



IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2014 002445

FINDINGS INTO DEATH WITH INQUEST

Form 37 Rule 60(1)

Section 67 of the Coroners Act 2008

Inquest into the Death of:

MICHAEL JOHN DARMODY

Delivered On:

10 April 2017

Delivered At:

Coroners Court of Victoria at Melbourne
65 Kavanagh Street, Southbank, Victoria 3006

Hearing Dates:

18-22 April 2016, 18-19 July 2016

Findings of:

JOHN OLLE, CORONER

Representation:

Mr James Fitzgerald of Counsel instructed by Victoria
Legal Aid for the Darmody family
Ms Erin Gardner of Counsel instructed by the VGSO for
the Chief Commissioner of Police
Ms Julia Greenham of Counsel instructed by Russell
Kennedy for Ms Karyn Hollenback

Counsel Assisting the Coroner:

Ms Naomi Hodgson of Counsel instructed by Ms Sarah
Gebert, Principal In-House Solicitor

I, JOHN OLLE, Coroner, having investigated the death of **MICHAEL JOHN DARMODY**

AND having held an inquest in relation to his death on 18-22 April 2016 and 18-19 July 2016 at the Coroners Court of Victoria at Melbourne

find that the identity of the deceased was MICHAEL JOHN DARMODY

born on 14 February 1963

and the death occurred on 12 May 2014

at the Monash Medical Centre

from:

- 1(a) COMBINED DRUG TOXICITY (METHADONE AND BENZODIAZEPINES) IN A MAN WITH CORONARY AND CEREBROVASCULAR DISEASE.

in the following circumstances:

BACKGROUND

1. Michael John Darmody (referred to in my finding as “Michael”) was born on 14 February 1963 and was aged 53 years at the time of his death. He was the son of Lola Jenkins and James Darmody, and was the oldest of 5 children – with sisters Tracey and Tammy, brothers Rodney and Ricky, and a half-brother Shane. Michael had long term relationships in the past but was not married and had no children¹.
2. In November 2013, Michael was released from prison and moved to the address of his ex-partner Samantha Bidmead in Frankston North². He was admitted to Frankston Hospital ICU in November with what was initially regarded as stroke illness but was later determined to be toxic leukoencephalopathy ‘*related to previous and recent Heroin and possible Cocaine use.*’³ He then spent several extended periods in Frankston Hospital between 19 November 2013 and April 2014, during the later stage of which he had no fixed address.⁴
3. Michael was a smoker and cannabis user whose medical history, according to Peninsula Health, included a history of injecting drug use, hepatitis C, previous stab wounds, left foot drop, and acquired brain injury.⁵

¹ Coronial Brief of Evidence, Summary, at page 2.

² Coronial Brief of Evidence, Statement of Dr Peter Gerard Lynch, dated 24 September 2014, at page 28.

³ Ibid at page 28.

⁴ Ibid at page 28.

⁵ Ibid at pages 28 and 29.

4. On 6 May 2014, Ms Bidmead called '000' and reported she had left her house, having been held against her will by Michael, who held a knife. She reported having an un-served family violence order against Michael who was at her premises in North Frankston.⁶ On arrival, police became aware of an outstanding County Court bench warrant⁷ and accordingly took him into custody. Michael was transported to Frankston Police Station at around 11.50pm.⁸
5. Following a Bail Justice hearing conducted at Frankston Police Station, Michael was remanded in custody.⁹ Due to the Frankston cells being at full capacity he was to be transported to the Moorabbin Police Station. Prior to transportation, Michael was searched and found in possession of 2 Kalma tablets¹⁰, (the drug name of which is alprazolam, a type of benzodiazepine).
6. A precis of police members observations in relation to Michael's health, including contact made with the Custodial Health Advice Line ('CHAL'), are set out below.
7. At approximately 6.05am, members at Moorabbin Police Station found Michael unconscious¹¹ and attempted CPR¹² and contacted '000'.¹³ Paramedics attended and obtained a pulse at approximately 6.27am, and transported Michael to Monash Medical Centre.¹⁴ Michael died on 12 May 2014.¹⁵

THE CORONIAL JURISDICTION

8. The primary purpose of a coronial investigation of a reportable death¹⁶ is to ascertain, if possible, the identity of the deceased person, the cause of death (interpreted as the medical cause of death) and the circumstances in which the death occurred.¹⁷ An investigation is conducted pursuant to the Coroners Act 2008 (the Act). The practice is to refer to the medical cause of death incorporating, where appropriate, the mode or mechanism of death,

⁶ Coronial Brief of Evidence, '000' Transcription, at pages 148-153.

⁷ Coronial Brief of Evidence, Bench Warrant to Apprehend, at page 159.

⁸ Coronial Brief of Evidence, Attendance Summary, dated 6 and 7 May 2014, at page 189.

⁹ Coronial Brief of Evidence, Remand Warrant, dated 7 May 2017, at page 161.

¹⁰ Coronial Brief of Evidence, Property Report, pages 507-508 (Exhibit 10).

¹¹ Coronial Brief of Evidence, Statement of Gina Golegos, dated 12 November 2014, at page 101 [102] (Exhibit 19); Statement of Brad Johnstone, dated 30 October 2014, at page 95 [96] (Exhibit 20).

¹² Coronial Brief of Evidence, Defibrillation Record, at page 235.

¹³ Coronial Brief of Evidence, '000' Transcription, at page 219.

¹⁴ Coronial Brief of Evidence, Statement of Stuart Morris, dated 17 July 2014, at pages 124-125.

¹⁵ Coronial Brief of Evidence, Report of Dr David Eddey, dated 5 April 2016, at page 467 [471] (Exhibit 1).

¹⁶ Section 4 of the Coroners Act 2008 (Vic) requires certain deaths to be reported to the coroner for investigation.

¹⁷ Section 67 of the Coroners Act 2008 (Vic).

and to limit the investigation to circumstances sufficiently proximate and causally relevant to the death.¹⁸

9. Coronial findings must be made on the basis of proof of relevant facts on the balance of probabilities and that in determining whether a matter is proven to that standard, consistent with the principles enunciated in *Briginshaw v Briginshaw*.¹⁹
10. Coroner's are empowered to report to the Attorney-General on a death they have investigated; to comment on any matter connected with the death, including matters relating to public health and safety or the administration of justice; and to make recommendations to any Minister, public statutory or entity on any matter connected with the death, including recommendations relating to public health and safety or the administration of justice.²⁰ This is generally referred to as the prevention role of the Coroner.

THE INVESTIGATION

11. I acknowledge the significant contribution of my coronial investigator, Detective Sergeant Mark Hatt, Homicide Squad who prepared a comprehensive coronial brief.

INQUEST

12. There is no dispute about Michael's identity or the medical cause of his death. It is the circumstances of his death with which I am principally concerned.
13. It is important to note that an inquest is not about finding fault and it is not about apportioning blame for Michael's death. That is not the coroner's role.
14. Further, in looking back at what was done or not done, or known or not known, coroners have the great benefit and luxury of hindsight - something which is not granted to those who live out the events, which coroners then review in the calmness of a courtroom. The question is not what was known now, but what was known and could have been done and by whom at the time.
15. Whilst my role is not to attribute blame, that does not mean that I cannot and should not try to identify moments in time where things might have been done differently, or signs of what was to come that were missed at the time.

¹⁸ Coroners are also empowered to report to the Attorney-General on a death they have investigated; the power to comment on any matter connected with the death, including matters relating to public health and safety or the administration of justice; and the power to make recommendations to any Minister, public statutory or entity on any matter *connected with the death*, including recommendations relating to public health and safety or the administration of justice. Sections 72(1), 72(2) and 67(3) of the Act regarding reports, recommendations and comments respectively.

¹⁹ *Briginshaw v Briginshaw* (1938) 60 C.L.R. 336.

²⁰ Sections 72(1), 72(2) and 67(3) of the Coroners Act 2008 (Vic) regarding reports, recommendations and comments respectively.

16. Saying something was missed or a different decision could have been made, is not the same thing as attributing blame or responsibility. Accordingly, it is entirely appropriate for me to make an assessment, not only of what the facts were and what was known, but of the reasonableness and the appropriateness of what was done by people who had access to information, including an assessment of systemic issues. To enable me to make an assessment of what could or should have been done, and whether systemic issues are identified which could enhance the welfare of prisoners in police cells.

Discrete Issues

17. The following issues were identified at the commencement of the hearing on 18 April 2016, and as otherwise arose during the course of the inquest:
- a. What information the police had about Michael's medical history on 6-7 May 2014.
 - b. The searches conducted on Michael and the finding of Kalma.²¹
 - c. The police members' observations of Michael and the application of the medical checklist from the police manual guideline.
 - d. The communications between the police members and the Custodial Health Advice Line (CHAL) nurse, Ms Karyn Hollenback.
 - e. The reasonableness of the advice of Ms Hollenback, together with her training and the systems involved in dealing with this situation.
 - f. Whether Michael's death would have been survivable with earlier intervention.
 - g. The operation of the defibrillation machine.
18. I now consider the evidence in relation to each of these issues in light of the applicable policies, procedures and training with a view to identify opportunities for prevention focused interventions.
19. I note at this juncture that a number of topics were canvassed at inquest but have not been covered in this finding. This decision was made having considered carefully my core mandate to investigate circumstances sufficiently related to the death and my coronial obligation in respect of prevention.

²¹ Brand name of alprazolam, a type of benzodiazepine.

20. I do not purport to summarise all of the material/evidence in this finding, but will refer to it only in such detail as is warranted by its forensic significance and where otherwise appropriate. The absence of reference to any particular aspect of the evidence, either obtained through a witness or tended in evidence, as well as submissions and replies, does not infer that it has not been considered.
21. As a death in custody, it is mandatory that I convene a public hearing by way of inquest. I heard oral evidence from the following witnesses:
- Dr David Eddey
 - Senior Constable Rodney Hayne
 - Constable Jason Morel
 - Dr Michael Burke
 - Acting Sergeant Kirby Tonkin
 - Senior Constable Matthew Slade
 - Constable Liliana Skotanis
 - Constable Gina Golegos
 - Sergeant Brad Johnstone
 - Sergeant Sean Mayne
 - Mr Tim Dorey
 - Ms Karyn Hollenback
 - Professor Marie Gertz
22. I have been greatly assisted by members of Counsel throughout the inquest and during the submission phase. The co-operation of Counsel enabled the formulation of agreed facts prepared by Counsel Assisting, who has succinctly and accurately detailed the relevant facts, and supporting evidence. I convey my sincere appreciation to all members of Counsel.

