billing told Ms Kerr she was bringing Mr Bloomfield in to the Accident and Emergency Department at Bairnsdale Hospital.

49. Ms Kerr told Ms Billing that Mr Bloomfield had a mental health history but he was not currently being case managed. She also told Ms Billing that the psychiatry triage nurse in Traralgon was the appropriate contact point to make this referral and provided her with the telephone numbers.

50. In evidence, Ms Kerr confirmed that the appropriate course of action in the circumstances was for police to ring the psychiatry triage nurse in Traralgon when they referred Mr Bloomfield for assessment. This advice applied whether or not he was a referral under section 10 of the *Mental Health Act* 1986.

Further, in any conversation between police and the psychiatry triage nurse, she expected that police would provide the triage nurse in Traralgon with information about what had occurred, the areas of concern that police were experiencing and how quickly the assessment was required.

51. Ms Kerr also expected that the mental health triage nurse in Traralgon would categorise the urgency of the case based on the information provide by police and would then contact the duty worker in Bairnsdale to allocate the assessment and inform them of the background facts and the triage category they had determined. The duty worker would then respond without necessarily waiting for the Accident and Emergency Department to inform them that the patient had presented there.

52. In evidence, Ms Billing confirmed that she did not contact the psychiatry triage nurse in Traralgon.

53. At 1.25pm, Mr Bloomfield returned to Gippsland Lakes Community Health Centre. He was writing out a list of phone numbers for them to contact if he set himself on fire that night. Ms Flukes contacted Bairnsdale Police Station again. In her internal report about the incident, Ms Flukes wrote:

> *"The police responded within 10 minutes of my call. Two female officers attended (Peta Billings and one of the policewomen). James would not co-operate with them, they wanted to take him to hospital, they called for back up. James still refused to accompany them to the hospital, he was saying the only way to get him there was by force. James did not want to go in the back of the police van as he is afraid of the dark. Peta Billings offered to take him in the police sedan, he again refused. Another police officer was called, he arrived driving a 4 wheel drive vehicle. The four police officers in attendance tried to "coax" James into the vehicle, he kept refusing. Finally James was forced into the back of the police van and taken to Bairnsdale hospital. James by this time was extremely distressed."*

54. At about 1.39pm, Ms Billing and Constable Brook Johnstone left the Bairnsdale Police Station in the Bairnsdale Holden Crewman divisional van. They met Mr Bloomfield at the Gippsland Lakes Community Health Centre. Ms Billing told the Court:

> *"When we arrived at Lakes Community Health he was OK with us until the conversation turned to him having to go to the hospital and sort of from that point it deteriorated quite significantly,* ***especially when we had to wrestle him in the back of the van and when we got him out to the hospital he absolutely hated us, didn't want us to be there at all and we were certainly making him significantly more agitated with our presence."*** (my underlining)

55. During Ms Billing's 40 minute conversation with Mr Bloomfield at Lakes Community Health, he became very agitated with a slightly raised voice talking extremely fast and sweating profusely. He

repeated his threat to set fire to himself. Mr Bloomfield also refused to voluntarily accompany police to the Bairnsdale Hospital because he did not want to travel in the dark in the back of the divisional van. Ms Billing offered Mr Bloomfield the option of travelling in a police sedan but he refused that too.

56. Ambulance Services Victoria is the lead agency for emergency transport of people with a mental illness. Therefore, the Protocol between Victoria Police and the Department of Human Services Mental Health Branch required police to facilitate ambulance transfer of section 10 patients. In evidence, Ms Billing told the Court that she understood that ambulance transport was the first option. However, she implied that Mr Bloomfield was unsuitable for and she did not seek assistance from Rural Ambulance Victoria.

57. At 1.51pm, Ms Billing formed the opinion that Mr Bloomfield appeared to be mentally ill and was likely to cause serious bodily harm himself or to some other person. Therefore, she called for police back-up to help her apprehend him under section 10 of the *Mental Health Act* 1986. She told Mr Bloomfield she was performing a section 10 apprehension and, when Mr Bloomfield asked whether he was under arrest, Ms Billing confirmed he was.

58. Ms Billing and three other police officers placed Mr Bloomfield into the back of their Victoria Police divisional van before they transported him to the Bairnsdale Hospital. Ms Flukes told the Court:

> ...."*the two policewomen that attended initially had to call for backup and so another policeman arrived and he subsequently called for more backup and another police vehicle arrived, this was a four-wheel drive, so there was actually four police in attendance. Peta also tried to encourage James Bloomfield to get ... into the back of a police sedan which he - by this he was extremely, extremely agitated and very distressed and he was saying at this stage, "Well, no, the only way you're going to get me to the hospital is by force", and unfortunately that's exactly what happened. There was four police - policemen did physically pick him up and place him in the back of a divisional van."*

59. However, Ms Billing did not form the opinion that Mr Bloomfield had made a connection between this intention to set himself on fire in protest against the lights being turned off at Applegum Caravan Park and the likely consequence of his being burned. She did not think he thought he would die.

60. At 2.15pm, Ms Billing notified police communications that they were leaving Lakes Community Health Centre and heading for Bairnsdale Hospital with a person they had apprehended under section 10 of the *Mental Health Act* 1986. Ms Billings left Mr Bloomfield's bicycle at Gippsland Lakes Community Health Centre. She said they would pick it up before 5pm.[2]

[2] Ms Billing also seized Mr Bloomfield's "Bic" type cigarette lighter. At 2.10pm, Ms Billing gave Mr Bloomfield's cigarette

61. Therefore, I find that Mr Bloomfield's transfer to Bairnsdale Hospital was executed under the authority and carried with it the obligations of section 10 of the *Mental Health Act* 1986 and associated provisions in the Victoria Police Manual.

Accident & Emergency Department at Bairnsdale Hospital

62. At 2.17pm on 10 November 2006, Ms Billing notified police communications that she was at the Bairnsdale Hospital with Mr Bloomfield.

63. Ms Billing and Ms Johnstone then approached Ms Jubb in the Accident & Emergency Department at Bairnsdale Hospital. Ms Billing told Ms Jubb that she had already contacted Ms Kerr from Bairnsdale Community Mental Health Service. She also directed Ms Jubb to contact Ms Kerr to tell her that Mr Bloomfield had arrived.

64. Ms Billing also told the Court she told Ms Jubb that Mr Bloomfield was transported under section 10 of the Mental Health Act 2006. Ms Jubb denies knowing that Mr Bloomfield was transported subject to section 10 of the *Mental Health Act* 1986.

65. Ms Jubb went into the Emergency Department to prepare the so-called 'plaster room' cubicle also known as Cubicle 5 to make it safe for a mental health patient. Cubicle 5 was a curtained partition in the Emergency Department near the ambulance bay and the desk where ambulance officers could complete their paperwork. She then went outside and told the police that the cubicle was ready.

66. In the meantime, Mr Bloomfield was outside in the ambulance bay with two male police officers. Another Accident & Emergency Department nurse, Rick Lightowler. Mr Lightowler told the Court that he saw and heard that Mr Bloomfield was agitated and swearing loudly. He presumed the tirade was about the power at the Applegum Caravan Park.

67. In evidence, Ms Billing and Mr Lightowler said that Mr Bloomfield relaxed while they had a cigarette outside the Accident & Emergency Department at Bairnsdale Hospital. Therefore, sometime before 2.30pm, Mr Lightowler told police that he had control of the situation and they could leave. He

lighter to Rick Lightowler and told him not to give it to Mr Bloomfield. At 3.10pm, Mr Lightowler gave Mr Bloomfield's cigarette lighter to Caroline Overy. At about 5.00pm, Ms Overy gave Mr Bloomfield's cigarette lighter to Mr Jenkin. However, Mr Jenkin says that he used his own lighter when he took Mr Bloomfield for another cigarette. At about 3.30pm, Ms Overy gave the cigarette lighter to Mr Bloomfield so that he could have a cigarette. He returned the lighter when they came inside. There is no evidence that Mr Bloomfield had further access to it. This cigarette lighter has since disappeared. It is not the cigarette lighter involved in Mr Bloomfield's ignition and death.

also said he would call them if he needed them. Accordingly, Ms Billing handed Mr Bloomfield over to Mr Lightowler.

68. In so-doing, Ms Billing admitted she was unclear about the distinction between a mental health assessment and a psychiatric examination. Ms Billing believed a "registered medical practitioner" to be a doctor or a registered nurse.

69. Ms Billing also told the Court that she told Mr Lightowler that Mr Bloomfield had been transferred subject to section 10 of the *Mental Health Act* 1986. Further, she said that Mr Lightowler said Mr Bloomfield would be assessed as required under the *Mental Health Act* 1986.

70. However, Mr Lightowler also denies knowing that Mr Bloomfield was transported subject to section 10 of the Mental Health Act 1986. His understanding was that police were required to stay with the patient if he had been transported under section 10 of the *Mental Health Act* 1986. If they bring patients to the Accident & Emergency Department under some other authority, he believed they do not have to stay. Mr Lightowler also said:

> *".... my understanding is if the police bring someone it's involuntary, and they're not s.10, they don't have to stay; if they're s.10 they're obliged to stay, and if they're s.10 they're obliged to call triage."*

71. However, Mr Lightowler says he did not know Mr Bloomfield had been apprehended under section 10 to the *Mental Health Act* 1986. Although he did not presume he came to the hospital voluntarily because the police were with him, Mr Lightowler presumed Mr Bloomfield remained at the hospital voluntarily:

> *"At the time I didn't feel that he was - after talking to him I didn't feel he was a threat to myself or any of the staff in the department. He calmed down quite a lot and I was happy for the police to go."*

72. Mr Lightowler also told the Court he was not worried about Mr Bloomfield's threat to set himself on fire:

> *"At the time I wasn't greatly worried about it. He said it once and then he walked off and said he wanted to have a smoke, and so I said to him, "No worries, well, go and have a smoke...*
>
> *.... after talking to him I didn't feel he was a threat to myself or any of the staff in the department. He calmed down quite a lot and I was happy for the police to go."*

73. Ms Billing and the other three police officers were at the hospital for about 15 minutes. There is no evidence that Ms Billing formally released Mr Bloomfield from custody. There is also no evidence

before me that she left Mr Bloomfield prematurely because she was called out to another more important job.

74. At 2.30pm, Ms Billing notified police communications that they had left the hospital.

75. Mr Lightowler stayed outside with Mr Bloomfield for about 10 minutes so that he could calm down further and have another cigarette. He then persuaded Mr Bloomfield to come into the Accident & Emergency Department and placed him in Cubicle 5. Mr Bloomfield was still ranting about the power being cut off at the caravan park and Mr Lightowler told the Court he stayed with Mr Bloomfield most of the time until he went off duty at about 3.15pm.

76. At 2.25pm on 10 November 2006, Mr Lightowler triaged Mr Bloomfield as Category 5 according to the National Triage Scale.[3] Category 5 is the least urgent category available and requires assessment by a medical officer within two hours. At 2.56pm, he also organised his urine samples and blood tests.

Afternoon Shift

77. On 10 November 2006, Dr Manpreet (Mannie) Heer was the first year resident medical officer on duty. He was two weeks into his 12 week placement at Bairnsdale Hospital. At Bairnsdale Hospital, first year medical officers are supervised by senior medical staff during office hours and by registrars and senior doctors at weekends.

78. At about 3.00pm on 10 November 2006, Dr Heer examined Mr Bloomfield at Bairnsdale Hospital. He did not consult or need to consult with the senior medical staff supervising him. He did not consult with Mr Lightowler. Mr Bloomfield's breath test indicated his blood alcohol concentration was 0.072g/100mL. His urine screen indicated cannabis use but it was negative for opioids and amphetamines. His blood tests were essentially within normal limits.

79. Dr Heer recorded in the hospital notes that Mr Bloomfield said he would burn himself to death with gasoline if the Applegum Caravan Park manager turned off the lights again tonight. Accordingly, Dr Heer assessed Mr Bloomfield as moderate risk of self harm and suicidal ideation and referred him for mental health assessment. The Court heard that the senior medical officer on duty should have reviewed Mr Bloomfield's management but there is no evidence that this occurred on 10 November 2006.

[3] Bairnsdale Regional Health Service "Triage AE/3" April 2006.