CIRCUMSTANCES IN WHICH THE DEATH OCCURRED

Medical Examination

23. A post mortem examination was conducted by Dr Michael Burke, Forensic Pathologist of the Victorian Institute of Forensic Medicine (VIFM). He determined the cause of death to be:
 - 1 (a) Combined drug toxicity (methadone and benzodiazepines) in a man with coronary and cerebrovascular disease.
24. Dr Burke noted the post mortem examination showed significant heart disease with myocardial fibrosis and associated coronary artery atherosclerosis. The degree of heart disease would be consistent with causing sudden death as a result of a cardiac arrhythmia (heart attack).
25. The toxicological examination showed the presence of methadone, amphetamine, and benzodiazepines and cannabis, in addition to therapeutic drugs.
26. Dr Burke noted that Michael may well have been absorbing any drugs taken orally whilst he was in the police lock up. He further commented that it would seem reasonable to suggest Michael succumbed to the combined effects of drugs in his system, and may well have been more susceptible due to his underlying natural disease.

Facts and Circumstances

Information police had about Michael's medical history

27. All police members who had contact with Michael on 6 and 7 May 2014, were unaware of his medical history. This is consistent with the information on the police records including the Electronic Patrol Duty Return²², Attendance Summary²³, Custody Overview²⁴, Custody Module²⁵, LEAP records²⁶ and LEAP Dossier.²⁷ The exception is that Frankston and Moorabbin Police knew of Michael's pre-existing back injury which was recorded on both

²² Coronial Brief of Evidence, Electronic Patrol Duty Return, at pages 522-528 (Exhibit 4).

²³ Coronial Brief of Evidence, Attendance Summary, at page 189.

²⁴ Coronial Brief of Evidence, Custody Overview, at pages 191-192.

²⁵ Coronial Brief of Evidence, Custody Module, at page 215 (8 pages).

²⁶ Coronial Brief of Evidence, LEAP records, at pages 437-447.

²⁷ Exhibit 9, LEAP Dossier.

Custody Risk Assessments²⁸ and also that Frankston (A/Sergeant Kirby Tonkin) recorded 'hep C' under diseases and 'valium' under medication on the risk assessment. A/Sergeant Tonkin said that the note about the medication valium was information provided by Michael.²⁹ The LEAP Dossier also contained information that Michael was a known drug user.³⁰ It appears only A/Sgt Tonkin accessed this information on the evening of 6-7 May 2014.³¹

28. Dr Eddey considered Michael's medical and drug use history would be useful information but not particularly relevant in making a triage decision about what needs to be done to a patient *'who's in front of them with breathing difficulty and is quite drowsy and is not waking up.'*³²

Searches conducted and the finding of Kalma tablets

29. At Frankston Police Station, Senior Constable Rodney Hayne conducted a pat down search of Michael prior to putting him in the police van upon arrest.³³ He understood it was an obligation to do a pat down search prior to taking a person into custody³⁴ - *'A pat down of exterior clothing. Supposed to be a search to make sure there's no weapons or items that can be used to harm us.'*³⁵ He explained he did not have authority to perform a full search; that he would only do so if directed, and further, he needed a reason, for example suspected drug trafficking.³⁶
30. Upon Michael's remand hearing³⁷ First Constable Jason Morel and First Constable Butler conducted a full search, including removal of clothes. At this time two tablets, later identified as Kalma tablets, were found in his pocket.³⁸ F/Constable Morel explained that prior to remand, there was no authority to conduct a full search.³⁹
31. The property register contains a handwritten note including *'2 x Tablets (Kalma)'* and the second page includes typed *'TEAB...containing 2 pink tablets'*.⁴⁰ Neither F/Constable Morel nor S/Constable Hayne could recall telling anyone at Moorabbin about the

²⁸ Coronial Brief of Evidence, Custody Risk Assessments, at pages 185 and 217.

²⁹ Transcript of Inquest, dated 19 April 2016, page 158, lines 8-11.

³⁰ Exhibit 9, LEAP Dossier.

³¹ Transcript of Inquest, dated 19 April 2016, at page 151, lines 26-31.

³² Transcript of Inquest, dated 18 April 2016, at page 45, lines 17-22.

³³ Transcript of Inquest, dated 18 April 2016, at page 54, lines 9-10.

³⁴ Transcript of Inquest, dated 18 April 2016, starting at page 54 line 29 - page 55 line 3.

³⁵ Transcript of Inquest, dated 18 April 2016, at page 54, lines 16-19.

³⁶ Transcript of Inquest, dated 18 April 2016, starting at page 81 line 24 - page 82 line 6.

³⁷ Coronial Brief of Evidence, Statement of Jason Morel, dated 9 May 2014, at page 47 [49] (Exhibit 5).

³⁸ Transcript of Inquest, dated 18 April 2016, at page 97, lines 21-29.

³⁹ Transcript of Inquest, dated 18 April 2016, at page 81, lines 3-16.

⁴⁰ Coronial Brief of Evidence, Current Prisoner Property document, at pages 507-508 (Exhibit 10).

discovery of the Kalma tablets.⁴¹ S/Constable Hayne explained - *'it seems like something that we would hand over the property and say, "This is - well, this is the property".'*⁴² A/Sgt Tonkin did not tell any member at Moorabbin about the discovery of the Kalma tablets.⁴³

32. Sergeant Sean Mayne, who was rostered to perform the role of both Section Sergeant and Custody Sergeant of Moorabbin overnight⁴⁴, did not know about the discovery of the tablets at Frankston.⁴⁵ Constable Liliana Skotanis, the watch house keeper, was also unaware of the discovery of tablets at Frankston, nor reference to them on the property sheet. In any event, she did not know what the pills were or what they are used for.⁴⁶

Police member's observations and medical checklist

Senior Constable Hayne

33. S/Constable Hayne initially transported Michael from the Frankston North address to Frankston Police Station. Although he considered Michael was a drug user, he did not consider Michael presented as drug or alcohol affected.⁴⁷ Whether he referred to the medical checklist, he explained - *'Um, not - not really, no, I - I, ..., it's sort of almost an automatic, um, process that you - that you'll assess someone when they come into police custody and if they're - if they're, ..., not confused or disorientated or coma scale five, then I don't really need to take it - I don't really need to refer to that to go any further really.'*⁴⁸

First Constable Morel

34. F/Constable Morel did not consider that Michael was drugged or drug affected⁴⁹ or that he appeared drowsy or dozy or had any change in his level of alertness.⁵⁰ Whether he considered any of the issues from the flowchart on the medical checklist relevant to Michael, he replied: *'No, there was nothing - there was nothing presenting that would've made me believe that it was anything other than a five or anything less than that.'*⁵¹ The

⁴¹ Transcript of Inquest, dated 19 April 2016, at page 157, lines 5-18.

⁴² Transcript of Inquest, dated 18 April 2016, at page 57, lines 1-4.

⁴³ Transcript of Inquest, dated 19 April 2016, at page 157, lines 1-7.

⁴⁴ Coronial Brief of Evidence, Statement of Sean Mayne, dated 15 May 2014, at page 66 [69] (Exhibit 22).

⁴⁵ Transcript of Inquest, dated 21 April 2016, at page 412, lines 6-15.

⁴⁶ Transcript of Inquest, dated 20 April 2016, at pages 339 lines 13-19, and 274 lines 9-18.

⁴⁷ Transcript of Inquest, dated 18 April 2016, at page 57, lines 5-17.

⁴⁸ Transcript of Inquest, dated 18 April 2016, at page 58, lines 14-22.

⁴⁹ Transcript of Inquest, dated 18 April 2016, at page 101, lines 4-11.

⁵⁰ Transcript of Inquest, dated 18 April 2016, at page 103, lines 22-26.

⁵¹ Transcript of Inquest, dated 18 April 2016, at page 102, lines 14-17.

medical checklist records a coma scale of 5 as 'Oriented knows and clearly states name, date and place and that 'No Action' is required'.

Senior Constable Slade

35. S/Constable Slade did not consider that Michael was drug or alcohol affected, and said he had limited dealings with him.⁵² While he did not have direct reference to the medical checklist, he explained that Michael presented as no risk on the coma scale.⁵³

Acting Sergeant Tonkin

36. A/Sgt Tonkin did not consider that Michael was drug or alcohol affected.⁵⁴ The medical checklist did form part of his risk assessment on the evening of 6 May 2014. Throughout his contact, he stated Michael remained a coma scale 5.^{55,56}

Constable Skotanis

37. Const Skotanis did not consider Michael was drug or alcohol affected on the night. Further, she had never seen anyone (who was drug affected) present as Michael presented that evening.⁵⁷ She could not recall making reference to the medical checklist - rather the categories and Michael's responses to rouses against the scale.⁵⁸
38. Const Skotanis explained had she referred to the medical checklist, between 4.08am and 4.18am and Michael wasn't confused, thus, was not a four, but she could not categorise him a five.⁵⁹ At 5.07am, Michael was breathing, although she could not recall him providing a verbal response. He had '*really phlegmy, snotty type breathing*'⁶⁰ and that by reference to the medical checklist was '*probably a three*'.⁶¹ Because of the deterioration he would associate with a coma scale category three, it was necessary to - '*Just kept checking on him, making sure we checked on him, ..., and, ..., informing - or not me personally, but Sergeant Mayne informing CHALs as well.*'⁶² When asked if she considered calling an ambulance, Const Skotanis responded - '*...we're not medical experts*

⁵² Transcript of Inquest, dated 19 April 2016, at page 229, lines 4-11.

⁵³ Transcript of Inquest, dated 19 April 2016, at page 228, lines 13-23.

⁵⁴ Transcript of Inquest, dated 19 April 2016, at page 157, lines 16-18.

⁵⁵ Note this '5' is according to the medical checklist, not according to the Glasgow Coma Scale.

⁵⁶ Transcript of Inquest, dated 19 April 2016, at page 159, lines 2-8.

⁵⁷ Transcript of Inquest, dated 20 April 2016, at page 272, lines 11-28.

⁵⁸ Transcript of Inquest, dated 20 April 2016, at page 286, lines 1-12.

⁵⁹ Transcript of Inquest, dated 20 April 2016, at page 287, lines 288.

⁶⁰ Transcript of Inquest, dated 20 April 2016, at page 289, lines 24-25.

⁶¹ Transcript of Inquest, dated 20 April 2016, at page 291, lines 11-14.

⁶² Transcript of Inquest, dated 20 April 2016, at page 292, lines 2-5.

*so that's why the calls were made to CHALs, to seek medical advice on what to do.*⁶³ The medical checklist records a coma scale of 3 as 'Meaningless unintelligible unable to be understood' and that 'Send to hospital or seek urgent medical advice' is required. Further, the medical checklist records a coma scale of 4 as 'Confused unable to state name, date, place etc.' and that 'Consider obtaining medical advice. Monitor regularly for signs of deterioration' is required.