80. At 3.10pm on 10 November 2006, Mr Lightowler handed over care of Mr Bloomfield to Mr Jenkins. At 3.20pm, Mr Lightowler and Ms Jubb went off duty and left the hospital.

Mental health triage and assessment

81. Some time before 2.56pm on 10 November 2006, Ms Jubb attempted to contact Ms Kerr at Bairnsdale Community Mental Health Service but she was on the phone. She left a message that the patient she was expecting had arrived. Ms Kerr denies getting that message.

82. Sue Milkearns was the mental health practtioner on duty at the Bairnsdale Community Mental Health Service on 10 November 2006 . Between 2 and 3pm, Mr Jenkins approached Ms Milkearns in the Accident & Emergency Department and asked her to look at Mr Bloomfield. Ms Milkearns advised Mr Jenkins to organise a drug screen and a preliminary breath test before Mr Bloomfield was examined by a medical officer. She did not speak to Mr Bloomfield. She did not speak to Ms Kerr until she went back to the Community Mental Health Service office at 4.45pm.

83. Mr Jenkins said that it was routine practice to use blood and urine tests to rule out any organic or a substance issues that that might affect their mental health assessment and to know if somebody is drug-affected.

84. On 10 November 2006, Peter Foote was the mental health triage nurse on duty at Latrobe Regional Hospital.

85. At 4.30pm on 10 November 2006, Dr Heer contacted Mr Foote and left a message about Mr Bloomfield. At 4.38pm, Mr Foote returned Dr Heer's call and they had a six minute conversation. Mr Foote was not aware that Mr Bloomfield had presented subject to section 10 of the *Mental Health Act* 1986.

86. In his written referral, Mr Foote says he questioned the appropriateness of referring Mr Bloomfield to psychiatry triage. However, Dr Heer insisted on his assessment because he deemed Mr Bloomfield to be a risk of suicide and was reluctant to send him home without a mental health assessment.

87. The outcome of triage assessment and the Triage Response Criteria code selected on the mental health triage scale is based on the triage clinician's decisions about:

- the person's need for specialist mental health services
- the level of risk to the person and/or others

- the urgency of the response required from mental health or other services.

88. Accordingly, Mr Foote accepted Mr Bloomfield for assessment by a mental health practitioner and recorded that the Mental Health Triage Response Criteria 2. At 4.45pm, he notified the duty mental health practitioner at Bairnsdale Community Mental Health Service, Sue Mulkearns. I am unable to say whether Dr Heer was aware of the results of Mr Foote's assessment and its implications for delay.

89. At 4.45pm, Mr Foote rang Ms Mulkearns and faxed the Psychiatry Triage Referral Sheet to her. Ms Mulkearns was due to go off duty at 5.00pm when Gillian Kerr took over as mental health practitioner on duty.

90. However, at about 4.45pm, Mr Bloomfield had left the Bairnsdale Hospital. He told Mr Jenkins that he was going to get his bicycle from the front of the office of the Member of Parliament and collect his Panadeine Forte from the chemist. Mr Bloomfield said he would return to the hospital after that. Mr Jenkins did not object.

91. Mr Jenkins was not aware that Mr Bloomfield had presented subject to section 10 of the *Mental Health Act* 1986. Unless he had been told by Dr Heer, he could not have known about his recent mental health triage allocation. Therefore, I presume Mr Jenkins had made the judgement based on the information available to them that he did not meet the criteria for involuntary treatment imposed by section 8 of the *Mental Health Act* 1986.

92. Further, when Ms Billing contacted the Accident & Emergency Department at 4.45pm to make arrangements about Mr Bloomfield's bike, Mr Jenkins told her that he had left. No further information was sought or given.

93. At about 4.50pm, Ms Kerr arrived at the Accident & Emergency Department at Bairnsdale Hospital to assess Mr Bloomfield. At this time, Mr Jenkins informed Ms Kerr that he had gone down the street to collect his bicycle and medication from a local pharmacy. She told them to contact her when he returned.

94. Ms Kerr was surprised that Mr Bloomfield had been allowed to leave the Accident & Emergency Department:

> *"I guess I was pretty shocked initially because he was a Category 2 and regarded as being seriously unwell, and that he'd actually gone down the street to pick up his medication I thought was not the usual situation you would find."*

95. Latrobe Regional Hospital Mental Health Service policy requires the Emergency Department staff to notify police when a patient who has presented subject to section 10 of the *Mental Health Act* 1986 leaves prior to their mental health assessment being completed.

96. However, Ms Kerr says that she was not told that Mr Bloomfield had been brought to the hospital under section 10 on the *Mental Health Act* 1986. Further, she told the Court that she had no reason to believe that Mr Bloomfield was at risk in a manner that attracted a duty to inform police if he absconded. Therefore, she did not notify police of his departure.

97. Rather, at 5.00pm, Ms Kerr rang Mr Foote to say that Mr Bloomfield had left the Emergency Department without mental health assessment. He did not notify police of Mr Bloomfield's departure.

98. Mr Bloomfield returned to Ms Cooper's house for about 45 minutes and picked up another bicycle. He was fuming and said police would not let him have Ms Cooper's daughter's bicycle back. Ms Cooper said:

> *"He was just so angry that he wouldn't say a lot, he'd just say he was just really pissed off with people, that no one was listening and no one gave a damn and no one wanted to clear up the caravan park."*

99. At 5.30pm, Mr Bloomfield returned to the Bairnsdale Hospital and threatened to burn property at the caravan park. Dr Heer rang Mr Foote to say that Mr Bloomfield had returned and required assessment. Hospital staff also re-contacted Ms Kerr directly to arrange his assessment.

100. At 5.30pm, Mr Foote contacted Ms Kerr and advised her that Mr Bloomfield had returned and that his major diagnosis was related to drug and alcohol problems. He obtained that information from reviewing the statewide register of clients who have a mental health problem.

101. At 5.50pm, Mr Bloomfield left the Bairnsdale Hospital again through the ambulance bay. As he passed ambulance officer Simon Walsh, he said to himself in a loud voice that he was not being attended to by "psych services". Mr Walsh told Nurse Angela Lawlor about these comments. Ms Lawlor recorded Mr Bloomfield as discharged without medical approval. She did not know Mr Bloomfield had presented subject to section 10 of the *Mental Health Act* 1986 so she did not report his disappearance to police.

102. At 5.55pm, following her conversation with Mr Foote, Ms Kerr returned to work and attended the Accident & Emergency Department again. Mr Bloomfield was gone again. She could not find his

medical and nursing notes for earlier in the day but she reviewed his urine drug screen and noted in the mental health file that these results were inconclusive. She told the Court the indicators were so pale that she did not know whether they were positive or not. Ms Kerr spoke to Dr Heer and they agreed they would assess him involuntarily when he returned.

103. At 5.55pm, Ms Kerr rang Mr Foote to say that Mr Bloomfield had left again and mental health workers would await further contact with the Accident & Emergency Department.

104. At 7.00pm, Mr Bloomfield returned to Ms Cooper's house. Ms Cooper said that Mr Bloomfield had bought a cigarette lighter with a child proof mechanism during the week but he was having trouble using it. Her 12 year old son had shown Mr Bloomfield how to operate it. She had also given him a normal Bic lighter so he would have two.

105. By 8.30pm, Mr Bloomfield had left Mrs Cooper's house on her son's racing bicycle.

106. At 7.00pm, Sergeant Ben McWilliam, Senior Constable Stacey Kronk, Senior Constable Handley and Constable Brooks came on duty at Bairnsdale Police Station. This shift would normally involve six hours on the van and six hours in the station.

107. Mr McWilliam recorded very detailed notes of his conversation with Ms Billing when she handed over responsibility for Station Sergeant duties. These notes indicate that Ms Billing said that Mr Bloomfield had been detained under section 10 of the *Mental Health Act* 1986 because he was threatening to set himself alight. She explained to Mr McWilliam that there was a dispute between Mr Bloomfield and the management at Applegum Caravan Park because they turned off the power at midnight and he was frightened of the dark. The hospital had given him batteries for his torch but there was still a possibility that he would become a concern again during the night shift.

108. Ms Billing and Mr McWilliam also say Ms Billing told Mr McWilliam that Mr Bloomfield had been released from the hospital and what had happened during the day before they had arrested him. However, Mr McWilliam did not record this information in his notes.

109. Further, there is no evidence that Ms Billing knew that he had not been assessed before he left the hospital at 4.45pm or that she knew he had returned and left again at 5.40pm. It is also unclear whether Ms Billing understood that, if she knew Mr Bloomfield had absconded from Bairnsdale Hospital without assessment, police were responsible for further detaining him and returning him for assessment.

110. At about 8.10pm, Mr Brooks and Mr Handley saw Mr Bloomfield at the Applegum Caravan Park when they were there on another matter. Mr Brooks had not seen him before or heard his name. They were also unaware he had absconded from hospital and did not arrest him.

111. Other residents at the Applegum Caravan Park also told police that Mr Bloomfield was walking around the property with a torch during the evening saying he that he was going to set himself alight.

112. At 10.45pm, Mr Somerville commenced night duty again in the Accident & Emergency Department at Bairnsdale Hospital. He was the only nurse on duty. The afternoon shift did not mention Mr Bloomfield in their handover of information.

11 November 2006

113. At 1.01am on 11 November 2006, police communications despatched the Bairnsdale divisional van with Mr Handley and Senior Constable Stacey Kronk to the Applegum Caravan Park. They understood that Mr Bloomfield was at the Applegum Caravan Park and had made more threats to "torch himself". They remained unaware of his previous contact with police.

114. At 1.30am, Mr Bloomfield returned to Bairnsdale Hospital. He spoke to Mr Somerville for less than five minutes. Mr Somerville remembered Mr Bloomfield from the night before but he did not know he had been back during the day and had absconded.

115. Mr Bloomfield spoke to Mr Somerville for close to 20 minutes. He was agitated and angry and delivered basically a one way tirade. He complained about the power and left saying he was getting some petrol but he did not mention self harm in any explicit way. Mr Somerville did not get the opportunity to assess Mr Bloomfield's mental condition. He presumed he was getting the petrol to fuel the generator.

116. Mr Bloomfield then went to Ms Cooper's house and poured a mixture of flammable liquids into an empty plastic bottle from containers in her shed. He seems to have rung their door bell as he entered their property. Mrs Cooper was not aware of this visit until next day when she found a note that said:

> *"I'm really sorry to wake you dudes at 1.00am but if I had stayed up there another minute there would have been mind bumbling bloodshed, and you guys would have been visiting me in prison for heaps of years. I'm sorry mate. (I will tell you about it later.*
> *Love Bloomers XO*
> *Fuck its good to have someone."*

117. At 1.50 am, Mr Bloomfield spoke to Mr Somerville again. He was there for less than five minutes and, in that time, he told Mr Somerville he was going to the caravan park and had a can of "petrol". He was going back to the Applegum Caravan Park to burn it.

118. At 1.57am, Mr Somerville rang 000. He told them that Mr Bloomfield was mentally unstable and about Mr Bloomfield's threat which he interpreted as a threat to burn the caravan park.

Further Police Response

119. At 1.58pm on 11 November 2006, Mr McWilliam responded to police communications and to a possible call from the phone box outside the Applegum Caravan Park about a man who was threatening to burn down the caravan park. He despatched the Bairnsdale divisional van with Mr Kronk and Mr Brooks to the Applegum Caravan Park to keep a look out for a male somewhere between the Hospital and the Applegum Caravan Park possibly carrying a jerry can. They were also told that this man was threatening to set the manager's office alight at the Applegum Caravan Park.

120. Mr Kronk and Mr Brooks patrolled through the caravan park with their spotlight on and stopped in front of Mr Bloomfield's van. They did not find anything so they searched further up Main Street in the direction of the hospital. Senior Constable Kronk noticed that the security guard was looking in the car park at the hospital.

121. Mr McWilliam also tasked Mr Handley to contact service stations to find out if they had sold any fuel to Mr Bloomfield. No one had.

122. At 2.04am, Mr Bloomfield rang 000 from the telephone box at the front of the Applegum Caravan Park. He told the call taker he was going to carry about his threat right now. This threat was interpreted to be that he would set fire to the caravan park. The call was logged at 42 seconds.

123. At 2.05am, Mr Brooks sought information through the police radio about Mr Bloomfield's plan. At 2.07am, Mr Handley advised that the person they were looking for was probably Mr Bloomfield and that he lived at the Applegum Caravan Park.