39. Const Skotanis did not recall if she had regard to the medical checklist at around 5.45am when she observed Michael through the door-slot with Const Golegos, and could not recall if she tried to elicit a verbal response at that time.⁶⁴
40. In respect to Michael's breathing, she explained - *'...it was a snotty, phlemmy breathing, and I've never heard that in anyone before. ..., and like I said, I'm not a doctor to make that call as to why he was breathing that way.'*⁶⁵
41. Due to her concerns, Const Skotanis wrote 'constant obs' on the whiteboard next to Michael's name to ensure that the morning shift and other members were aware that he required constant observation.⁶⁶ She explained Sgt Mayne and herself decided - *'with his breathing the way it was, we made a decision to do more regular checks than what we would normally do.'*⁶⁷ In hindsight, she stated the word 'constant' was probably incorrect. She wanted more regular checks conducted on Michael, but did not envisage an officer never leave his side.⁶⁸

Sergeant Mayne

42. Sgt Mayne did not consider Michael drug or alcohol affected on the night.⁶⁹ His assessment at initial reception to Moorabbin Police Station - *'Initial entry he was fine. It was, you know, good verbal response, oriented, everything. Everything was good, you know, we're having a chat, he's just tired. He's telling me he's tired, he's telling me he wants to go to sleep, he doesn't want to be by himself, he wants to go in with the others... he was quite happy at that stage so there was no further action needed at this stage.'*⁷⁰

⁶³ Transcript of Inquest, dated 20 April 2016, at page 292, lines 10-14.

⁶⁴ Transcript of Inquest, dated 20 April 2016, at page 292 line 25 – page 293 line 3.

⁶⁵ Transcript of Inquest, dated 20 April 2016, at page 317, lines 16-19.

⁶⁶ Coronial Brief of Evidence, Statement of Liliana Skotanis, dated 13 May 2014, at page 82 [89] (Exhibit 16).

⁶⁷ Transcript of Inquest, dated 20 April 2016, at page 281, lines 22-24.

⁶⁸ Transcript of Inquest, dated 20 April 2016, at page 282, lines 4-8.

⁶⁹ Transcript of Inquest, dated 22 April 2016, at page 503, lines 1-3.

⁷⁰ Transcript of Inquest, dated 21 April 2016, at page 413 line 28 – page 414 line 8.

43. Regarding Michael's presentation at 4.22am, Sgt Mayne said when asked if he had regard to the coma scale, *'If you look at the bottom left-hand corner, the blue box, "needs medical attention or medication, seek medical advice" was what I'm working on, and - which I did, and that's why I made the call, and the information you'll find somewhere in the document is that you give an indication to the nurse as to what sort of conditions that the person is presenting with.'*⁷¹
44. As to whether he referred to the coma scale during Michael's presentation at 5.10am, Sgt Mayne stated, *'No, because I checked him - I had a loose conversation with him, he presented as being fine apart from frail in health at that point. I didn't suspect that he had any other ailments apart from just, ..., the standard health issues. I didn't consider that he had an issue where his health was deteriorating in any way, so I checked him not long prior and he woke up and gave me a response and went back into a deep sleep. I assumed that that's how he sleeps.'*⁷²
45. Sgt Mayne said he thought Michael was not going to be able to 'front at court' that day. He said that at that stage, *'I'm thinking well he's - we might want to get him looked at on the scene, ..., him make an assessment with his frailty, whether he's sick, whether he needs some attention and whether, you know, the best facility would be for him to be in at the Custody Centre, ..., as soon as possible so he can get that help.'*⁷³ He said that was why he phoned Ms Hollenback.⁷⁴
46. Sgt Mayne did not consider him against the coma scale *'... because all things known to me, as I stated, ..., I didn't feel it necessary to, ..., measure him against that scale when I just had the interaction with him over the last couple of hours that were fine - apart from his frailty.'*⁷⁵
47. Sgt Mayne also said at 5.10am, the best verbal response Michael provided was an annoyed grunt, *'Like leave me alone, I'm seeping [sic]-type grunt.'*⁷⁶ When asked if he considered rousing him to get a response, Sgt Mayne said, *'No, I was considering the fact that he had to get up for court in a couple of hours. I'm not going to keep waking him up, I'm just checking to see if he was okay, his pulse and his breathing and everything, because I - I'm not going to shake him up. Like, you know, I'm not going go and shake all the prisoners up*

⁷¹ Transcript of Inquest, dated 21 April 2016, at page 414, lines 20-31.

⁷² Transcript of Inquest, dated 21 April 2016, at page 425, lines 22-30.

⁷³ Transcript of Inquest, dated 21 April 2016, at page 426, lines 2-21.

⁷⁴ Ibid.

⁷⁵ Transcript of Inquest, dated 21 April 2016, at page 426, lines 24-28.

⁷⁶ Transcript of Inquest, dated 21 April 2016, at page 427, lines 3-4.

*in the morning, they end up rioting if you wake them up all the time. So I wasn't going to do that to him.*⁷⁷

48. Whether Sgt Mayne considered Michael's condition had deteriorated between 4.22 am and 5.10am - *'No, I think he's gone from being really tired being in custody all night and being of poor general health and then going into a deep sleep. I'm pretty sure that - that - you know, I just assumed that that's his style of sleeping and you can't - you know, you - he sleeps like that and I'm not going to keep waking him up.'*⁷⁸

Communications between the police members and Ms Hollenback

Frankston

49. The evidence reveals three calls made from Frankston Police Station to the CHAL service at 1.09am, 1.16am and 1.39am (based on the times recorded in the Telstra Record).⁷⁹ A/Sgt Tonkin and S/Constable Slade recall speaking to the CHAL nurse on that evening. The evidence does not reveal which officer was responsible for which call or calls in that period.

Senior Constable Slade

50. At approximately 1.15am S/Constable Slade was tasked by A/Sgt Tonkin to call the CHAL in regard to back and kidney problems for which Michael was seeking medical attention.⁸⁰ He entered into the Custody Module, the information *'existing injuries to back, nil new injuries'*⁸¹ and created Michael's profile in the Custody Module by linking from the Attendance Summary⁸² after he spoke to the CHAL nurse.⁸³ S/Constable Slade stated he did not use the term 'not on this planet' to the CHAL nurse, which appears as a comment made by Victoria Police on the CHAL computer record⁸⁴ because they are not words he would ever use to describe someone who was drug affected and in any event did not think Michael was drug affected.⁸⁵
51. He advised the CHAL nurse of Michael's symptoms, as outlined to him (back and kidney problems). He entered the interview room with a cordless phone, however Michael refused

⁷⁷ Transcript of Inquest, dated 21 April 2016, at page 427, lines 5-14.

⁷⁸ Transcript of Inquest, dated 21 April 2016, at page 427, lines 17-23.

⁷⁹ Coronial Brief of Evidence, CHAL Telstra Record for 7 May 2014, at page 197.

⁸⁰ Coronial Brief of Evidence, Statement of Matthew Slade, dated 19 August 2014, at page 56 (Exhibit 14).

⁸¹ Coronial Brief of Evidence, Custody Module, at page 215 (8 pages) (Exhibit 15).

⁸² Transcript of Inquest, dated 19 April 2016, at page 233, lines 6-14.

⁸³ Transcript of Inquest, dated 19 April 2016, at page 234, lines 14-16.

⁸⁴ Coronial Brief of Evidence, CHS triage consultation, at page 426.

⁸⁵ Transcript of Inquest, dated 19 April 2016, at page 229, lines 18-29.

to speak to the nurse. He further recalled the nurse had no concerns and immediate medical attention was not required.⁸⁶

Acting Sergeant Tonkin

52. A/Sgt Tonkin recalls only one phone call to the CHAL nurse on 7 May 2014, however acknowledged a second call would have been made to inform her of Michael's remand and impending transport to Moorabbin Police Station.⁸⁷ Though unable to recall directing S/Constable Slade to call the CHAL, he does not dispute that he would have done so.⁸⁸
53. A/Sgt Tonkin recalls apprising the CHAL nurse of Michael's complaint of bad back and kidneys, and her agreement that immediate medical attention was not required.⁸⁹ He did not inform the CHAL nurse about the finding of the Kalma tablets.⁹⁰ He did not describe to the CHAL nurse that Michael was 'not on this planet' on the CHAL computer record⁹¹ as it is not a term he would use, and further he did not consider Michael drug affected.⁹²
54. Michael told A/Sgt Tonkin he refused to speak to the CHAL nurse on the telephone, saying he wanted a Doctor, or nothing.⁹³ After the remand hearing, A/Sgt Tonkin spoke to Sgt Mayne at Moorabbin and detailed the conversation he had with the CHAL nurse - that in his opinion Michael's condition did not require immediate attention and that the nurse advised that they would see Michael in the morning.⁹⁴
55. A/Sgt Tonkin entered information into the Thin Blue Line (TTBL) Attendance Summary being one initial supervisor check entry, two welfare check entries and one disposal interview entry.⁹⁵ Relevant to his communication with CHAL, he recorded at the welfare check entry at 1.15am, *'CHAL called, Nil concerns for pre-existing back problems. Darmady [sic] refused to speak with nurs [sic] on phone and again requested Dr. Advised nil Dr avail. CHALS Nurse – Karen nil concerns and immediate med att not required.'*⁹⁶

⁸⁶ Coronial Brief of Evidence, Statement of Matthew Slade, dated 19 August 2014, at page 56 (Exhibit 14).

⁸⁷ Transcript of Inquest, dated 19 April 2016, at page 161, lines 21-29.

⁸⁸ Transcript of Inquest, dated 19 April 2016, at page 160, lines 16-29.

⁸⁹ Coronial Brief of Evidence, Statement of Kirby Tonkin, dated 9 May 2014, at page 59 [61] (Exhibit 7).

⁹⁰ Transcript of Inquest, dated 19 April 2016, at page 162, lines 5-8.

⁹¹ Coronial Brief of Evidence, CHS triage consultation, at page 426.

⁹² Transcript of Inquest, dated 19 April 2016, at page 153, lines 11-26.

⁹³ Coronial Brief of Evidence, Statement of Kirby Tonkin, dated 9 May 2014, at page 59 [62] (Exhibit 7).

⁹⁴ Ibid.

⁹⁵ Coronial Brief of Evidence, Attendance Summary, at page 189.

⁹⁶ Ibid.

Moorabbin

56. There is no record of the outgoing calls from the CHAL. However it is not in dispute that around 2.40-2.45am, Ms Hollenback called the Moorabbin Police Station and spoke to Sgt Mayne. There are two further calls from Moorabbin Police Station to the CHAL at 4.24am and 5.22am (based on the times recorded in the Telstra Record).⁹⁷ Evidence has revealed that these two calls from Moorabbin Police Station to CHAL were made by Sgt Mayne to CHAL nurse Karyn Hollenback. I refer to the 4.24am call as 'the 1st call' and the 5.22am call as 'the 2nd call'.

Sergeant Mayne

57. Sgt Mayne explained that at 2.40am he received a call from the CHAL nurse advising that Michael was en route from Frankston, did not need to be sent to hospital, she had dealt with the issue via Frankston and that he was going to the County Court. He recalled being told that Michael would be seen by doctors once he was transferred to the city. In his contemporaneous notes, he records the nurse telling him '*please don't call an ambulance.*'⁹⁸
58. Sgt Mayne recorded an entry on the Custody Module at 2.40am, which reads: '*Arrival of Carmady [sic] to SMB. Searched and given toast and tea as requested in holding cell. Requested to go into cell with others. Has obvious back problems, bent over. S/T Custodial nurse, Karen states matter dealt with at SFK and no further medical attention needed. Lodged with blanket and mattress [sic].*'⁹⁹ He says the entry was taken from the notes he made at the time of speaking to the nurse.¹⁰⁰
59. In respect to the 1st call, Sgt Mayne explained he spoke to Ms Hollenback between 4.22am and 4.36am. He summarised this conversation in notes made by him at approximately 4.37am: '*Called Karen at Custodial Nursing, Re concerns of frailty and naisily [sic] breathing. Was told that not suitable to go to hospital and his condition was a product of poor care for himself. Stated will have custodial Doctor deal with him first thing in the morning. Told not to call an ambulance and that she deals with these types of patients regularly.*'¹⁰¹

⁹⁷ Coronial Brief of Evidence, CHAL Telstra Record for 7 May 2014, at page 197.

⁹⁸ Coronial Brief of Evidence, Statement of Sean Mayne, dated 15 May 2014, at page 66 [70] (Exhibit 22).

⁹⁹ Coronial Brief of Evidence, Coronial Brief of Evidence, Custody Overview, at page 191.

¹⁰⁰ Coronial Brief of Evidence, Statement of Sean Mayne, dated 15 May 2014, at page 66 [73] (Exhibit 22).

¹⁰¹ Ibid, at page 66 [75].

60. Sgt Mayne felt reassured after speaking to Ms Hollenback, specifically that Michael was healthy enough to be in custody and that no other action was needed.¹⁰² *'Karen told me that she had plenty of experience, that she encounters this type of thing all the time at the Custody Centre, particularly in detainees with alcohol abuse problems.'*¹⁰³ Sgt Mayne recorded on the Custody Module at 4.20am *'Chkd in cell, other detainees complaining about snoring. Sleeping heavily, chkd pulse A/C, breathing sounded thick with mucus. General ill health problems and frailty. Awoken and gave response. Called nurse due to general health concerns. Deemed not suitable for MAS attendance. Doctor to be notified for morning attendance.'*¹⁰⁴ In respect to his notes of the 1st call, Sgt Mayne explained: *'I tried to paint it on a theme of the conversation that we had. It was probably not - unless you recorded the conversation, it was probably - it wasn't - you're not going to get every bit of it out and I can't recall the conversation up from 14 minutes two years on, but I'd make brief notes about it in relation to it to try and paint a general theme of it to myself and my notes as to the conversation that we had, and if there's some um parts in there where I've described it as nasally or - or fluidy or having um mucus, they're all true.'*¹⁰⁵ Throughout his evidence, he steadfastly maintained that he accurately conveyed his observations of Michael to Ms Hollenback during the fourteen minute duration of the 1st call.¹⁰⁶
61. Sgt Mayne estimated the 2nd call occurred at approximately 5.15am. Ms Hollenback informed him there was a doctor starting at 6.00am in the morning (a fact she disputes¹⁰⁷) doing a clinic at the Custody Centre. *'Karen re-assured me that this breathing was normal for drinkers. I actually did a physical demonstration of how Mr Darmody was breathing over the phone to her. I was hoping she could get a Doctor out early this morning to see Mr Darmody.'* And further *'Karyn said this was fairly normal for people who don't look after themselves.'* Once again her comments reassured him. Further, that she had canvassed his concerns with a colleague, and had implemented a care plan for Michael. He understood that Michael was going to be fine based on Ms Hollenback's opinion: *'I don't have advanced medical training like Karen. Karen told me 'Don't call an*

¹⁰² Ibid.

¹⁰³ Ibid.

¹⁰⁴ Coronial Brief of Evidence, Coronial Brief of Evidence, Custody Overview, at page 191.

¹⁰⁵ Transcript of Inquest, dated 21 April 2016, at page 415 line 23 – page 416 line 3.

¹⁰⁶ Transcript of Inquest, dated 21 April 2016, at page 416, lines 24-27.

¹⁰⁷ Transcript of Inquest, dated 19 July 2016, at page 813, lines 13-15.

*ambulance, you'll waste a couple of hours taking him to Accident Emergency, tying up your guys when he need to go to court. He'll get better care from us in here.'*¹⁰⁸

62. At 5.10am Sgt Mayne recorded on the Custody Module: *'Checked with C/SKOTANIS. Mucus filled breathing with deep irregular patterns, pulse ok. Update nurse via phone.'*¹⁰⁹
63. With respect to the 2nd call, Sgt Mayne stated: *'I was probably a little bit disappointed that I didn't get what I wanted, have someone come out and see him, ..., and I was pushing the issue that I wanted somebody to come out to see him. I didn't want to discuss it any further but I'll give you an update on how he is now, ..., I wanted somebody to come. I think Karyn did say that she would - someone would contact Dr Morgan and get him to come through in the morning.'*¹¹⁰
64. Sgt Mayne said at no stage did he suggest to Ms Hollenback that an ambulance should be called. He assumed she told him not to call an ambulance (which she disputes) because of the previous email he had received.¹¹¹ It was submitted that this was a reference to the email regarding police calling CHAL in cases of when an injury/medical condition becomes evident, which would have the effect of reducing unnecessary call outs to Ambulance Victoria.¹¹²
65. Sgt Mayne said, *'... it was never an issue for me to call an ambulance'*¹¹³ and *'My line of thinking was getting Mr Darmody up for court and getting him in a - making - you know, getting him assessed to go to court because he's not a well man.'*¹¹⁴ He said, *'I was giving the triage as best of my ability from what I saw. I was looking at a bloke that's generally holistically unwell, for various reasons. I want a doctor to come in in the morning to have a look at him, assess whether he's going to be able to go to court, whether he needs to be in care or whether he needs to be taken into the custody centre where he can receive that 24-hour care from the CHALs nurses in there. We don't have a nurse on site, we don't - he's going to wake up back in general population with a whole lot of other people, you know. I want to see him before that happens.'*¹¹⁵
66. When asked if he thought Michael needed medical attention prior to the 1st or 2nd call, Sgt Mayne replied, *'I don't know, Your Honour, that's why I called CHALS and I was*

¹⁰⁸ Coronial Brief of Evidence, Statement of Sean Mayne, dated 15 May 2014, at page 66 [76-77] (Exhibit 22).

¹⁰⁹ Coronial Brief of Evidence, Coronial Brief of Evidence, Custody Overview, at page 191.

¹¹⁰ Transcript of Inquest, dated 21 April 2016, at page 429, lines 3-11.

¹¹¹ Transcript of Inquest, dated 21 April 2016, at page 429 - page 430.

¹¹² Coronial Brief of Evidence, Email dated 1 May 2014, at page 466.

¹¹³ Transcript of Inquest, dated 21 April 2016, at page 430, lines 29-30.

¹¹⁴ Transcript of Inquest, dated 21 April 2016, at page 431, lines 12-13.

¹¹⁵ Transcript of Inquest, dated 21 April 2016, at page 432, lines 18-28.

*expressing the - the - what I was seeing. I was trying to triage without experience to someone that was experienced. I don't know, I was hoping for some sort of guidance as to whether he did need immediate medical attention or not um, but all I did know is I would wish to have a doctor come out and see him because he was sick.*¹¹⁶

67. Sgt Mayne refutes Ms Hollenback's assertion he described Michael as *'rose coloured like that of a chronic alcohol drinker'*.¹¹⁷¹¹⁸ He further refutes her claim he described Michael's breathing as shallow, during the 1st call.¹¹⁹ ¹²⁰

Nurse Karyn Hollenback

68. Ms Hollenback recorded her assessment of Michael on the CHAL Computer system.¹²¹ She described that she was told by Victoria Police that Michael was *'not on this planet'*¹²² during her conversation with Frankston members.¹²³
69. Her statement was based on her recollection and the notes she made of events the following day. In respect to her contact with Frankston Police members, at 1.46am on 7 May 2014, she received a call from S/Constable Slade that Michael was remanded to the County Court in the morning. That he had back and kidney problems, was on medication, with nil other medical issues. That they would transport him to Moorabbin. That Michael refused her offer to speak, but was advised she would ring back to see if he changed his mind. She phoned 20 minutes later, and he again refused to talk to her. She said she would check to see on the TTBL where he was lodged.¹²⁴
70. Ms Hollenback recorded on the CHAL computer system at 2.45am, *'T/F SFK to SMB. CNS rang SMB to advised [sic] they know about prisoner but he will not take to CNS. Advised VP to ring CHAL if needed or if prisoner changes his mind.'*¹²⁵
71. Regarding the 2.45am call to Moorabbin, Ms Hollenback said she rang the Custody Sergeant to let him know that she'd been informed about Michael who was refusing to

¹¹⁶ Transcript of Inquest, dated 21 April 2016, at page 433, lines 19-26.

¹¹⁷ Transcript of Inquest, dated 21 April 2016, at page 421, lines 25-28.

¹¹⁸ Coronial Brief of Evidence, Statement of Karyn Hollenback, dated 9 July 2014, at page 107 [114] (Exhibit 26).

¹¹⁹ Transcript of Inquest, dated 21 April 2016, at pages 422-423, and page 425.

¹²⁰ Coronial Brief of Evidence, Statement of Karyn Hollenback, dated 9 July 2014, at page 107 [114] (Exhibit 26).

¹²¹ Coronial Brief of Evidence, CHS triage consultation, at page 426.

¹²² Ibid.

¹²³ Transcript of Inquest, dated 18 July 2016, at page 696, lines 17-19.

¹²⁴ Coronial Brief of Evidence, Statement of Karyn Hollenback, dated 9 July 2014, at page 107 [112] (Exhibit 26).

¹²⁵ Coronial Brief of Evidence, CHS triage consultation, at page 426.