124. At 2.13am, Mr Kronk and Mr Brooks did a U-turn and returned to the caravan park. At the same time, Mr McWilliam left the police station.

125. Mr Kronk and Mr Brooks returned to the Applegum Caravan Park and parked the divisional van in the driveway. There was no other light at the scene but they could see Mr Bloomfield walking in front of them near the telephone box in the light of their headlights. He had his back to them.

126. Mr Bloomfield had poured liquid over himself and, as Mr Kronk got out of the van, they saw him throw a plastic bottle towards the garden bed. However, Mr Kronk was not sure whether the fluid was flammable. Subsequent analysis showed the liquid was a mixture of petrol and diesel fuel and another medium petroleum distillate, probably kerosene.

127. Mr Bloomfield then turned around to face the police and continued to move backwards, hunched over and flicking a Stelco disposable butane cigarette lighter in his hands.

128. Mr Kronk took charge of the incident. When he completed a Victoria Police Use of Force Form 237 on 2 June 2007, Mr Kronk indicated that he was confronted without warning and no response was planned.

129. Mr Kronk was excused from giving evidence at the Inquest. However, he told the Victoria Police debrief of the incident on 28 November 2006 that he could see flashes from the sparks coming from the cigarette lighter but there was no flame. Mr Brooks could also hear running water from a tap nearby.

130. Mr Bloomfield tried unsuccessfully to ignite the cigarette lighter and muttered about it not working. He did not respond to Mr Kronk's calls to drop the lighter. The cigarette lighter was later found to be empty[4] but it sparked and had a child proof mechanism requiring two distinct and co-ordinated movements to operate.

131. Mr Kronk ran towards Mr Bloomfield and sprayed him in the face with Beacon oleoresin capsicum ("O/C") spray to try and distract him and stop him flicking the lighter.

132. Even if Mr Bloomfield was not in custody before this event, the circumstances prior to and arising from Mr Kronk's use of O/C spray in effect created a custodial situation with attendant responsibilities.

133. The O/C spray distracted Mr Bloomfield for a short time. However, Mr Brooks told the Court that, after about two seconds and less than five seconds, Mr Bloomfield started backing away and flicking the lighter again.

4 Butane in the cigarette lighter may have evaporated during the incident.

134. At about 2.14am, Mr Bloomfield continued to flick the cigarette lighter and back away from Mr Kronk. Mr Kronk could see the spark coming from the lighter. Mr Brooks says it was close to Mr Bloomfield's chin. However, Mr Kronk was unable to approach Mr Bloomfield to get the lighter because he could not see very well because of the irritant effect of the O/C spray on his eyes. He had turned away from the irritant when Mr Brooks said "*He's alight*".

135. Mr Brooks says he saw the flames start of Mr Bloomfield's chest rather than in the O/C propellant that remained in the air between Mr Kronk and Mr Bloomfield. It then spread to the rest of Mr Bloomfield's body.

136. Mr Bloomfield said *"I told you so", "I told you I'do it", "Now they might listen" and "I didn't think it would hurt that much"*. Although he was still able to talk to them, Mr Kronk and Mr Brooks realised that his injuries were serious.

137. Victoria Police Manual para 4.5.1 states:

"A fire extinguisher must be carried in all police vehicles. Recharge used extinguishers at the Transport Branch or replace at local expense."

138. Accordingly, police officers are trained in stowing the fire extinguisher on the Holden Crewman divisional van, how to test it and how to use it. It is part of the pre-drive check list which they are required to perform before they commence operational duties. However, Mr Brooks was unable to find the fire extinguisher in the divisional van so he and Mr Kronk threw water on Mr Bloomfield and covered him their jackets and with a fire retardant blanket.

139. Neither Mr Kronk nor Mr Brooks had ever had to use the fire extinguisher in their divisional van. The fire extinguisher was secured on the floor of the right hand compartment on the outside of the divisional van. It was covered in other gear and there was no light to assist them.

140. Victoria Police Transport Branch have now installed a decal on the door of the compartment housing the fire extinguisher which states:

"Fire extinguisher is located on the floor of the Compartment".

141. At 2.14am, police communications called Rural Ambulance Victoria to say that there was a patient on fire at Applegum Caravan Park. In response to a question from the police communications officer, Rural Ambulance Victoria said:

"Get some water on him."

142. In their communications with Mr Brooks this was interpreted as:

"Ambulance is en route. And they suggested to apply as much water as possible until such time as they arrive."

143. Soon after these communications, Mr Brooks became concerned that Mr Bloomfield was starting to have trouble breathing and asked how far away the ambulance was.

144. Victoria Police Probationary Constables course documents include a requirement for all members to carry a dispenser of Salbutamol and a Volumatic spacer when they carry O/C spray. There is no evidence that Mr Kronk and Mr Brooks had access to these medications which would have delayed or reduced Mr Bloomfield's respiratory difficulties.

145. At 2.15am, Mr McWilliam arrived at the Applegum Caravan Park and took charge of the incident. He directed Mr Brooks to accompany Mr Bloomfield in the ambulance. He also directed Mr Kronk to photograph the scene and collect exhibits.

146 Police did not find a suicide note or anything else to indicate that Mr Bloomfield intended or expected to die.

147. However, on 2 June 2007, Mr Kronk completed a Victoria Police Use of Force Form 237. On the bottom of that form, he stated that:

"Police attended address Re: suicidal male.
Soaked in fuel lighting self (with) lighter
O/C (spray) deployed - minimal effect-/ then set fire to self.... ."

Medical response to Mr Bloomfield's injuries

148. At 2.16am, the ambulance was despatched. It arrived at 2.19am. Mr Bloomfield was sitting on the ground. He had partial and full thickness burns to 90% of his body and airway burns. His airway was beginning to become obstructed.

149. At 2.29am, the ambulance crew and Mr Brooks left the scene to transfer Mr Bloomfield to Bairnsdale Hospital. The ambulance officers notified Mr Somerville to expect them and he notified the general practitioner on duty.

150. At 2.31am, Mr Bloomfield presented at the Emergency Department of Bairnsdale Hospital in an ambulance. He was sedated, intubated and resuscitated with fluids. After discussion with The Alfred hospital, he was also treated with antibacterial ointments and dressings.

151. While they were waiting at the hospital, Mr Bloomfield asked Mr Brooks to return to the scene to recover his bag because his children would need his cards and his identification.

152. At 3.52am, the Helimed team accepted Mr Bloomfiled's transfer. At 4.20am, he was airlifted to The Alfred hospital in Melbourne.

153. At 6.11am on 11 November 2006, Mr Bloomfield was admitted to The Alfred hospital. However, he was diagnosed with non-survivable injuries and his condition continued to deteriorate.

154. At 5.45pm on 11 November 2006, the ventilator was disconnected and palliative care was instituted.

155. At 4.45am on 12 November 2006, James Bloomfield died.

Use of O/C Spray

156. Oleoresin capsicum is the active ingredient in Beacon O/C spray. It was imported as 12.80% to 14.00% solution in isopropanol. Oleoresin capsicum is insoluble in water.

157. Ensign Laboratories Ltd in Mulgrave hold a Governor in Council Exemption issued under section 5(a) of the *Control of Weapons Act* 1990 and approval of the Chief Commissioner of Police to possess oleoresin capsicum for trading purposes. Ensign Laboratories developed and prepared Beacon O/C spray (also referred to as Capsicum Spray Live) to Victoria Police specifications.

158. The contents of a Beacon 44g O/C spray canister comprised about 5% by weight oleoresin capsicum preparation in about 31g isopropanol with a further 11g of propellant made up of 60:40 propane/isobutane and a small amount of fluorecent dye.[5]

159. John Kelleher is a scientist at the Victoria Police Forensic Centre. Mr Kelleher explained the the Court that the three most important factors which influence the ease with which ignition can happen in circumstances where a spark occurs in contact with volatile vapour are:

1. The flash point of the vapour being ignited,

[5] Ensign Laboratories Ltd Formulating Sheet FORVP15, Data Entry complete 13/7/05.

2. The available oxygen. and

3. The minimum spark ignition energy.

160. The flash point of a volatile material is the lowest temperature at which it can vaporize to form an ignitable mixture in air. Flash point assumes there is a spark or some other source of ignition which contains enough heat to warm the liquid to a vapour to start the fire.

161. Isopropanol, propane and isobutanol are all easily flammable hydocarbons. David Cowper from Ensign Laboratories told the Court that the flashpoint of Beacon O/C spray is -81 degrees C.[6] Accordingly, Beacon O/C spray is classified as a hazardous substance and dangerous goods according to the National Occupational Health and Safety Code and the Australian Dangerous Goods Code because it is extremely flammable, irritating to eyes, there is risk of explosion if heated under confinement and vapours may cause drowsiness and dizziness.

162. Mr Kelleher also calculated that the flashpoint of the liquid mixture on Mr Bloomfield's clothing would probably be around -30 degrees C or possibly a little higher. This is significantly higher than the flashpoint of the Beacon O/C spray. In other words, it would require more heat to establish a flame on Mr Bloomfield's drenched clothing than it would to light the Beacon O/C spray.

163. Further, to establish ignition there needs to be enough oxygen for the flame to burn. The flammable range for a mixture like that used by Mr Bloomfield to drench himself is about 1.4 and 7.8 per cent mixture in air. If there is more petrol vapour than that in the air around the spark, it will not ignite.

164. Mr Kelleher also said that the minimum spark energy is the energy in the smallest spark that will ignite the flammable liquid vapour. If this energy is not reached no ignition occurs. For example, the minimum spark energy to ignite the liquid vapour from Mr Bloomfield's clothes may not be achieved if the cigarette lighter was empty of fuel and the spark was too weak to ignite the flammable liquid on Mr Bloomfield's clothing.

165. Mr Kelleher formed the opinion that the propellant and the isopropanol solvent vapour in the Beacon O/C spray would significantly change the flashpoint of the liquid on Mr Bloomfield's clothing so that, in the immediate area of impact of the spray, the flashpoint would decrease from about -30 degrees C to about -104 degrees C. It would also temporarily lower the minimum spark ignition energy which would increase the likelihood of a flame igniting. The short delay in Mr Bloomfield's flicking of his

6 A Chemwatch Material Safety Data Sheet 6860 was issued on 20 May 1999 and printed on 25 July 2000. In Court, David Cowper from Ensign Laboratories explained that the composition of the propellant is incorrect in this data and therefore the flashpoint was also incorrect.

cigarette lighter or his moving the cigarette lighter slightly could have allowed enough oxygen to enter the mixture around the spark so that it also became more flammable for that reason.

166. On 19 May 2005, Victoria Police issued the Purchase Order for 1000 44g cans of Beacon O/C Spray which included the Beacon O/C Spray canister used by Mr Kronk in Bairnsdale on 11 November 2006.

167. Ensign Laboratories delivered this Beacon O/C spray can with a flammable liquid warning and label including "For Police Use Only" . However, the Court heard that the labels on the cans wear off from constant rubbing against their holsters. There was no evidence about the label on Mr Kronk's can of Beacon O/C spray.

168. Victoria Police Oleoresin Capsicum Spray Training Manual & Standard Operating Procedures 1996 ("Victoria Police Operating Procedures") and The Victoria Police Constables' Course (Recruit Phase) Operational Skills Manual, Defensive Tactics Workbook teach recruits that the criteria for use of O/C spray include:

> *".... where a person is involved in violent or physical conduct likely to seriously injure them or result in suicide.... "*

169 Victoria Police Operating Procedures also say:

> *"The deployment of OC is considered serious physical control and as such, its use can only be justified when there is a need to prevent serious injury. The member must establish that the subject has demonstrated the intent to inflict serious physical injury to either the member, another person or themselves. This intent maybe telegraphed through body language (demeanour) and/or verbalisation. The member must also establish that the subject has the physical capabilities to carry out the threat."*

170. Senior Sergeant Andrew Miles is in charge of the Victoria Police Operational Safety & Tactics Training (OSTT) Unit. In a statement, Mr Miles explained that Victoria Police implemented mandatory regular OST training in 1994 through Project Beacon. This project emphasises that Victoria Police tactics reflect a "Safety First" philosophy. Where members are effective in use of communication skills most potential confrontations can be defused or avoided. Mr Miles also stated that Victoria Police has been aware of the flammability of Beacon O/C spray since about 1998. This forms part of the OST training programme and includes the warning on the canisters.