Speak to her and that either a doctor or nurse would see him in the morning. She said if the prisoner changed his mind about speaking to her, she was happy to speak to him.¹²⁶

72. In evidence, when asked if she said to Sgt Mayne at 2.45am, please don't call an ambulance, Ms Hollenback said, *"Please don't call an ambulance" is something that I would never say. I wouldn't even phrase it like that. And at 2.45 Sergeant Mayne hadn't even seen Mr Darmody so I don't know why I'd even be mentioning an ambulance to him.*¹²⁷
73. Ms Hollenback recorded on the CHAL computer system at 4.26am, *'WHK Rang to say prisoner is hunched over walking, snorting while he sleeps. Does not have labored breathing. WHK states his pulse is strong. WHK says he looks frail, looks like he has the body of an 80yr old and is concerned about this. I explained that it sounds as if the man has abused himself over the years, perhaps is malnourished and in need of a good meal. Prisoner is coming to county court this am and will be seen by CMO this morning.'*¹²⁸
74. In her statement, regarding the 1st call, Ms Hollenback said; she was told he was walking hunched over and told them he had alleged back pain and she was not concerned and would get further information about his GP and medication in the morning; that he was offered tea and toast and accepted; he had been bedded down with other prisoners but he had been moved out of the cell due to keeping other prisoners awake snoring; that he had a piece of toast in hand when he fell asleep on the side of the bed; that he looked as if he was 80years old, frail and police were concerned about this; that his face was rose coloured, like that of an alcoholic; that there was no smell of alcohol on his breath. She told them it sounded as if he had neglected himself and that an emergency department could not do anything about this in the immediate time frame; and that he would be seen in the morning by the medical staff. She was told by the member that Michael was *'snoring and had some snot coming out of his nose.'* She said she asked him if the prisoner's breathing appeared normal, not laboured, short of breath, shallow breaths, difficulty taking breaths or anything abnormal. She says she was told no and that his pulse was strong. She said she asked if he was rousable and was told he responded by grunting at them when they talked to him. She said she did not feel that an ambulance was required at that stage.¹²⁹

¹²⁶ Coronial Brief of Evidence, Statement of Karyn Hollenback, dated 9 July 2014, at page 107 [113] (Exhibit 26).

¹²⁷ Transcript of Inquest, dated 18 July 2016, at page 689 line 30 – page 690 line 3.

¹²⁸ Coronial Brief of Evidence, CHS triage consultation, at page 426.

¹²⁹ Coronial Brief of Evidence, Statement of Karyn Hollenback, dated 9 July 2014, at page 107 [113-114] (Exhibit 26).

75. In relation to whether she said not to call an ambulance during the 1st call, Ms Hollenback stated, *'I wouldn't have said to him, "Don't call an ambulance". I would have said, "Look, you know, I don't think, you know, we need an ambulance at this stage"'*¹³⁰
76. Ms Hollenback recorded on the CHAL computer system at 5.15am, *'WHK rang back to say prisoner has 'snot' coming out of his nose, is snorting/snoring and he is concerned. Reassured that this type of breathing is not life threatening.'*¹³¹
77. Although Ms Hollenback referred to WHK or watch house keeper on the CHAL computer record in respect of the 1st and 2nd call, it is common ground she spoke to Sgt Mayne, the Custody Sergeant, rather than Const Skotanis, the watch house keeper.
78. In her statement, regarding the 2nd call, Ms Hollenback said; the member rang to say that the prisoner was still snoring as above and he still has the same secretions from his nose; that the member was concerned about this. She said she asked the same questions as she'd asked in the 1st call. She said the member said Michael's breath cycles were not all the same, so she asked him to demonstrate over the phone. She said it sounded like someone who was snoring heavily with regularly, irregular breaths. She said she asked if Michael was still rousable to verbal stimuli and was told he was still grunting to police. She said she asked police to do a sternal rub to rouse him and they had already done so and Michael was responding. She said she told them much of the population snore and it wasn't life threatening.¹³²
79. Ms Hollenback denies telling Sgt Mayne not to call an ambulance during the 2nd call.¹³³ (However, it is noted in respect to the 1st call, Ms Hollenback conceded she would have said I don't think we need an ambulance at this stage.)
80. In her statement, beyond what she recorded in her notes the following day, Ms Hollenback remembered asking Sgt Mayne if it looked like 'snot' coming from his nose or something different and he said it looked like 'snot'.¹³⁴ Further, she recalled asking whether it appeared Michael was having trouble breathing and from information received, formed the opinion he was not struggling to breathe. She did not consider his breathing or colour had

¹³⁰ Transcript of Inquest, dated 18 July 2016, at page 690, lines 5-10.

¹³¹ Coronial Brief of Evidence, CHS triage consultation, at page 426.

¹³² Coronial Brief of Evidence, Statement of Karyn Hollenback, dated 9 July 2014, at page 107 [115] (Exhibit 26).

¹³³ Transcript of Inquest, dated 18 July 2016, at page 690, lines 15-19.

¹³⁴ Coronial Brief of Evidence, Statement of Karyn Hollenback, dated 9 July 2014, at page 107 [116] (Exhibit 26).

changed since the previous phone call. She said he was described as pink in colour (disputed by Sgt Mayne as noted above).¹³⁵

81. It is common ground Ms Hollenback was not told that Michael had been found with 2 Kalma tablets. In evidence if told he had any medication, legal or otherwise, she would have advised police to immediately call an ambulance.¹³⁶

Reasonableness of the advice of the CHAL nurse.

82. Ms Hollenback maintained that if Michael was gasping for breath and/or only responding to painful stimuli, her assessment and decisions would have been different¹³⁷ - *'We get a lot of prisoners with runny or 'snotty' noses. We also get a lot of complaints about snoring prisoners, particularly at the Custody Centre. Prisoners regularly complain about others snoring loudly. Snoring is a common thing throughout the entire community.'* And further *'In our protocol book one of the questions to ask is about breathing patterns of persons and if their breathing patterns have changed in the previous two hours. From what I was told there was no indication that his breathing had changed.'*¹³⁸
83. When asked if in hindsight she could have asked different questions to elicit information about his breathing, Ms Hollenback said *'yeah, look, I mean look I've had a long time to think about it and there are probably other questions I could have asked, like does it sound like it's coming from deep in his lungs or up high, but at the time, you know, I was just told he had a snotty nose.'*¹³⁹
84. During questioning in respect to the 2nd call, Ms Hollenback conceded when Sgt Mayne informed her Michael's best response was a grunt, she should have told Sgt Mayne to go and try to wake him.¹⁴⁰ Ms Hollenback made a similar concession in respect to being told of Michael's grunt response in the 1st call.¹⁴¹ Further, on reflection, her assumption that Michael had moved from his cell prior to the 1st call should have caused her to question Sgt Mayne about what time and by what means he moved cells.¹⁴² (CCTV reveals Michael did not move cells).

¹³⁵ Ibid.

¹³⁶ Coronial Brief of Evidence, Statement of Karyn Hollenback, dated 9 July 2014, at page 107 [117] (Exhibit 26).

¹³⁷ Coronial Brief of Evidence, Statement of Karyn Hollenback, dated 9 July 2014, at page 107 [116] (Exhibit 26).

¹³⁸ Ibid

¹³⁹ Transcript of Inquest, dated 18 July 2016, at page 695, lines 13-17.

¹⁴⁰ Transcript of Inquest, dated 19 July 2016, at page 837, lines 15-17.

¹⁴¹ Transcript of Inquest, dated 19 July 2016, at page 839.

¹⁴² Transcript of Inquest, dated 19 July 2016, at page 840, lines 1-18.

Associate Professor Marie Gerdtz

85. At my request, an expert in nursing, Associate Professor Marie Gerdtz, reviewed the clinical advice of Ms Hollenback to Sgt Mayne and issues with respect to the training of CHAL nurses.¹⁴³
86. In respect to the 1st call A/Prof Gerdtz did not consider Ms Hollenback's advice was reasonable or appropriate, explaining - *'This was a relatively long call, lasting 13 minutes, which was initiated by Victoria Police (SM) due to his concerns about an acute alteration in MD's health status. Specifically, SM observed in MD an inability to maintain his airway (the presence of thick mucus in his airway and noisy breathing/snoring), additionally MD was reported to have an abnormal breathing pattern (slow and deep respirations). SM also noted MD was difficult to rouse but stated that he was able to lift his head off the pillow¹⁴⁴ and speak (MD was reported to have uttered a single word 'yes' when asked by SM if he was OK). Taken together the signs of a partially obstructed airway, heavy mucous in the airway, slow deep respirations¹⁴⁵, and an altered state of consciousness support the premise that MD's condition had deteriorated. According to SM's statement of the telephone consultation this information was recorded and conveyed to KH.'*¹⁴⁶
87. Further, A/Prof Gerdtz highlighted the significance of not including in her assessment during the 1st call, the reference to 'not on this planet'¹⁴⁷ - *'at the very least, the possibility of drug intoxication causing deterioration in MD's level of consciousness at this time required further investigation and intervention.'*¹⁴⁸

¹⁴³ Coronial Brief of Evidence, Report by Marie Francis Gerdtz, dated 16 April 2016, at page 699 (Exhibit 29).

¹⁴⁴ Which Ms Hollenback denied being told at Transcript of Inquest, dated 18 July 2016, at page 695, lines 18-30.

¹⁴⁵ Which Ms Hollenback denied being told at Transcript of Inquest, dated 18 July 2016, at page 693, lines 25-31.

¹⁴⁶ Coronial Brief of Evidence, Report by Marie Francis Gerdtz, dated 16 April 2016, at page 699 [701-702] (Exhibit 29).

¹⁴⁷ Which no member states he/she said to Ms Hollenback.

¹⁴⁸ Coronial Brief of Evidence, Report by Marie Francis Gerdtz, dated 16 April 2016, at page 699 [702] (Exhibit 29).

88. Relating to the 2nd call, A/Prof Gerdtz considered Ms Hollenback's advice was not reasonable or appropriate - *'this call was again initiated by SM due to his increasing concerns about MD's health status. At this time SM reported MD's best verbal response to stimuli was 'grunting'. Based on this information alone, and in accordance with VP's medical checklist...MD's condition at this time required immediate medical attention which should have included basic life support interventions (positioning MD to clear his airway) and calling an ambulance.'*¹⁴⁹
89. According to A/Prof Gerdtz, the observations conveyed by Sgt Mayne in the 2nd call - *'concerns about MD's inability to maintain his airway (the continued presence of mucus in his airway and noisy breathing/snoring), [and] an abnormal and now irregular breathing pattern. These observations and the increased concern of SM should have been taken into account - immediate medical intervention was required at this time.'*
90. A/Prof Gerdtz discounted the relevance of Ms Hollenback's claim that she was not made aware Michael's respirations were deep or there was a partially obstructed airway, explaining - *'So in relation to the partially obstructed airway, the snoring and noises that are coming from his airway as well as whether you refer to it as mucus or snot, it's not really that relevant to differentiate that is something in the airway that's impeding the ventilation which means that the patient won't be oxygenated and so that in itself is in my view evidence of a deterioration in the patient's level - or clinical condition, their level of urgency...'*¹⁵⁰
91. Further, A/Prof Gerdtz did not share Ms Hollenback's distinction between snot and mucous, considering each clinically significant. In addition, whether a police member said snot or mucous, she explained, *'I wouldn't expect them to be able to differentiate. As far as my opinion is, is that it's something there that shouldn't be there that's impeding ventilation.'*¹⁵¹
92. In respect to Michael's conscious state, A/Prof Gerdtz deposed - *'Well, again it's more about the depth of - that is more related to the level of consciousness in fact you know so um in terms of getting more information, we might have asked when he's roused, what's his status like...'*¹⁵² A/Prof Gerdtz detailed the means by which Ms Hollenback should have assessed Michael's altered conscious state - *'So the Glasgow Coma Score looks at three*

¹⁴⁹ Ibid.

¹⁵⁰ Transcript of Inquest, dated 19 July 2016, at pages 849-850.

¹⁵¹ Transcript of Inquest, dated 18 July 2016, at page 650, lines 13-16.

¹⁵² Transcript of Inquest, dated 19 July 2016, at page 850, lines 19-23.

*components, looks at eye opening, best verbal response and best motor response. So eye opening is obviously spontaneously eye opening or eyes - you know, opens eyes on command. It goes through and it actually scores an accumulation of out of 15, so each component has you know a score attached to it and when you add that up, we decide what the patient's level of consciousness is and then that correlates with a particular intervention. Nursing or medical intervention, yes.*¹⁵³

Training & Systems

93. Ms Hollenback detailed the extent of the CHAL induction training she received – namely, someone running her through the CHAL Program, guidance through a reference book (police stations etc) and showing the Triage Protocol Book (Briggs). She asserted there was no formal training for the CHAL role.¹⁵⁴ Critically, she recounted spending the first four hours of her first shift on her own and then had someone sit with her (Alice Ryan).¹⁵⁵ She said the Triage Protocol was in a lever arch binder for everyone to look at and when asked if she was taken through it on her first shift, she said ‘not every single one’.^{156 157}
94. Ms Hollenback conceded familiarity with the primary survey approach, which she likened to DRABC, in which she had been trained.¹⁵⁸
95. A/Prof Gerdtz explained the CHAL Guidelines¹⁵⁹ provide clinicians with a basic approach to telephone triage, which are predominantly focused on specific health conditions. The general principles guiding triage, considered by A/Prof Gerdtz fundamental to the decision making process, were not immediately apparent. She maintained the primary survey approach is universally used as a decision making framework by nurses, doctors and paramedics making triage decisions.¹⁶⁰
96. Mr Timothy Dorey, the Chief Custodial Health Officer of the Custodial Health Service (including CHAL) deposed the primary survey approach was the modern terminology for DRABC, or Danger Response Airway Breathing Circulation.¹⁶¹ It is taught as part of basic nursing training.¹⁶² CHAL employs nurses who possess emergency/triage or clinical

¹⁵³ Transcript of Inquest, dated 19 July 2016, at page 850 line 24 – page 851 line 7.

¹⁵⁴ Coronial Brief of Evidence, Statement of Karyn Hollenback, dated 9 July 2014, at page 107 [108] (Exhibit 26).

¹⁵⁵ Transcript of Inquest, dated 18 July 2016, at page 666, lines 4-8.

¹⁵⁶ Transcript of Inquest, dated 18 July 2016, at pages 666 - 667.

¹⁵⁷ Transcript of Inquest, dated 18 July 2016, at page 669, lines 5-12.

¹⁵⁸ Transcript of Inquest, dated 18 July 2016, at pages 671-672.

¹⁵⁹ Coronial Brief of Evidence, CHAL Guidelines, at page 396.

¹⁶⁰ Coronial Brief of Evidence, Report by Marie Francis Gerdtz, dated 16 April 2016, at page 699 [702] (Exhibit 29).

¹⁶¹ Transcript of Inquest, dated 22 April 2016, at page 568, lines 6-8.

¹⁶² Transcript of Inquest, dated 22 April 2016, at page 568 line 30 – 569 line 5.

intake experience¹⁶³ with at least five years experience, together with particular experience in emergency/acute nursing, drug and alcohol and/or psychiatric nursing.¹⁶⁴

97. Mr Dorey noted the primary survey approach is picked up in the Briggs Protocol used by the CHAL service.¹⁶⁵ However, he queried its appropriateness of the CHAL service using the same approach as emergency departments. He explained the former need a normal triage protocol for less than 5 percent of their population, with the balance presenting with non-urgent problems.¹⁶⁶ He agreed there was a need for a triage scale, but a slightly different tool for the cohort CHAL dealt with, which takes into account issues such as suicide and self-harm.¹⁶⁷

Whether death survivable with earlier intervention.

98. Dr Eddey deposed that Michael's death could have been prevented if he had received first aid or medical treatment within one to six hours prior to the welfare check at 6.01am.¹⁶⁸ He explained – the *'cardiac arrest was most likely the end point of a prolonged episode of hypoxia related either to depression or cessation of respirations and/or the aspiration of stomach contents into the airway.'*¹⁶⁹
99. Dr Eddey added if Michael - *'was under appropriate care at this time, it is likely that the risk of this would have been recognized and these events prevented or at least dealt with in a timely fashion. From a medical point of view such care would have been straightforward...'*¹⁷⁰
100. According to Dr Eddey, failing to identify Michael's breathing problems and altered conscious state, were missed opportunities for successful medical intervention, which could interrupt the chain of events that most likely led to Michael's cardiac arrest and subsequent death. Dr Eddey pointed out he would not expect police members to fully appreciate the significance of signs exhibited by Michael, or the difference between 'snoring' or 'snotty' and the stridor associated with a compromised airway. Nor would he expect them to be able to communicate in medical terminology, a sense of medical urgency or effectively describe the symptoms and signs to a medical professional. He added it would be equally difficult for a medical professional to achieve a clear diagnostic

¹⁶³ Coronial Brief of Evidence, Statement of Timothy Dorey, dated 13 April 2016, at page 533 [538] (Exhibit 24).

¹⁶⁴ Ibid.

¹⁶⁵ Transcript of Inquest, dated 22 April 2016, at page 571, lines 27-31.

¹⁶⁶ Transcript of Inquest, dated 22 April 2016, at pages 572-573.

¹⁶⁷ Transcript of Inquest, dated 22 April 2016, at pages 574-575.

¹⁶⁸ Coronial Brief of Evidence, Report of Dr David Eddey, dated 5 April 2016, at page 467 [481] (Exhibit 1).

¹⁶⁹ Coronial Brief of Evidence, Report of Dr David Eddey, dated 5 April 2016, at page 467 [481] (Exhibit 1).

¹⁷⁰ Ibid.

picture of the relevant clinical signs and symptoms based upon a verbal description from police members who are effectively non-medical bystanders.¹⁷¹

101. Dr Eddey recommended the use of a system called ISBAR as used in hospitals.¹⁷² The acronym stands for Identify, Situation, Background, Assessment and Recommendation. It is used to improve communication of critical information to ensure safe patient outcomes and is used to ensure critical information is included in all communication.¹⁷³

The operation of the defibrillation machine.

102. Dr Eddey considered the resuscitation undertaken by police following Michael's discovery at 6.01am did not affect the outcome, particularly in light of the chance of survival from this type of cardiac arrest. He said their attempts were reasonable in the circumstances of non-expert personnel performing CPR with basic equipment.¹⁷⁴

Conclusion as to individual assessments and decision making

103. I turn to the appropriateness of the information transfer in the 1st and 2nd call which failed to identify the need for immediate hospital transfer.
104. I accept the evidence that the role of CHAL nurse performing telephone triage is complex. A CHAL nurse does not have the benefit of sighting the individual or performing a medical examination, and her point of contact is not medically trained.
105. Ms Hollenback's 8th May email was drafted in the knowledge of Michael's parlous state. I accept that Ms Hollenback sought to accurately record her recollection of the conversations with Sgt Mayne the previous evening. The evidence as to precisely what information was conveyed between Sgt Mayne and Ms Hollenback is however inconsistent.
106. In the final analysis, whilst noting the obvious attraction of Sgt Mayne's contemporaneous notes, Ms Hollenback's significant concessions made in evidence, specifically that in both calls Sgt Mayne told her that the best verbal response elicited from Michael was a grunt, have removed the necessity of determining evidentiary inconsistencies. Therefore, I am able to conclude whether the advice of Ms Hollenback was reasonable and appropriate, based solely on the information she acknowledges receiving from Sgt Mayne. In so doing, I make no criticism of the accuracy of the contemporaneous notes of Sgt Mayne.

¹⁷¹ Coronial Brief of Evidence, Report of Dr David Eddey, dated 5 April 2016, at page 467 [488] (Exhibit 1).

¹⁷² Transcript of Inquest, dated 18 April 2016, at page 31, line 6.

¹⁷³ Exhibit 30, ISBAR document.

¹⁷⁴ Coronial Brief of Evidence, Report of Dr David Eddey, dated 5 April 2016, at page 467 [479] (Exhibit 1).

107. I accept the evidence of Dr Eddey and Associate Professor Gerdtz that non-medically trained police officers would not likely appreciate the significance of Michael's presentation in respect to a potentially compromised airway.
108. I accept the evidence of A/Prof Gerdtz that Michael's grunting and respirations should have concerned Ms Hollenback.¹⁷⁵ She considered Ms Hollenback's notes recorded a deterioration in Michael's status between the 1st and 2nd call. Further, that at the 2nd call Sgt Mayne was concerned to communicate Michael's status.¹⁷⁶ In A/Prof Gerdtz view, that snoring and snot had been mentioned in both calls, meant it was a persistent issue and *"The patient obviously couldn't change his position and clear his airway"*.¹⁷⁷ A/Prof Gerdtz explained why Ms Hollenback's notes revealed a deterioration in Michael's symptoms - *"having an obstructed airway-snoring and snorting and having mucus in your airway is fairly indicative of a deteriorating scenario... It's ongoing for a start because it was at 4.26 and it's also being observed at 5.15. It's ongoing and it's not being corrected."* A/Prof Gerdtz firmly stated that references to snoring, snotty nose and grunting were indicative of a life threatening situation.¹⁷⁸
109. From a registered nursing perspective, both A/Prof Gerdtz and Mr Dorey considered that based on Ms Hollenback's notes in isolation, the information conveyed to her in both the 1st and 2nd call revealed Michael had an obstructed or partially obstructed airway.¹⁷⁹ Mr Dorey considered her notes disclosed an individual unable to appropriately respond, and in decline.¹⁸⁰
110. Further, the experts considered Ms Hollenback should have attached weight to the fact that the 1st and 2nd call were made in relatively close succession. Dr Eddey doubted police would routinely call CHAL to provide condition reports. His impression was that they ring if they have a specific concern.¹⁸¹
111. Dr Eddey also considered Ms Hollenback should have requested that Sgt Mayne rouse Michael to obtain his best verbal response and undertake a proper assessment of his conscious state.^{182 183}

¹⁷⁵ Transcript of Inquest, dated 19 July 2016, at page 877, lines 4-10.