171. Mr Kronk and Mr Brooks were qualified and up to date with their mandatory OST training. In the Victoria Police Use of Force Form 237 completed on 2 June 2007, Mr Kronk indicated that the OST training was generally effective during the incident. However, on the same form, Mr Kronk indicated that the OST equipment was not generally effective. I presume he meant that the O/C spray was not effective because he did not use any other OST equipment.

172. Senior Sergeant Greg Moon is in charge of the Continuous Improvement Section of the Operational Safety Division of Victoria Police. Mr Moon also said that the flammability of Beacon O/C spray is well known and has been covered in detail at initial training and following this incident a specific package was promulgated in the January to June 2007 OSTT cycle to highlight flammability of Beacon O/C spray.

173. There was no evidence before me to suggest that Mr Kronk and Mr Brooks were not typical of uniform operational police in all regional areas. Neither Mr Kronk nor Mr Brooks was aware that Beacon O/C was flammable. Therefore, I can only assume that the OSTT training around use of O/C spray is not absorbed or retained by Victoria Police members.

174. The State Coroner also considered the effectiveness of OSTT training in her investigation of the death of Tyler Cassidy. In her Finding she noted that it cannot be assumed that the OSTT has been absorbed and that members should be tested. The State Coroner also noted that there used to be examinations after OSTT but these had been dropped in about 2007. [7] She recommended reintroduction of some form of assessment following completion of OSTT.

175. This recommendation was implemented in January 2012. All police attending Operational Safety and Tactics Training must now successfully complete an assessment to maintain their qualification to use and carry operational safety equipment.[8]

176. The Court heard evidence about options for reducing the flammability of O/C spray from Mr Cowper, Mr Kelleher, Mr Moon and Inspector Robin Craig Walsh who was the Manager of the Centre for Operational Safety within the Education Department at Victoria Police.

177. They all agreed that their options were limited by two factors:

---

[7] State Coroner, Finding of the Coronial Investigation of the Death of Tyler Cassidy , 23 November 2011, para 645.

[8] Victoria Police response to the State Coroner's recommendations in the Finding of the Coronial Investigation of the Death of Tyler Cassidy, 17 February 2012.

- the solubility of the oleoresin capsicum active ingredient of the spray in less flammable solvents, and
- the need to use a propellant that maintained pressure of the spray as the contents of the can reduced with use.

178. Victoria Police has reviewed other O/C products and propellants with a view to improving the less than lethal capability Beacon O/C spray.

179. In evidence, Mr Kelleher said that a water-based solvent for oleoresin capsicum has been investigated in New Zealand but it has reduced effectiveness. Mr Miles recommended that Victoria Police should replace the flammable O/C composition with a non-flammable water-based alternative using an aqueous solution of propylene glycol.

180. Mr Kelleher explained to the Court that nitrogen would be a better propellant if a water-based solvent was used. However, this would change the operational effect of the propellant because nitrogen does not expand as the quantity diminishes in the can. Therefore, the pressure reduces and the distance achieved by the O/C spray would reduce. Mr Miles also referred to non-flammable nitrogen-based propellants.

181 However, by June 2010, Victoria Police Operational Response Teams had been issued water-based O/C systems because they also carry Tasers.

182. On 18 September 2007, a US patent was issued for a non-flammable non-toxic, non-carcinogenic solvent system Non-Lethal Temporary Incapacitation Formulation and Novel Solvent System (Patent No. US 7,270,802 B2). This solvent system comprises a mixture of propylene glycerol dicaprylate/caprate and glycerol tris(2-ethylhexanoate)and does not include water. I refer to this product only to indicate that there are operationally effective solvent options other than water that may be useful in designing appropriate O/C delivery systems.

183. Inspector Robin Craig Walsh is the Manager of the Centre for Operational Safety within the Education Department at Victoria Police. In considering the propellant in O/C spray, Mr Walsh said that the alcohol-based carrier was the most effective carrier available in 1997 when O/C spray was introduced. Mr Moon also said that the alcohol-based propellant evaporates when sprayed and, generally speaking, will not be an issue if sprayed from greater then one metre.

184. As I understand it, the water-based O/C spray issued to the Operational Response Teams continues to use the propane and isobutanol propellant used in Beacon O/C spray.

185. Mr Cowper says there are some non-flammable liquefied propellants that may be suitable but they are slowly being phased out of the market due to their potential effect on global warming. He also said it would be difficult to develop O/C spray systems based on these propellants.

186. In hearing all the evidence about the problem with maintaining operational capability with a less flammable O/C spray system, I was conscious of the fact that development and production of O/C spray systems requires sophistocated scientific, operational and business qualifications that are not usually found in one person. Accordingly, I formed the view that some of the issues that needed to be considered were outside the expertise of the witnesses providing me with the information.

187. I was also aware that the tender for an upgraded system was about to be released. Further, extended avaibility of Tasers was on the agenda. I formed the impression that some of the evidence provided to me was influenced by these background issues.

188. Therefore, I am concerned about whether or not Victoria Police has the professional in-house capacity to review all of the options available to them in determining a safe alternative O/C spray delivery system.

COMMENTS:

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

Background

1. James Bloomfield lived in an on site caravan at the Applegum Caravan Park in Bairnsdale. Sergeant Ben McWilliam described the residents of the Applegum Caravan Park as:

> *" .... largely itinerant people, unemployed people, alcoholics, drug addicts, people with mental illness, people in need of crisis accommodation."*

2. Mr Bloomfield's medical history included schizophrenia/psychosis, alcohol and drug abuse, generalised anxiety disorder and borderline personality disorder as well as attempted suicide. He had a long-standing fear of the dark that had been generated by his sexual abuse as a young boy. He had also sustained serious facial injuries in a bicycle accident and experienced chronic pain.

3. On 6 November 2006, a major electrical fault occurred at the Applegum Caravan Park and a temporary generator was installed to provide electricity. The caravan park owner turned off the generator at midnight each night because of the noise it made.

4. On the morning of 10 November 2006, Mr Bloomfield visited at least four community agencies in Bairnsdale. He told the workers at these agencies that the lights at the Applegum Caravan Park were extinguished each night because of an electrical fault and that he was frightened of the dark. He warned them that he would set himself on fire that night if the lights were turned off again at midnight.

5. At 1.59pm on 10 November 2006, Acting Sergeant Peta Billing and three other police officers apprehended Mr Bloomfield under section 10 of the *Mental Health Act* 1986. They took him to the Accident & Emergency Department at Bairnsdale Hospital in the divisional van.

6. At about 3.00pm on 10 November 2006, Dr Manfret Heer examined Mr Bloomfield at Bairnsdale Hospital. At 4.35pm, Dr Heer spoke to psychiatry triage at Traralgon on the telephone to arrange a mental health assessment by a mental health practitioner. On the basis of the information provided to him by Dr Heer, the psychiatry triage nurse assessed Mr Bloomfield as Mental Health Triage Category 2 and referred him to the duty mental health practitioner at Bairnsdale Community Mental Health Service for assessment.

7. At 5.50pm on 10 November 2006, Mr Bloomfield left the Accident & Emergency Department at Bairnsdale Hospital muttering that was not being attended to by "psych services". The duty mental health practitioner, Gilliam Kerr, had still not had the opportunity to perform a mental health assessment.

8. At 8.10pm on 10 November 2006, Victoria Police members in the Bairnsdale divisional van saw Mr Bloomfield at the Applegum Caravan Park but they were unaware he had absconded from Bairnsdale Hospital earlier in the day and they did not speak to him.

9. At 1.58am on 11 November 2006, Sergeant Ben McWilliam despatched Senior Constable Stacey Kronk and Constable Michael Brooks to the Applegum Caravan Park. At 2.13am, Mr Kronk and Mr Brooks found Mr Bloomfield at the front of the caravan park. He had poured a mixture of petrol, diesel fuel and another medium petroleum distillate, probably kerosene, over himself. He was flicking a Stelco disposable butane cigarette lighter in his hands and Mr Kronk could see the spark from the lighter. Mr Bloomfield did not respond to the policemen's calls to drop the lighter.

10. Mr Kronk sprayed Mr Bloomfield with O/C spray in an attempt to prevent him setting fire to himself. However, after about 10-20 seconds, Mr Bloomfield commenced flicking his lighter again and, almost immediately, his clothing caught fire.

11. Despite attempts to put out the fire, Mr Bloomfield sustained partial and full thickness burns to 90% of his body as well as airway burns.

12. At 4.45am on 12 November 2006, James Bloomfield died at The Alfred hospital as a result of the severe burns sustained in the fire.

13. The evidence is clear that Mr Bloomfield intended to set himself on fire on the night of 10/11 November 2006 to protest against the nightly black out at the Applegum Caravan Park caused by an electricity failure and concern about the noise of the replacement generator. Further, Dr Heer says Mr Bloomfield said he would burn himself to death with gasoline if the Applegum Caravan Park manager turned off the lights again that night.

14. In determining the weight to place on Dr Heer's evidence that Mr Bloomfield intended to die from the injuries he sustained in the fire, I note that:

- Dr Heer was a junior medical officer.
- Dr Heer assessed Mr Bloomfield as only moderate risk of self harm and took over 90 minutes to refer him to mental health triage to arrange an assessment.
- Dr Heer completed his examination at about 3.30pm on 11 November 2006 which is about 10 hours before the incident occurred.

Therefore, Dr Heer's report that Mr Bloomfield intended to commit suicide when he set fire to himself is not enough for me to determine Mr Bloomfield's mental state at 2.13am on 11 November 2006.

15. On the contrary, I have also considered the following evidence:

- There was no suicide note or other indication that Mr Bloomfield was planning to die when he set fire to himself.
- He had acquired brain injury and therefore, he cannot be expected to necessarily follow the otherwise logical connection between severe burns and death.
- Ms Billing did not form the opinion that Mr Bloomfield had made a connection between this intention to set himself on fire in protest against the lights being turned off at Applegum Caravan Park and the likely consequence of his being burned. She did not think he thought he would die.

- Mr Bloomfield indicated he would see Ms Cooper next day in the note he left at her house at about 1.00am on 11 November 2006.
- Mr Somerville was the last person to talk to Mr Bloomfield. Mr Somerville did not understand that Mr Bloomfield intended to use the fuel to commit suicide. He thought he intended to set fire to the Applegum Caravan Park.
- After the incident, Mr Bloomfield said words like "*I told you so*", *"I told you I'do it*" and "*Now they might listen*" which do not indicate an intent to die but rather an intention to draw attention to his complaint about the lights.

16. Therefore, although it is possible that Mr Bloomfield committed suicide, the evidence before me does not reach the higher standard of proof of intention required for me to over-ride the presumption against intentional death.

17. Although I am unable to find that Mr Bloomfield committed suicide, Mr Bloomfield's death has exposed several serious systemic failures in the way in which the community, health care providers and police in Bairnsdale responded to the difficult circumstances experienced by people with mental illness associated with alcohol or drug abuse and/or personality disorders.

18. In particular, the coronial investigation of Mr Bloomfield's death has focussed on the following issues:

- Mental health services in Bairnsdale,
- Mental health triage,
- Police interaction with people with a mental illness,
- Communication between service providers, and
- Victoria Police use of oleoresin capsicum (O/C) spray.

Mental health services in Bairnsdale

19. In Victoria, mental health patients frequently use the Accident & Emergency Department of a public hospital as their point of care for managing mental health issues because they are referred by another service (22%) and alternatives are unavailable (17%).[9]

20. The Chief Psychiatrist provides general leadership, clinical advice and secondary consultation and comment to Area Mental Health Services in the State. Although she has no direct role in provision of services through emergency departments, the Chief Psychiatrist issues relevant clinical practice guidelines and programme management circulars in areas such as assessment of drug and alcohol intoxicated

9 Department of Human Services, "Mental health presentations to the emergency department", May 2006, p. 2.

patients. She is also a member of the Interdepartmental Liaison Committee which comments on the interaction between mental health services.