¹⁷⁶ Transcript of Inquest, dated 19 July 2016, at pages 878 lines 1-8, 879 lines 7-13, Mr Dorey expressed that from a medical point of view grunting indicates a patient is unconscious; and 19 July 2016, at page 642, lines 16-18.

¹⁷⁷ Transcript of Inquest, dated 19 July 2016, at pages 879, lines 21-26.

¹⁷⁸ Transcript of Inquest, dated 19 July 2016, at pages 870, lines 27-31, and 880, lines 1-6.

¹⁷⁹ Transcript of Inquest, dated 19 July 2016, at pages 880 lines 10-26, 18 July 2016, at page 648, lines 10-14.

¹⁸⁰ Transcript of Inquest, dated 18 July 2016, at page 648, lines 15-19.

¹⁸¹ Transcript of Inquest, dated 18 April 2016, at page 41, lines 1-13.

¹⁸² Transcript of Inquest, dated 19 July 2016, at page 866, line 17-31, and 867, line 1-10, dated 18 April 2016, at page 642.

¹⁸³ Transcript of Inquest, dated 18 July 2016, at page 689 lines 20-22, 699 lines 15-18, 701 lines 1-3, 793 lines 16-26, 839 lines 7-13.

112. In respect to additional information, A/Prof Gerdtz agreed with my proposition that *'the more information the better'*, but clearly stated *'once you hear grunt...you've got to go further'*.¹⁸⁴
113. Ms Hollenback was unable to explain why the grunt response conveyed in each call did not alert her to a potential compromised airway or altered conscious state. She concurred with the expert opinion that CHAL nurses must err on the side of caution.¹⁸⁵
114. I accept the evidence of A/Prof Gerdtz and Mr Dorey that Ms Hollenback's failure to advise police that an ambulance was required for Michael, was a departure from the basic triage principles of DRABC. They explained that basic concepts including how to conduct a Glasgow Coma Scale assessment and a primary survey are taught during nurse undergraduate training. Further, that a nurse of Ms Hollenback's experience would readily apply the Glasgow Coma Scale or DRABC.¹⁸⁶ Ms Hollenback agreed the DRABC and primary survey is basic and fundamental.¹⁸⁷
115. The concessions made at inquest by Ms Hollenback are to her credit. In particular, her concession that during both the 1st call and the 2nd call, Sgt Mayne told her a grunt was Michael's best verbal response, she should have advised him to wake Michael, and if unable, effect immediate hospital transfer.
116. In other words, whilst not resiling from her position that relevant information in possession of Sgt Mayne was not conveyed in the 1st and 2nd call, nonetheless, she conceded Sgt Mayne did provide her crucial information in both calls which should have caused her to advise Sgt Mayne to conduct further investigation, which in hindsight, would have resulted in Michael's immediate transfer to hospital.
117. I refer to Ms Hollenback's evidence had she been made aware 2 Kalma tablets were located on Michael, she would have called an ambulance. I consider this evidence is made in hindsight. In my view, Ms Hollenback formed an early opinion that Michael did not require an ambulance. In circumstances where a grunt response did not cause her alarm, I consider it unlikely that knowledge of 2 Kalma tablets would have altered her assessment in respect to calling an ambulance.

¹⁸⁴ Transcript of Inquest, dated 19 July 2016, at page 886, lines 30-31 – 887, lines 1-6.

¹⁸⁵ Transcript of Inquest, dated 19 July 2016, at page 890, lines 2-9.

¹⁸⁶ Transcript of Inquest, dated 19 July 2016, at page 863, lines 29-31 – 864, lines 1-7, 865 lines 20-31, dated 18 July 2016, at pages 568-569, 598, 633, 638 and 648-649.

¹⁸⁷ Transcript of Inquest, dated 18 July 2016, at page 709, lines 1-21.

118. As previously stated, I do not propose to determine inconsistencies in the recollections of Ms Hollenback and Sgt Mayne. However, Ms Hollenback's colleague Nurse Govett, accurately portrays the role and responsibility of a CHAL nurse at triage:-

*...One needs to gain a good clinical picture of the situation, which must be done by extracting as much information as possible about the prisoner via the custody staff. If in doubt, I would always err on the side of caution and call for an ambulance.*¹⁸⁸

119. In fairness to Ms Hollenback, she concurred with her colleague and the expert witnesses, that nurses get as much information as they need to form a clinical picture and ask questions proactively.¹⁸⁹ That CHAL nurses take cues from what they are told over the telephone, that those cues inform decision making and that it is an exercise in logic and common sense.¹⁹⁰

120. To her credit Ms Hollenback conceded she should have:-

- Sought to clarify information;¹⁹¹
- Asked more questions about precisely when Mr Darmody had been moved;¹⁹²
- Asked about the way Mr Darmody had moved;¹⁹³
- Asked about what time Mr Darmody had moved;¹⁹⁴
- Told the members to wake Mr Darmody up at 4.26 and 5.15 am;¹⁹⁵
- Tried to get a verbal response rather than a grunt from Mr Darmody in both calls;¹⁹⁶
- Asked the members to take a telephone to Mr Darmody so she could hear him breathing;¹⁹⁷ and
- Probed Sgt Mayne regarding Michael and "delted deeper".¹⁹⁸

¹⁸⁸ Coronal Brief of Evidence, Statement of Nurse Govett, dated 30 October 2014, at page 122, see also the evidence of Dr Eddey regarding erring on the side of caution at Transcript of Inquest, page 32 lines 7-9 and A/Prof Gertz at page 890, and Dorey at pages 598, 605-606.

¹⁸⁹ Transcript of Inquest, dated 19 July 2016, at page 756, lines 16-22.

¹⁹⁰ A/Prof Gertz gave evidence at Transcript of Inquest, pages 856-857 that the nurse should have asked additional questions of Sgt Mayne including re sleeping position, movement between cells, what time the patient walked between cells, the time at which the patient was grunting. Her evidence was that the nurse should have attempted to resolve the inconsistency between the information that Mr Darmody had walked between cells yet was grunting.

¹⁹¹ Submission on behalf of Nurse Karyn Hollenback, at page 4[4].

¹⁹² Submission on behalf of Nurse Karyn Hollenback, at page 32[92], Transcript of Inquest, dated 19 July 2016, at page 840, lines 13-18.

¹⁹³ Submission on behalf of Nurse Karyn Hollenback, at page 32[92], 39[106, 108], 64[196], Transcript of Inquest, dated 19 July 2016, at 840, lines 13-18.

¹⁹⁴ Submission on behalf of Nurse Karyn Hollenback, at page 32[92], 39[106], Transcript of Inquest, dated 19 July 2016, at page 840, lines 13-18.

¹⁹⁵ Transcript of Inquest, dated 19 July 2016, at pages Hollenback T689:22-31, T693:13-15, T699:11-17, T701:1-2, T742:13-17, T767:1-8, T793:16-26, T837:15-23, T839:10-31, Nurse's submission p39[108], p44[120], p46-47[130], p49[137], p64[196]

¹⁹⁶ Transcript of Inquest, dated 19 July 2016, at page 693, lines 7-12, Submission on behalf of Nurse Karyn Hollenback, at page 39[206], 64[196].

¹⁹⁷ Transcript of Inquest, dated 19 July 2016, at page 693, lines 29-31 – at page 694, lines 1-16.

¹⁹⁸ Transcript of Inquest, dated 19 July 2016, at page 694, lines 23-31.

Adequacy of the CHAL Nurse's Assessment

121. I consider that in the exercise of her clinical judgement, there was sufficient information available to Ms Hollenback during the 1st and 2nd calls to determine that Michael required immediate medical intervention. Namely, immediate hospital transfer via ambulance, thereby ensuring he received the medical care described by Dr Eddey as straight forward.

Adequacy of CHAL Training

122. Counsel for the family submits that the CHAL system as it currently operates has the following inherent risks:
- a. The availability of only basic first aid training to police presents an ongoing risk that police will fail to appreciate the significance of, and fail to advise the CHAL nurse of, detainees' symptoms; and
 - b. The inability of CHAL nurses to independently view detainees presents an ongoing risk that the CHAL nurse needs to place a high level of reliance on the observations of police with minimal medical training.

The Importance of Effective Training for CHAL Nurses and Lack of Such Training

123. Ms Hollenback detailed her training and experience:
- She has been a Division 1 Registered Nurse for 29 years, qualifying in 1985.
 - That she had been working as a Custodial Nurse (Registered Nurse with the Victoria Police Custodial Health Unit (CHU) for three and a half years at the time of this incident.
 - Prior to working at the CHU, she worked in an Emergency Department at Maroondah Hospital for approximately five years.
 - She also worked as a Forensic Nurse for the Victorian Institute of Forensic Medicine in a casual capacity for approximately 8 years¹⁹⁹.
 - Induction at CHAL comprised having someone on her first shift, run them through the CHAL program, guide them through a reference book containing contact

¹⁹⁹ Coronial Brief of Evidence, Statement of Karyn Hollenback, dated 9 July 2014, at page 107 (Exhibit 26).
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information (police stations etc) and show them the Triage Protocol Book. She says '*there was no formal training specifically for the CHAL role*'²⁰⁰.

- Though maintaining she did not receive formal training at CHAL, she acknowledged some triage related work. In light of her experience, predominantly in custodial settings, she felt sufficiently experienced and equipped to do her job as an on-call nurse at CHAL. She expressed it in this way '*...I never really felt incompetent in doing it*'²⁰¹.

124. Nonetheless, acknowledging the unique challenges posed by the CHAL role, there is a need for appropriate training tailored to the role. Ms Hollenback's counsel submitted with merit, that the training was focused on orientation to the phones and the Access Database, but absent formal training regarding how to conduct phone triage, the challenges, pitfalls or scenario training²⁰². Nor was there any systematic manner in which calls were monitored, reviewed and assessed in the first few months after a nurse commenced to work in the role²⁰³. Mr Dorey suggested that there was monitoring, noting he was sitting behind a glass wall in his office but could hear through the wall and the clinical manager was sitting beside the staff. I do not consider this sufficient. I note there was no regular basis upon which monitoring occurred²⁰⁴.

125. A/Prof Gerdtz identified perceived training deficits in her statement, inter alia,²⁰⁵ that:

- Ms Karyn Hollenback did not receive adequate training to prepare her for the role of CHAL nurse.
- Triage decision making is a complex and challenging process, which is normally allocated to nurses who have had specific training and supervised experience.
- Clinical Triage Guidelines was required. Such training should have included not only orientation to the triage service and clinical protocols, but supervision and monitoring of her triage advice and decisions in the first few months over which staff are required to perform the role."