21. In 2008, Paul Smith was Director of Operations in the Mental Health and Drugs Division of the Department of Health when he provided information to the Court about regional mental health services in Victoria. Mr Smith noted that the objects of the *Mental Health Act* 1986 include treatment, care and protection of mentally ill people who do not or cannot consent to that care, treatment and protection. The Director of Mental Health accepts accountability for service delivery throughout the region.

22. The Department of Human Services (now Department of Health) funds Latrobe Regional Health to provide mental health services across the whole of Gippsland through Latrobe Regional Mental Health Service.

23. Vikki Farthing was the Director of Nursing at Bairnsdale Hospital when the Inquest was heard. Consistent with these general statistics, her audit of mental health presentations to the Accident & Emergency Department at Bairnsdale Hospital showed that there were 14 presentations in July 2009 and nine in August 2009.

24. Therefore, on average, the Accident & Emergency Department at Bairnsdale Hospital can expect to manage three patients with a mental illness each week.

25. Mental health services at Bairnsdale Regional Health Service are provided by Latrobe Regional Mental Health Service. Latrobe Regional Hospital is the only approved mental health service in Gippsland Area Mental Health Service and mental health triage is provided from Traralgon.

26. The East Gippsland area is also supported by a community mental health service which includes mental health practitioners co-located with Bairnsdale Hospital. Latrobe Regional Mental Health Service provides assessment and community mental health services in Bairnsdale at premises which are co-located with Bairnsdale Regional Health Services. Bairnsdale Hospital also has an Accident & Emergency Department where patients can access a registered medical practitioner.

27. Dr Cayte Hopner is a trained psychiatric nurse who is now Director of Mental Health for Latrobe Regional Mental Health Service. This is a new position established in 2009 and reports to the Chief Executive of Latrobe Regional Health. Therefore, she is now responsible for administration of all Government-funded mental health services in Bairnsdale.

28. Dr Hopner is based at at Latrobe Regional Hospital in Traralgon West. However, Bairnsdale Regional Health Services is a small regional health service:

- It is over 60 minutes drive from Traralgon.
- There can be quite lengthy delays in getting an ambulance to transport patients between Bairnsdale and Traralgon.
- It is not an approved mental health service under the *Mental Health Act* 1986.
- It does not have security arrangements to effectively detain involuntary mental health patients.
- There is no local psychiatrist.

29. Further, if a patient is recommended for involuntary admission to an approved mental health service by the Senior Medical Staff or the visiting medical officer at a regional health service, they must be transferred to Flynn Unit at Traralgon Hospital.

30. Mr Smith said:

"Security arrangements at approved health services are the responsibility of each health service. Bairnsdale Hospital is not an approved mental health service."

31. However, in 2006, the Accident & Emergency Department at Bairnsdale Hospital was undergoing renovations. The only bed available for a mental health patient was in the plaster room which was usually used for other purposes. This room was a curtained alcove close to the doors to the ambulance bay. There was no secure arrangement for patients awaiting assessment by a mental health practitioner or transfer to Traralgon.

32. The renovations in the Accident & Emergency Department at Bairnsdale Hospital are now complete. They include a lockable, padded room with a video camera that displays on a screen at the front triage desk. The risk of unobserved absconding is removed when the door is locked.

33. On 4 October 2005, Mr Bloomfield had been admitted as an involuntary patient to Flynn Unit. He was diagnosed with drug-induced psychosis and discharged as a voluntary patient on 21 October 2005.

34. Mr Bloomfield had also presented to Bairnsdale Community Mental Health Service six times in 2006. On each occasion, he was not accepted for case management because he was not suicidal and/or he was diagnosed with alcohol and drug related-issues with associated acquired brain injury. He was referred to alcohol and drug services.

35. Accordingly, in November 2006, Mr Bloomfield was known to Latrobe Regional Mental Health Service. However, he was not registered as a mental health client at or case managed by Latrobe Regional Mental Health Service.

36. On the contrary, on 2006, Mr Bloomfield had been rejected for case management by the Bairnsdale Community Mental Health Service because of his alcohol and drug abuse and acquired brain injury. In the absence of this service, his mental health issues were managed by at least five community agencies including the Bairnsdale Alcohol & Drug Service, the Centre Against Sexual Assault and his general practitioner, Dr Peter Worboys.

37. In Victoria, as in other parts of the world, mental health and alcohol and other drug services are working with increasing numbers of people who are experiencing both mental health and drug and alcohol problems and disorders. The concurrence of these problems and disorders (one aspect of dual diagnosis) adds complexity to assessment, diagnosis, treatment and recovery, and is known to increase the risk of relapse.[10]

38. In May 2007, the Department of Human Services committed itself to promoting the development of a systematic approach to service provision through integrated assessment, treatment and care in both mental health and alcohol and other drug services so that a person of any age experiencing dual diagnosis has timely access to quality treatment and support.[11]

39. Accordingly, the most recent Victoria Police-Department of Health Protocol for Mental Health now provides:

> *"Police can apprehend a person under section 10, who along with appearing to be mentally ill is also drug or alcohol-affected, as intoxication is not a barrier to commencing an assessment."*[12]

40. Further, mental health and substance abuse services have been integrated under the the Minister for Mental Health. This arrangement has continued with a change in Government in 2010 with the new Minister for Mental Health offering awards for delivering innovative and integrated programmes for alcohol and drug and mental health care.[13]

---

[10] Department of Human Services, "Dual Diagnosis: Key directions and priorities for service development ", State of Victoria, 2007, p. 1.
[11] Department of Human Services, "Dual Diagnosis: Key directions and priorities for service development ", State of Victoria, 2007, p. 2.
[12] Mental Health & Drugs Division, Department of Health, Victoria, "Department of Health and Victoria Police Protocol for Mental Health", September 2010, p. 4.
[13] 2011 Victorian Public Healthcare Awards, 16 November 2011.

41. In particular, Latrobe Regional Hospital Mental Health Service now hosts a Dual Diagnosis Program and the new approach aimed to provide 100% of dual diagnosis clients with integrated assessment and treatment by December 2010.[14]

42. Therefore, if Mr Bloomfield presented at Bairnsdale Community Health Service for assessment now, he could expect to be triaged, assessed and treated for both his substance abuse and mental health issues in an integrated programme administered through Latrobe Regional Hospital Mental Health Service. However, patients like Mr Bloomfield are unlikely to be able to travel to Traralgon to access this service. Therefore, they require coordinated service delivery in Bairnsdale. However, there is no reference in the Department of Health website to dual diagnosis services in other Gippsland Community Mental Health Services. **Recommendation 1**

Mental health triage

43. In Victoria, psychiatry triage is primarily a telephone screening and advice service.[15] The triage service can organise mental health assessment and medical examination as required.

44. Latrobe Regional Health Service Mental Health Service provides a single point entry for all mental health client contacts in Gippsland. The primary role of mental health triage is the initial screening, information gathering and assessment of all referrals leading to activation of a service response. It operates 24 hours, seven days a week and is run by senior mental health practitioners who have access to psychiatrists and medical support.

45. Mental health patients presenting at a regional Accident & Emergency Department are examined by a medical practitioner who can refer them to mental health triage for specialist assessment by a mental health practitioner. If appropriate, this assessment may lead to referral to a community mental health service or recommendation for involuntary treatment at an approved mental health service.

46. Alternatively, the protocol between Victoria Police and the Department of Human Services Mental Health Branch[16] and the Latrobe Regional Health Service Mental Health - Community Clients Referral and Assistance Protocol[17] also provide for police to refer people who appear to have a mental illness

[14] Department of Human Services, "Dual Diagnosis: Key directions and priorities for service development", State of Victoria, 2007, p. 27.
[15] Department of Human Services, "A Review of Crisis Assessment and Treatment (CAT) services and functions", State of Victoria, 2007, p. 1.
[16] "Protocol between Victoria Police and the Department of Human Services Mental Health Branch - 2004"
[17] Latrobe Regional Health Service Mental Health - Community Clients Referral and Assistance Protocol issued on 16/10/2001 and reviewed on 17/4/2008.

directly to the mental health triage service or through the Police Communications Centre. Police can then transport the patient to the nearest Accident & Emergency Department for mental health assessment or medical examination.

47. The mental health triage clinicians rely on the information provided to them by medical practitioners in the Accident & Emergency Departments of regional hospitals or the police who are arresting the patient under section 10 of the *Mental Health Act* 1986 to assess the patient's acuity. They then allocate priority to their face-to-face mental health assessment and notify the relevant local community mental health worker on duty to perform their mental health assessment.

48. Mental health triage clinicians are unable to see the person seeking access to mental health services or conduct a physical examination. This can make it difficult for them to provide an adequate mental state assessment because they have to interpret the urgency of the current presentation in the context of his or her previous mental health history which is recorded on the Statewide mental health computer system and the information provided by the referring agency.

49. I understand that mental health triage guidelines are intended to provide structure to the referral process and protect patients' privacy. However, there is no process to take into account referrals to mental health triage other than those from police or medical practitioners.

50. On 10 November 2006, the circumstances of Mr Bloomfield's referral to the mental health triage system demonstrated the unintended consequence of its failure to accept referral from agencies other than the Accident & Emergency Departments of regional hospitals or Victoria Police. The sequence of these circumstances was this:

- At 12.40pm, Elizabeth Noone at the Bairnsdale office of Community Housing Victoria Ltd contacted mental health triage at Traralgon to report Mr Bloomfield's presentation. She was not from Victoria Police or a medical practitioner so her call did not constitute a referral under the Latrobe Mental Health Service protocols.
- At 1.03pm, Ms Billing spoke to the Bairnsdale Community Mental Health Service before she apprehended Mr Bloomfield and transported him to Bairnsdale Hospital. They told her that she should contact mental health triage in Traralgon. Ms Billing did not make that call. Therefore, the appropriate processes and procedures for Mr Bloomfield's rapid mental health assessment were not formally initiated.
- At 2.15pm, Nurse Rick Lightowler applied the Emergency Department Triage Scale to allocate priority for Mr Bloomfield's management as Category 5. Although Mr Lightowler placed Mr Bloomfield in Cubicle 5 and observed him until 3.15pm, his departure from protocol also meant that

the appropriate processes and procedures for Mr Bloomfield's rapid mental health assessment were still not formally initiated as required under the Latrobe Mental Health Service protocols.

- Between 2 and 3pm, Nurse Evan Jenkins approached the duty mental health practitioner, Sue Mulkearns, in the Accident & Emergency Department at Bairnsdale Hospital and asked her to look at Mr Bloomfield. In the absence of his prior mental health triage, Ms Mulkearns advised Mr Jenkins to organise a drug screen and a preliminary breath test before Mr Bloomfield was assessed by a medical officer. She did not speak to Mr Bloomfield. Still no mental health assessment occurred.
- At 3.00pm, Dr Manfret Heer examined Mr Bloomfield as required under Emergency Department Triage Category 5. He decided to refer him to mental health triage for mental health assessment to determine whether he met the criteria imposed by section 8 of the *Mental Health Act* 1986.
- At 4.38pm, Dr Heer spoke to the mental health triage nurse on duty at Latrobe Regional Hospital, Peter Foote. Dr Heer's delay in contacting Mr Foote further delayed Mr Bloomfield's formal referral for assessment by a mental health practitioner. At first, Mr Foote questioned the appropriateness of the referral to psychiatric services. However, on the basis of his conversation with Dr Heer, Mr Foote applied the Latrobe Regional Mental Health Service triage policy to triage Mr Bloomfield into Mental Health Criteria 2.
- At 4.45pm, Mr Foote communicated this decision to the duty mental health practitioner in Bairnsdale, Sue Mulkearns. She was about to go off duty so she referred Mr Bloomfield's assessment to the in-coming duty mental health practitioner, Jill Kerr. Mr Bloomfield had already left Bairnsdale Hospital to get his bike and his prescription.
- At 5.30pm, Mr Foote re-contacted Ms Kerr because Mr Bloomfield had returned to the Accident & Emergency Department. By then, Mr Foote had checked Mr Bloomfield's history on the statewide register of mental health clients. He determined that Bloomfield's major diagnosis was alcohol and drug problems.
- At 5.40pm, when Ms Kerr returned to the Accident & Emergency Department, Mr Bloomfield had gone again. She spoke to Dr Heer and they agreed he would be recommended for involuntary treatment when he returned.
- At 8.10pm, Mr Brooks and Mr Handley saw Mr Bloomfield in the Applegum Caravan Park but they did not speak to him because they were unaware of his absconding prior to mental health assessment.

51. Mr Bloomfield left the Accident & Emergency Department on 10 November 2006 before he was triaged and assessed by a mental health practitioner. As he left he was complaining about "psych services". Therefore, I infer that at least one reason that Mr Bloomfield left was the long delay between his presentation and his mental health assessment. This delay was caused by the time taken for Dr Heer to contact mental health triage.

52. If the triage system accepted referrals from a wider group of professional referrers or was more flexible in its response to these reports, Mr Bloomfield would have been assessed by a mental health practitioner on or soon after arrival at Bairnsdale Hospital. **Recommendation 2**

53. Further, Ms Billing was notified that Mr Bloomfield had left the Accident & Emergency Department but she did not know that he had not been assessed and she did not ask about his risk. No one notified police about his departure from the Accident & Emergency Department despite their decision to assess him as an involuntary patient when he returned.

54. If Ms Kerr had reported Mr Bloomfield as a missing person after he left the hospital prior to mental health assessment or, alternatively, after she and Dr Heer had agreed he would be assessed as an involuntary patient when he returned, police would have been prompted to check on Mr Bloomfield's welfare at 8.10pm when they saw him in the Applegum Caravan Park. If they considered he remained a risk to himself or others, they could have further invoked section 10 of the *Mental Health Act* 1986 to return him to the Bairnsdale Hospital for mental health assessment.[18] **Recommendation 3.**

55. The triage scales applied to mental health patients in the Accident & Emergency Department are also complicated. To summarise those that were applied to Mr Bloomfield on 10 November 2006:

- Mr Lightowler triaged Mr Bloomfield as Category 5 according to the National Triage Scale.[19] Category 5 is the least urgent category available and requires assessment by a medical officer within two hours. Mr Lightowler explained that Mr Bloomfield had calmed down quite a lot and he did not feel that he was a threat to himself or any of the staff in the Accident & Emergency Department.
- On the other hand, under Latrobe Regional Mental Health Service Policy, Mental Health Triage Response Criteria 2 patients have been assessed as having a psychiatric illness of severity sufficient to indicate moderate risk to self or others. In the absence of a case manager, the duty mental health practitioner must respond within one hour.
- The Victorian Emergency Department mental health triage scale is different again. It indicates that Mental Health Triage Category 2 patients require assessment within 10 minutes.
- Ms Farthing has also further reviewed the Bairnsdale Hospital's policies and changed triage policy and procedure, management, assessment and treatment of mental health patients under the 2007 policy to require use of the Emergency Department Mental Health Triage Tool rather than the Latrobe Regional Mental Health Service Policy.

---

18 See also Mental Health & Drugs Division, Department of Health, Victoria, "Department of Health and Victoria Police Protocol for Mental Health", September 2010, p. 4.

19 Bairnsdale Regional Health Service *"Triage AE/3"* April 2006.

- On 12 May 2009, Bairnsdale Regional Health Service also discussed plans to implement new draft triage guidelines requiring section 10 clients to be seen within 10 minutes of presentation. This escalation of section 10 patients seems to be independent of the mental health triage arrangements and relies on communication of their legal status.

56. Therefore, there are now three or four mental health triage scales operating for assessment of mental health patients in the Accident & Emergency Department at Bairnsdale Hospital. Further, in the case of Mr Bloomfield in 2006, the triage criteria applied by Mr Lightowler in the Accident & Emergency Department at Bairnsdale Hospital was inconsistent with the triage criteria applied by Mr Foote at Mental Health Triage in Traralgon on the basis of information provided by Dr Heer.

57. Further, the Office of the Chief Psychiatrist has been coordinating a Mental Health Triage Scale Advisory Committee to develop a consistent approach across all mental health services in triaging mental health conditions and service responses.

58. In July 2010, the Mental Health Triage Scale Advisory Committee published the Statewide Mental Health Triage Scale Guidelines (2010) and the Statewide Mental Health Triage Scale Train the Trainer Manual. These Statewide Mental Health Triage Guidelines 2010 use letters A to G to prioritise triage classifications. Inevitably, this will further complicate a complicated system.

59. These 2010 Statewide Mental Health Triage Scale - Guidelines state and I agree:

"Mental health triage inherently carries significant clinical risk. It is therefore a role for experienced mental health practitioners."

60. Ms Farthing also said in evidence and I also agree:

"(Triage) can be a very subjective tool.... it can be subjective on the assessment of the person who's doing that triage assessment. My understanding, and as I said I'm not an expert in triage, but my understanding is that there's very subtle differences between certain triage categories and just a slight change can push you up a category."

61. Therefore, the mental health triage system for patients presenting to small hospitals like Bairnsdale is becoming more rather than less complicated and is not coordinated with other triage systems operating in the hospital. This confusion flies in the face of the streamlined predictable assessment process which is the intended purpose of mental health triage. **Recommendation 4**

Police interaction with people with a mental illness

62. The reason that the *Mental Health Act* 1986 provides authority for police to detain and transfer patients involuntarily is to keep them and the rest of the community safe. Accordingly, section 10 of the *Mental Health Act* 1986 provides police with authority to apprehend a person if he or she appears to be mentally ill and is likely to cause serious bodily harm to themselves or to some other person. Police must present these detainees for examination by a medical practitioner or assessment by a mental health practitioner.

63. Ms Farthing's audit of mental health presentations at the Accident & Emergency Department at Bairnsdale Hospital showed that eight patients in August and September 2009 or one third of all mental health presentations were involuntary presentations under section 10 of the *Mental Health Act* 1986.

64. In 2006, the 2004 Protocol between Victoria Police and the Department of Human Services Mental Health Branch prescribed the working arrangements between the two agencies. This Protocol provided that the authorised psychiatrist or his or her delegate will attempt to contact a person who leaves the Accident & Emergency Department without medical clearance to request their return and offer assistance. When this fails staff will contact police and inform them of their level of concern.

65. Further, the Protocol between Victoria Police and the Department of Human Services Mental Health Branch - 2004 stated:

> *" in **all situations** where police have initiated a referral for prompt/urgent assessment, they will remain present at the location (including within an accident and emergency department or mental health service) until an initial assessment is conducted and preliminary decisions are made by CAT/Triage service staff regarding management of the situation. All reasonable steps must be taken to expedite the assessment process with a full awareness that police resources are limited. If ongoing police assistance is not required, the CAT/Triage service staff will communicate **this as soon as possible** to the police who may then decide to withdraw."*

66. In evidence in 2010, Mr McWilliam said he was not aware of this 2004 Protocol between Victoria Police and the Department of Human Services Mental Health Branch.

67. The current Department of Health Victoria Police Protocol for managing mental health clients is also clear:

> *"The person remains in police custody until:*
>
> *a mental health practitioner completes the psychiatric assessment and advises police to release*

the person, or completes an Authority to Transport without Recommendation for ambulance transport, or a registered medical practitioner formally accepts responsibility for the person in order to conduct a psychiatric examination, or any law enforcement matters are resolved.

Police cannot delegate custody to a security guard, receptionist or nurse in a hospital ED. Nor can police leave a person who is still in police custody in a secured room within a hospital."[20]

68. In 2006, there was no provision for secure detention of patients transferred to and waiting for assessment at the Accident & Emergency Department at Bairnsdale Hospital. Therefore, in Bairnsdale, mental health patients' continuing safety relied on cooperation between Victoria Police and Bairnsdale Hospital Accident & Emergency staff.

69. On 12 October 2006, Victoria Police had conducted a focus group in Bairnsdale to discuss the interactions, strategies, problems and recommendations that operational police had in responding to the needs of people with a mental disorder. In this focus group, Bairnsdale police expressed frustration with what they saw as a "revolving door" and the time consuming nature of section 10 apprehensions as well as a need for better case management of some repeat clients and better active liaison with the local mental health services. On 12 October 2006, Bairnsdale police also complained that accessing background information was difficult and they felt they were managing situations "blind" even though they were expected to act as the sole service provider after hours.

70. Acting Sergeant Peta Billing was the police officer responsible for apprehending Mr Bloomfield and transporting him to the Accident & Emergency Department at Bairnsdale Hospital.

71. Ms Billing told the Court that she began working in Bairnsdale in 2001 and that she performed one section 10 apprehension per fortnight on average while she was there. Therefore, using those data, Ms Billing would have invoked section 10 of the *Mental Health Act* 1986 on about 100 occasions in Bairnsdale before she arrested Mr Bloomfield.

72. In 2006, the protocol between Victoria Police and the Department of Human Services required police apprehending a person under section 10 of the *Mental Health Act* 1986 to contact mental health triage. Ms Kerr told the Court that mental health triage could then activate the mental health practitioner and so enable their timely assessment.

[20] Mental Health & Drugs Division, Department of Health, Victoria, "Department of Health and Victoria Police Protocol for Mental Health", September 2010, p. 4.

73. However, at 1.03pm on 10 November 2006, Ms Billing contacted the Accident & Emergency Department at Bairnsdale Hospital and Ms Kerr at the Bairnsdale Community Mental Health Service. Ms Billing knew the information about Mr Bloomfield that had been provided to her during the day by other Bairnsdale service agencies.

74. Ms Kerr at Bairnsdale Community Mental Health Service gave Ms Billing some information about Mr Bloomfield and advised her to contact mental health triage. Ms Kerr also gave Ms Billing the phone numbers to make that referral. However, although Ms Billing was 'not responding in the dark' , she did not act on this advice and contact mental health triage.

75. Ms Billing's failure to contact mental health triage was inconsistent with the opinions expressed by her Bairnsdale colleagues at the focus group only one month earlier. It also delayed Mr Bloomfield's mental health referral and assessment and precipitated his leaving the Accident & Emergency Department before it occurred and may have contributed to his death.

76. At 1.51pm on 10 November 2006, Ms Billing formed the opinion that Mr Bloomfield appeared to be mentally ill and was likely to cause serious bodily harm himself or to some other person. Ms Billing appropriately invoked section 10 of the *Mental Health Act* 1986 to apprehend Mr Bloomfield and transport him to the Accident & Emergency Department at Bairnsdale Hospital in the police divisional van.

77. Ms Billing admitted that police presence increased Mr Bloomfield's agitation particularly when she told him she was taking him to hospital in the back of a divisional van. She also admitted that police:

> *"had to wrestle him in the back of the van and when we got him out to the hospital he absolutely hated us, didn't want us to be there at all and we were certainly making him significantly more agitated with our presence."*

78. Ms Billing's experience on 10 November 2006 supports that expressed by senior Victoria Police members quoted in "The Age":

> *"They have found that the traditional authoritarian approach can escalate issues resulting in a disproportionate reliance on force to deal with irrational offenders. Internal records show that in 28 per cent of the cases in 2010/11 police used force to subdue the mentally ill. The figures show 2173 confirmed cases where physical restraint, capsicum spray, stun-guns, batons or firearms were used against someone with a psychological condition."*[21]

[21] John Silvester, "*Police to revamp training for handling mentally ill*", "The Age", 25 February 2012.

79. Further, in her Finding of the coronial investigation of the death of Tyler Cassidy, the State Coroner noted that Victoria Police has made considerable effort to redress a decline in emphasis on tactical communication skills, conflict resolution skills, planning, cordon and containing mentally ill people. She was concerned to introduce a system that ensures vigilence against this decline happening again. Accordingly, the State Coroner recommended that Victoria Police ensure the data collected from Critical Incident Response sheets is recorded, analysed and incorporated into OSTT where appropriate.[22] I agree.

80. Victoria Police Centre for Operational Safety have implemented this recommendation by analysing incidents on a daily basis and recording all reports involving use of force. To ensure each six monthly cycle of OSTT is evidence based, an examination of all reported incidents, use of force reports, debriefing reports and coronial findings are considered when developing the next six months curriculum.[23]

81. On 31 May 2010, James Ogloff, Director of the Centre for Forensic Behaviour at Monash University and Forensicare wrote:

> *"The high rate of mental illness in the criminal justice system is not the responsibility or fault of the police or the justice system; nor is it the fault or responsibility of the mental health system. It is a whole-of-government problem; a problem for all Victorians that is emblematic of the problems in mental health more generally. The problem is too large and cuts across too many areas to be solved by work done in any one of them. "*[24]

82. The first Practice Principle articulated in the 2010 Victoria Police-Department of Health Protocol for Mental Health also acknowledges the multidisciplinary nature of their joint responsibilities in this area:

> *"**Collaboration:** Staff from Victoria Police and public sector health services will work together in the best interests of the person with a mental illness. This means communicating all relevant information at the earliest opportunity, respecting professional judgment and independence (for example: operational decisions rest with police and clinical decisions rest with clinicians) and applying a problem solving approach to requests for assistance."*[25]

83. Ms Billing was faced with a patient who became agitated when he realised he would require transport in a divisional van. However, she did not consider seeking ambulance assistance. Mr

---

[22] State Coroner, Finding in the coronial investigation of the death of Tyler Cassidy, 23 November 2011, para 641.
[23] Victoria Police response to the State Coroner's recommendations in theFinding of the Coronial Investigation of the Death of Tyler Cassidy, 17 February 2012.
[24] James Ogloff, "The nether regions of justice: in custody and mentally ill", Opinion, The Age 31 May 2010.
[25] Mental Health & Drugs Division, Department of Health, Victoria, "Department of Health and Victoria Police Protocol for Mental Health", September 2010, p. 4.

Bloomfield's transfer to the Accident & Emergency Department at Bairnsdale Hospital would have been different if Ms Billing had invoked the help of ambulance officers.

84. Ambulance Victoria is now the lead agency for transfer of mentally ill patients to the Accident & Emergency Department of the local hospital for mental health assessment. Therefore, this work requires effective co-operation between law enforcement and other health professionals including Ambulance Victoria. **Recommendation 5**

Section 10 of the *Mental Health Act* 1986

85. Section 10(4) of the *Mental Health Act* 1986 provides:

"A member of the police force must, as soon as practicable after apprehending a person under subsection (1) ..... arrange for-

(a) an examination of the person by a registered medical practitioner; or

(b) an assessment of the person by a mental health practitioner."

86. In 2003, the *Mental Health Act* 1986 was amended to define a mental health practitioner as:

".... registered nurse, psychologist, social worker or occupational therapist who is employed by an approved mental health service and engaged in the provision of acute psychiatric assessment and treatment functions in the community."(my underline added).

87. In 2006, Victoria Police Operational Procedures: "Responsibilities of the Attending Unit" took the provisions of the *Mental Health Act* 1986 further in requiring police to stay with the client with a mental illness until the initial assessment was performed by Crisis Assessment Team (CAT) staff. There were no CAT services in Bairnsdale and mental health assessments are performed by the duty mental health practitioner.

88. Victoria Police Mental Health-Operational Information which was published in 2005 and distributed on the Victoria Police Intranet on 5 April 2007 took the direction further by requiring the police officer apprehending the patient under section 10 of the *Mental Health Act* 1986 to stay with the patient until he or she has been assessed by a mental health practitioner and accepted for admission or released.

89. Ms Billing and the other three police officers stayed at the Bairnsdale Hospital with Mr Bloomfield for less than 15 minutes on 10 November 2006. At 2.30pm, Ms Billing handed responsibility

for his management to Rick Lightowler to arrange for his assessment and examination. In that sense, she "arranged for his examination by a medical practitioner or assessment by a mental health practitioner", that is she complied with section 10(4) of the *Mental Health Act* 1986.

90. Mr Lightowler is a Division 1 nurse employed by the Bairnsdale Health Service to work in the Accident & Emergency Department. Therefore, he is not a medical practitioner and he is not a mental health practitioner with authority under the *Mental Health Act* 1986. Therefore, Ms Billing failed to comply with Police Operational Procedures.

91. Further, Mr Lightowler had not triaged Mr Bloomfield as failing to meet the criteria provided by section 8 of the *Mental Health Act* 1986 or at all when Ms Billing left the hospital. There is also no evidence that Ms Billing formally released Mr Bloomfield from custody.

92. I understand that Ms Billing might have assumed that Ms Judd or Mr Lightowler understood that Mr Bloomfield was an involuntary patient subject to section 10 of the *Mental Health Act* 1986. For the same reasons, I have also formed the view that Mr Lightowler and other staff at the Accident & Emergency Department at Bairnsdale Hospital should have assumed that Mr Bloomfield's presentation was subject to section 10 of the *Mental Health Act* 1986 and/or checked as to his legal status.

93. However, I do not accept Ms Billing's evidence that she told Ms Judd or Mr Lightowler that Mr Bloomfield was transported to the Accident & Emergency Department at Bairnsdale Hospital subject to section 10 of the *Mental Health Act* 1986.

94. Ms Billing told the Court that she was confused about the distinction between a psychiatric assessment and a medical examination. She also said that she was confused about the definition of medical practitioner and thought it included a nurse. She thought she could legitimately hand over Mr Bloomfield to a registered nurse when that person accepted the transfer.

95. Further, in the context of Bairnsdale where there is no approved mental health service and mental health practitioners work from a building on the same grounds as the hospital, it is not surprising that Ms Billing was unable to distinguish between a medical practitioner, a registered Accident & Emergency Department nurse and a mental health practitioner employed by an approved mental health service.

96. This misunderstanding was corrected in Mental Health-Operational Information which was published in 2005 and distributed on the Victoria Police Intranet on 5 April 2007.

97. Ms Billing was an Acting Sergeant on 10 November 2006, she was experienced in using section 10 of the *Mental Health Act* 1986, she had taken the phone calls about Mr Bloomfield during the day and there had been a very recent police mental health focus group held in Bairnsdale.

98. Therefore, it is a matter of concern that she did not understand that she was obliged under section 10 of the *Mental Health Act* 1986 and Victoria Police policies and procedures to take the following actions:

- refer Mr Bloomfield to mental health triage,
- seek ambulance assistance to transfer Mr Bloomfield,
- stay with Mr Bloomfield until he was assessed by a mental health practitioner and/or examined by a medical practitioner,
- understand the distinction between a medical practitioner, a registered nurse and a mental health practitioner,
- adequately explain Mr Bloomfield's legal status to Ms Jubb or Mr Lightowler, or
- formally release Mr Bloomfield from custody.

99. In evidence, Ms Billing agreed that, in hindsight, she should have stayed at the Accident & Emergency Department at Bairnsdale Hospital until Mr Bloomfield had been examined by a medical practitioner or assessed by a mental health practitioner.

100. Further, Ms Billing was not alone in her failure to understand the practical operation of section 10 of the *Mental Health Act* 1986. For example:

- Mr Smith from the Department of Health had another interpretation of the requirements of section 10 of the *Mental Health Act* 1986. He told the Court that the Department of Health understood that police are required to deliver custody of a patient transported subject to section 10 of the *Mental Health Act* 1986 to a medical practitioner. Mr Smith also said that local procedures for handing over responsibility for section 10 clients could be negotiated between Victoria Police and the Health Service.
- Ms Kerr from the Bairnsdale Community Mental Health Service told the Court she understood that the *Mental Health Act* 1986 stated:

".... that the police would stay until either a mental health assessment had taken place, or they had been reviewed by a medical officer."

- Commander Ashley Dickinson was appointed to be the Corporate Sponsor Mental Health in Victoria Police. He says, despite the provisions of the *Mental Health Act* 1986, Victoria Police practice

guidelines advise members to transfer a person transported under section 10 of the *Mental Health Act* 1986 to a medical practitioner noting the time of handover. Handover may occur in the community at a hospital or at a police station. This handover depends on the availability and responsiveness of appropriate clinical staff.

101. Of course it is important that police and health professionals comply with the law. However, in the circumstances facing Mr Bloomfield, the extensive discussion in the Inquest about whether or not nursing and medical staff knew he presented at the Accident and Emergency Department subject to section 10 of the *Mental Health Act* 1986 seems to me to be something of a "red herring". I say this for five reasons:

1. Mr Lightowler kept Mr Bloomfield under observation until about 3.15pm when Dr Heer examined him. Dr Heer's examination fulfilled Ms Billing's obligations and no harm had come to Mr Bloomfield in the meantime. Mr Bloomfield left the hospital 90 minutes after Dr Heer's examination with nursing approval and, again, an hour after that without approval. Therefore, whether or not Mr Lightowler or Dr Heer was aware he had presented subject to section 10 of the *Mental Health Act* 1986 would have made no difference to whether or when he left the hospital.
2. Dr Heer did not recommend Mr Bloomfield for involuntary admission and, in the absence of effective security arrangements, send him straight to Traralgon. Rather, he took 90 minutes to refer him to mental health triage for further assessment as to whether he met the criteria for involuntary admission imposed by section 8 of *the Mental Health Act* 1986.
3. In the hypothetical circumstances that would have arisen if Ms Mulkearns had assessed Mr Bloomfield at or before 3.00pm, she may have said then, as she had said before, that either she needed to delay assessment because his blood alcohol level was 0.07g/100mL or she could not recommend him for involuntary admission because he was not expressing suicidal intention, and he was known to be dual diagnosis patient with a personality disorder. In these circumstances, whether or not Mr Lightowler or Dr Heer was aware he had presented at 2.00pm subject to section 10 of the *Mental Health Act* 1986 would have made made no difference to Ms Mulkearns assessment and Mr Bloomfield would have been discharged home to the Applegum Caravan Park.
4. At 6.00pm, after Mr Bloomfield left the Accident and Emergency Department the second time, Dr Heer and Ms Kerr agreed that they would recommend Mr Bloomfield for admission as an involuntary patient when he returned. This indicates to me that they had both informally assessed him as meeting the criteria imposed by section 8 of *the Mental Health* Act 1986 because he failed to stay voluntarily for four hours waiting for assessment. Therefore, his section 10 presentation was irrelevant to their decision about his management.

5. Irrespective of his legal status, the decision to recommend Mr Bloomfield for involuntary admission should also have triggered contact with the police to re-initiate a search for him to protect him from their assessed risk. In those circumstances, I have no doubt that Ms Billing would have included this status report in her handover to Mr McWilliam at 7.00pm. It would then have been Mr McWilliam's responsibility to notify the shift before they left in the divisional van so that Mr Brooks and Mr Handley could have picked him up at 8.10pm when they saw him in the Applegum Caravan Park.

102. Therefore, I do not accept that Ms Billing's failure to stay at the hospital with Mr Bloomfield until he was examined by a medical officer or accurately communicate Mr Bloomfield's legal status to hospital staff made any significant difference to the way in which he was managed at the Accident & Emergency Department at Bairnsdale Hospital or his subsequent leaving the hospital without a mental health assessment.

103. In July 2006, Victoria Police appointed Eva Perez as Manager of the Mental Health Project and she reviewed the Victoria Police mental health policy and practice. In evidence, Ms Perez told the Court:

"I think we'd all agree it was quite repetitive in terms of replicating the legislation but it didn't provide the sort of guidance that our members and a good number of health service personnel were saying they would appreciate in terms of the application of the legislation so certainly s.10, it seems to reproduce the legislation but it doesn't go that next step, in terms of addressing issues in terms of how do you apply those sections. So our focus has been very clear about who the audience for that protocol is and the audience we see is very much front line, particularly the supervisors on the police side, so that they quickly find the sort of guidance they need in a very plain English form."

104. As relates to the circumstances of Mr Bloomfield's death, Ms Perez identified variation across the State in the way in which police manage mental health clients. She attributed these localised differences in practice to local police working out what they think is the most effective way of operating often in partnership with their health counterparts.

105. However, Victoria Police cannot and should not try to manage this issue alone. Again I quote Dr Ogloff:

"Given the scope of the problems and the extent to which they cut across ministries, mental health regions and services, an inter-ministerial commission or agency with access to direct service delivery may be the only appropriate solution to ensure that the situation can improve significantly for vulnerable people at the crossroads of the mental health and criminal justice

systems. Such an agency could case manage mentally ill offenders and co-ordinate services for them across justice and health sectors. "

106. I agree. **Recommendation 6**

Communication

107. Communication within agencies and between people working to assist a person who is mentally unwell is always going to be difficult to maintain when an incident involves different professional groups, spread over several shifts and from, in effect, three different organisations. These issues should be minimised in a small community like Bairnsdale where there are small numbers of people in each shift and the geography and general community is contained. They were inadequate on 10 and 11 November 2006.

108. However, Mr Bloomfield was able to leave the Accident & Emergency Department at Bairnsdale Hospital without mental health assessment because the history and seriousness of his condition was not communicated by the Bairnsdale police to the hospital staff, by the night nurse on duty at 1am on 10 November 2006 to the morning shift, by the medical officer to the afternoon shift nurses, by the telephone receptionist at the Bairnsdale Community Mental Service to the duty mental health practitioner, by the afternoon shift nurses to the police, or by the sergeant in charge of the night shift to the crew in the divisional van.

109. In particular:

- Mr Somerville did not record his presentation or hand over information to the morning shift about his visit to the Accident & Emergency Department at 1.30am on 10 November because he did not need medical or psychiatric assessment.
- Ms Billing did not contact mental health triage as suggested by the receptionist at Bairnsdale Community Mental Health Service to arrange rapid mental health assessment.
- Ms Billing did not tell Mr Lightowler or Mr Lightowler did not hear her tell him that Mr Bloomfield had been transferred subject to section 10 of the *Mental Health Act* 1986.
- Mr Lightowler and Dr Heer did not discuss Mr Bloomfield's presentation at all before Dr Heer rang mental health triage.
- Dr Heer did not tell the afternoon shift nurses that Mr Bloomfield was triaged Category 2 after he spoke to mental health triage.
- Sergeant McWilliam did not tell his shift about Mr Bloomfield's apprehension during the day and his release.

- At 10.45pm, the afternoon shift nurses did not tell Mr Somerville that Mr Bloomfield had been brought in by police and had left against medical advice without mental health assessment.
- At 1.00am on 11 November 2006, Mr Somerville did not contact police when Mr Bloomfield re-presented at the Accident & Emergency Department.

110. Ms Billing's handover to Sergeant McWilliam at 7.00pm was expansive and his written record of this information is the obvious exception to this otherwise inadequate lack of information transfer between people who needed to know Mr Bloomfield's history on 10 and 11 November 2006.

111. Emergency Services Liaison Committees have been established in regional centres to facilitate this communication. These committees determine the arrangements for patient management between Victoria Police, the Accident and Emergency Department, ambulance and other emergency services. They are required to report progress up to the Department of Health and Victoria Police every six months.

112. In 2006, Mr McWilliam had never heard of or participated in the Latrobe Regional Hospital Emergency Services Liaison Committee. However, by 2008, he was recorded as an apology as the Victoria Police representative on the Latrobe Regional Hospital Emergency Services Liaison Committee and Ms Mulkearns represented Bairnsdale Mental Health. The Director of Mental Health is now also a member of each regional Emergency Services Liaison Committee in Gippsland.

113. Further, consistent management of these patients requires better communication at the intra-departmental and inter-departmental levels. Since 2006, Victoria Police has developed a Mental Health Strategy 2007 which includes an organisational approach to mental health clients and attempts to integrate the different areas relating to mental health. This includes release of the practice guides via the intranet and targeted emails.

114. I note a report in "The Age" on 25 February 2012 in which Superintendent Mick Williams is quoted to admit that there were obvious flaws in the way police were taught to deal with people suffering psychological episodes:

> *"Superintendent Williams said police often were ''flying blind'' when sent to potentially violent incidents with disturbed offenders because medical records were not immediately available through D24. ''It would be a great advantage to know the history of the people we are dealing with."*[26]

[26] John Silvester, "*Police to revamp training for handling mentally ill*", "The Age", 25 February 2012.

115. Therefore, I am unable to assume that these new communication arrangements have been effective in improving communication between police and the mental health sector.

116. On 1 December 2009, a Mental Disorder Transfer Form (VP Form L42) was introduced to accompany a patient transferred by police to an Accident & Emergency Department. This form is intended to provide written confirmation of the patient's legal status and remove any doubt about the operation of Section 10 of the *Mental Health Act* 1986.

117. The uptake and usefulness of the Mental Disorder Transfer Form (VP Form L42) could be better assessed if it was included in the documents that are provided to the Centre for Operational Safety and analysed every six months prior to establishing the curriculum for the next OSTT cycle.

Recommendation 7

Use of Beacon O/C spray

118. John Kelleher is a scientist at the Victoria Police Forensic Centre. In his opinion, there are three possible ways to explain the scenario in which Mr Bloomfield became engulfed in flames on 11 November 2006. However, only two are consistent with Mr Kronk seeing the lighter spark:

i. If the cigarette lighter was empty and only sparking, it is possible that the spark was too weak to ignite the flammable vapour from the liquid on his clothes. The addition of O/C spray may have altered the composition of the mixture to a point where it could be ignited by a weak spark. Obviously the lighter spark is designed to ignite flammable gas mixtures similar to that in the O/C propellant.

ii. Mr Bloomfield's first attempts to ignite his clothing may have been too close to the clothing where the vapour is too rich to ignite. Either as a consequence of being sprayed or by chance, the lighter may have moved into the zone where ignition could occur.

119. Mr Kronk sprayed Mr Bloomfield close to his face. Victoria Police already tells Probationary Constables to discharge O/C spray at a minimum distance of 60cm in order to allow for dispersal of the propellants. In this case, spray closer than 60cm also favours Mr Kelleher's first option.

120. Therefore, I have formed the opinion that a spark from Mr Bloomfield's cigarette lighter probably ignited the Beacon O/C and/or propellant which Mr Kronk had discharged close to his face. This increased heat was sufficient to ignite the accelerant on Mr Bloomfield's body so that he burst into flames.

121. Further, I find it unlikely that Mr Bloomfield's cigarette lighter would have been able to ignite the flammable liquid on his body without the changed conditions imposed by the Beacon O/C and/or propellant.

122. However, in accepting Mr Kronk's evidence on this matter, I also find that, at 2.13am on 11 November 2006, he had no knowledge and no warning of the circumstances which led to his discharge of the Beacon O/C spray and ignition of the flammable liquid Mr Bloomfield had poured over himself.

123. Senior Sergeant Gregory Moon is in charge of the Continuous Improvement Section of the Operational Safety Division of Victoria Police. He confirmed that:

> *"The options available to the members in dealing with the situation were extremely limited and given the circumstances the decision to use OC spray to cause the subject to drop the lighter was a reasonable call."*

124. Therefore, although Mr Bloomfield was displaying difficulty in igniting his cigarette lighter and may not have had the physical capability to carry out the threat, Mr Kronk's discharge of Beacon O/C spray on 11 November 2006 was within Victoria Police guidelines for its use against a reactive threat where it is required to prevent serious injury.

125. However, I note that Mr Kronk had only been at the Applegum Caravan Park for less than one minute when he discharged the O/C spray. He felt unprepared for the situation with which he was confronted. Other than ordering Mr Bloomfield to drop the cigarette lighter in an authoritarian manner, he did not attempt to otherwise defuse the situation.

126. The State Coroner was concerned about police over-reliance on operational equipment in her analysis of Tyler Cassidy's death.[27] In response to Her Honour's recommendations, Victoria Police indicated they have undertaken a literature review and =extensive consultation. An Options Paper is being produced. Although I understand the urgency with which Mr Kronk responded to seeing Mr Bloomfield's cigarette lighter flashing and the liquid all over him, his rapid use of Beacon O/C spray to Mr Bloomfield's situation is a further example of the deterioration in operational reliance on verbal skills.

127. Inspector Craig Walsh says that the flammability of the carrier and propellant in O/C spray had been well communicated within Victoria Police. However, Victoria Police Operating Procedures are not clear that O/C spray is highly flammable. Rather, they state:

[27] State Coroner, Finding in the coronial investigation of the death of Tyler Cassidy, 23 November 2011, para 641.

"Whilst the spray is inflammable research has shown that the spray will only be ignited by a naked flame when the flame is held at a distance where the spray has travelled far enough from the nozzle to allow sufficient oxygen to be present for the mixture to burn.
In order to completely avoid potential for injury, at no stage is OC to be deployed if there is any potential for the spray to come into contact with a naked flame. "

128. The Court also heard that the it is not unusual for the warning labels on Beacon O/C spray cannisters to be obscured or rubbed off by friction with other operational equipment. **Recommendation 8**

129. As I understand it, one reason for introducing mandatory OST training every six months was to ensure recall of specific operational information in rare emergency circumstances. In January to June 2007, the OSTT programme included a time-limited package demonstrating the flammable nature of Beacon O/C spray and the distance from the target required to minimise its flammability. However, there was no evidence before me that practical training in relation to the flammability of Beacon O/C spray is a routine component of the OSTT curriculum. **Recommendation 9**

130. Despite the publicity given to Mr Bloomfield's death and this specific OSTT package relating to flammability of O/C spray, Victoria Police members were involved in an incident in 2007 involving accidental ignition of O/C spray with a cigarette. In that case, Darren Dumughun was burned by the flames from the fire and was treated in hospital.

131. Therefore, I do not accept that operational Victoria Police members retain sufficient information about the otherwise well-known risk of fire associated with use of Beacon O/C spray to be able to recall it in the rare emergency operational circumstances when the need arises. **Recommendation 10**

132. The flammability of Beacon O/C spray is created by the flammability of the solvent for the oleoresin capsicum component and by the flammability of the propellant which carries the O/C solution towards the target. Victoria Police is well aware that both these issues also need to be addressed before it is possible to operate Taser and other spark-inducing operational equipment after or close to the time of Beacon O/C spray.

133. However, in 2010, the evidence before me suggested that Victoria Police efforts to find a less flammable composition for Beacon O/C spray were still restricted to water-based solvents for the oleoresin capsicum component. The operational effectiveness of these options was limited by the propellant that was required to transport them. In 2007, other options were available that may have been useful. These were not canvassed before me.

134. Accordingly, I have formed the view that Victoria Police members who were determining the specifications for Beacon O/C spray were not able to combine sufficient operational and scientific expertise to search widely for the best possible solution to the flammability and operational issues inherent in the Beacon O/C spray used by Mr Kronk on 11 November 2006. **Recommendation 11**

RECOMMENDATIONS:

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

1. That the Minister for Mental Health extend the policy of providing triage and integrated services to patients with dual diagnoses to small regional hospitals like Bairnsdale Hospital.

2. That the Department of Health and Victoria Police review their protocols relating to mental health telephone triage in Gippsland to improve flexibility of communication between mental health service providers including local service agencies, Ambulance Victoria, Victoria Police, Accident & Emergency Department at Bairnsdale Regional Health Service, Bairnsdale Community Mental Health Service, and the Mental Health Triage Service at Traralgon.

3. That the Latrobe Health Service ensure that Accident & Emergency Department staff report to police all patients who present in police custody and discharge themselves without assessment by a mental health practitioner.

4. That the Chief Psychiatrist ensure that the changes recommended by the Mental Health Triage Scale Advisory Committee are consistent with other triage scales used concurrently in Accident & Emergency Departments of regional health services.

5. That Victoria Police and Ambulance Victoria establish a protocol and practical guidelines for transport of patients suspected to have a mental illness under section 10 of the *Mental Health Act* 1986.

6. That the Minister for Mental Health and the Minister for Police and Emergency Services co-operate to establish an inter-ministerial commission or agency with access to direct service delivery for people with a mental illness and dual diagnosis across the justice and health sectors as recommended by Dr James Ogloff.

7. That Victoria Police arrange for copies of the Mental Disorder Transfer Forms (VP Form L42) to be forwarded to the Centre for Operational Effectiveness for analysis and consideration in developing the next six months curriculum for OSTT.

8. That Victoria Police review the specifications for the labelling of Beacon O/C spray to ensure that its flammability is well-communicated and the label does not rub off.

9. That Victoria Police include examples of the flammability of O/C spray including the distance required to reduce the likelihood of igniting the solvent in all six monthly Operational Safety & Tactics Training programmes.

10. That Victoria Police review the uptake of Operational Safety & Tactics Training to evaluate recall of safety information, including flammability relating to use of O/C spray, in operational circumstances.

11. That Victoria Police authorise an independent specialist review of the solvent and propellant systems for oleoresin capsicum to identify an appropriate non-flammable solvent that requires a less flammable propellant with characteristics that are consistent with operational requirements.

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

Attorney General
Minister for Health
Minister for Mental Health
Minister for Police & Emergency Services
Chief Psychiatrist
Australian and New Zealand College of Emergency Medicine
Ambulance Victoria
Dr Heer

Signature:

DR JANE HENDTLASS
CORONER

19 April 2012

Coroners Court of Victoria