126. In response to Ms Hodgson, A/Prof Gerdtz detailed what specific training in telephone triage and the application of triage guidelines required: -

²⁰⁰ Coronial Brief of Evidence, Statement of Karyn Hollenback, dated 9 July 2014, at page 108 (Exhibit 26).

²⁰¹ Transcript of Inquest, dated 19 July 2016, at page 789, lines 16-17.

²⁰² Transcript of Inquest, dated 19 July 2016, at page 824, lines 6-12 and see Timothy Dorey's evidence dated 18 July 2016, at page 626, line 8 to 628, line 5.

²⁰³ Transcript of Inquest, dated 19 July 2016, at page 824, line 29 through to 825, line 22.

²⁰⁴ See Timothy Dorey's evidence, Transcript of Inquest, dated 18 July 2016, at 629, line 23 to 630, line 20 and see Karyn Hollenback's evidence, Transcript of Inquest, dated 19 July 2016, at page 824, line 29 through to 825, line 22.

²⁰⁵ Coronial Brief of Evidence, Report by Marie Francis Gerdtz, dated 16 April 2016, at page 703 [28] (Exhibit 29).

*'First of all, presuming that people have the appropriate experience in assessment then it would move on to provide them with clear understanding of the protocols and procedures, and then what you'd normally do is put them through a series of scenarios so you - you know, simulations we use in teaching our nurses in face-to-face triage. Simulations are also used in mental health triage, telephone triage services and then once we're satisfied that their structure of their clinical decision-making is such that they are safe in theory, they then go out and do a supervised practice until such time as they're deemed safe. Yep. So it's a two-stage approach which would involve a simulation - is your word - first - -?-- -Yes.--- before moving into a supervised training scenario? ---That's right. And is this what you say would be best practice or how do you put that as your recommendation?--- That is best practice.'*²⁰⁶

127. Ms Hollenback indicated her willingness to engage in further training.²⁰⁷

128. I accept her counsel's submission that my assessment of Ms Hollenback's advice, should not ignore the deficits in her training, as set out by A/Prof Gerdtz. In particular, she did not receive specific training regarding the difficulties of the CHAL role in terms of communicating with lay people (in this case police) and understanding how lay people may not appreciate either the signs and symptoms they are seeing nor how to communicate those signs or symptoms, and how to overcome these barriers to effective communication.

CHAL Resources available to Nurses – the question of the following protocols and adequacy of protocols

Err on the side of Caution

129. Ms Greenham, acknowledged the need for CHAL nurses to err on the side of caution. She submits – “Certainly, that is undoubtedly the case. However, the concept of “erring on the side of caution” in a practical sense does not provide nurses with much real guidance in terms of how to react to certain actual situations when they are making risk assessments unless it is incorporated into appropriate training. “Erring on the side of caution” must be understood by nurses in the context of proper training in phone triage, including scenario training and monitoring, otherwise it is not likely to make a difference to how they conduct risk assessments. Nurses must be trained to understand, through scenario training, that when conducting phone triage just how big a gap there can be between what a lay person perceives and expresses and what is actually occurring “on the ground” and therefore the

²⁰⁶ Transcript of Inquest, dated 19 July 2016, at page 847, line 24 to 848, line 16.

²⁰⁷ Transcript of Inquest, dated 19 July 2016, at page 827, lines 10-13.

need for a great deal of focus, probing, prompting and a prompt application of “erring on the side of caution” at the slightest provocation. Without proper training, the breadth of the gap between what a lay person perceives and tells the nurse versus what is actually occurring is not otherwise likely to be fully appreciated by a telephone triage nurse. Viewing the CCTV footage in this case certainly brings the breadth of that gap into clear focus.”

Lessons Ms Hollenback has learnt

130. Ms Greenham further submits, in addition to the matters that in hindsight Ms Hollenback would have done differently, she had identified the following changes which Ms Hollenback has made to her practice from lessons learnt:

- Her note taking has changed significantly;
- She does not accept simply what she is told by police so she does more probing and where possible she confirms information for herself (for example if she is at the Custody Centre she asks the police to bring the detainee up so that she can assess the detainee)²⁰⁸.
- Thus, lessons she has learnt have positively influenced her current practice.

The Application of the Medical Checklist by Police

131. Mr Dorey explained – *‘All correspondence provided to police members in relation to CHAL asks police members to “please refer to the Victoria Police Medical Checklist” before calling and in an emergency, to call Triple Zero (000)’*²⁰⁹.

132. The applicable Victoria Police Manual Guidelines at the time say at 2.1²¹⁰.

2.1 Medical Checklist

“VPMP Persons in police care or custody requires members to assess persons that come into police care or custody using the Medical Checklist.

The Coma Scale provides the police response required dependent on a person’s best verbal response to questions. If their best verbal response deteriorates over time respond as indicated by the next lowest score. If the person appears to be intoxicated, the best verbal response should be assessed at least half hourly.”

²⁰⁸ See oral evidence of Karyn Hollenback, Transcript of Inquest, dated 19 July 2016, at page 833, lines 24-31, page 834, lines 1-22.

²⁰⁹ Coronial Brief of Evidence, Statement of Timothy Dorey, dated 13 April 2016, at page 136 (Exhibit 24).

²¹⁰ Coronial Brief of Evidence, Victoria Police Manual – Procedures and Guidelines, at page 722.

133. It also states, inter alia, that *‘when assessing and dealing with persons believed to be intoxicated, members should be mindful that the health of intoxicated persons may deteriorate more quickly than non-intoxicated persons’*²¹¹.
134. The Medical Checklist... *‘applies to all persons in the care or custody of police at all times’*.
135. Ms Greenham submitted that Ms Hollenback expected that police would have applied the medical checklist before calling²¹². Sgt Mayne explained – *“I didn’t feel it necessary to, um, measure him against that scale when I just had the interaction with him over the last couple of hours that were fine - apart from his frailty”*²¹³. Although I consider Ms Hollenback should have ascertained early in the 1st call that Sgt Mayne had not referred to the medical checklist I consider he should have made reference to the medical checklist before calling CHAL.
136. Whether Sgt Mayne would have identified Michael’s conscious state by reference to the Medical Checklist is speculative. I accept that he did not consider Michael presented a medical emergency and genuinely believed his concerns for Michael’s welfare were best directed to CHAL.
137. I accept the evidence of Mr Dorey that a standard question CHAL nurses ask of police members is whether they have applied the medical checklist.²¹⁴ Ms Hollenback was unaware of this requirement.
138. In my view, the inconsistency between Mr Dorey’s expectation and Ms Hollenback’s knowledge is an example of inadequate training. There should be no inconsistency in a matter as fundamentally important as ascertaining the category of an officer’s referral to the medical check list, when protracted concerns for the medical welfare of a prisoner are being conveyed to a CHAL nurse.

Systemic Improvements since Mr Darmody’s death

139. The role of CHAL nurses and Victoria Police watch house staff is onerous. The system in which they work must always reflect the complexity of their roles and facilitate the full and free flow of information. Prisoner welfare is paramount. I acknowledge that all parties at inquest have sought to learn lessons from this tragedy and ensure that systemic improvements are implemented to assist those to whom prisoner welfare is entrusted. A

²¹¹ Ibid.

²¹² See oral evidence of Karyn Hollenback, Transcript of Inquest, dated 19 July 2016, at page 815, lines 6-18.

²¹³ Evidence of Sergeant Mayne, Transcript of Inquest, dated 21 April 2016, at page 426, lines 22- 28.

²¹⁴ Transcript of Inquest, dated 18 July 2016, at page 638, line 27 – 639, line 17.

number of relevant improvements have been made to Victoria Police and CHAL policies, procedures and training²¹⁵. Key changes include:-

(a) The Custody Risk Assessment form was amended effective from 30 September 2015 and is required to be completed for all persons detained in police custody. The amended form is entitled Detainee Risk Assessment. Relevantly the new form prompts the assessor to ask questions about detainees' health and substance use including whether a detainee:-

- has seen a doctor or been to hospital recently for treatment and details thereof;
- is taking or supposed to be taking medication and details regarding the medication;
- is using drugs and details of the type, amount per day, frequency and last drug use;
- consumes alcohol and details of the type, amount per day, frequency and last drink;
- has any prohibited articles including drugs in their possession.
- The revised Custody Risk Assessment form also prompts the completion of a coma scale assessment upon a detainee entering custody. The medical checklist and observation levels are included on the assessment form for ease of reference.²¹⁶

(b) CHAL calls between nurses and members are now recorded.²¹⁷

(c) CHAL call recordings are used to audit the performance of CHAL nurses.

(d) CHAL call recordings are used for training purposes.

(e) Improvements have been made to CHAL policies, practices and work environment.²¹⁸

(f) Training specific to telephone triage has been enhanced incrementally since CHAL was established in 2011, including active feedback on staff performance.²¹⁹

²¹⁵ Mr Darmody's death was not the catalyst for these changes, however they are relevant matters to inform the Court in relation to.

²¹⁶ Coronial Brief of Evidence, Statement of A/Superintendent Gregory Barras, date 15 April 2016, at page 710[27], Attachment 7, and Detainee Risk Assessment, at pages 830-831, see also Sgt Tonkin Transcript of Inquest, dated 19 April 2016, at page 204, lines 14-28.

²¹⁷ Coronial Brief of Evidence, Supplementary statement of Timothy Dorey, dated 13 April 2016, at page 538[18] (Exhibit 24).

²¹⁸ Coronial Brief of Evidence, Supplementary statement of Timothy Dorey, dated 13 April 2016, at page 540-542[28-29] (Exhibit 24).

²¹⁹ Coronial Brief of Evidence, Supplementary statement of Timothy Dorey, dated 13 April 2016, at page 540-542[29.7] (Exhibit 24).

- (g) CHAL nurses are now trained one on one and there is a buddy system.²²⁰
- (h) Upon the introduction of JCARE in late 2016, CHAL nurses will have access to historical information concerning a detainee's health.²²¹ JCARE will result in a universal electronic medical record which will be accessible to prisons and police including CHS and the CHAL. The sources of the historical health record would include all previous information that has been gathered whilst a detainee has been in custody. For example, during a previous period in custody, a detainee's records from general practitioners, hospitals, Ambulance Victoria, pharmacies, community health providers and corrections health may have been requested and uploaded onto JCARE which would then be accessible to CHS and the CHAL. In addition, the record will reflect medical and psychiatric risk ratings from the Department of Justice (for example, medical, psychiatric and suicide and self-harm risks).
- (i) There will be further updates to CHAL policies and procedures after the implementation of JCARE in 2016²²².

Despite training deficits set out above, I accept the submission of Counsel for Victoria Police that Ms Hollenback's failure to obtain emergency assistance for Mr Darmody was due to a lapse in professional judgement, as opposed to a broader systemic failure on the part of the Victoria Police or the CHS.

FINDINGS

Having considered all the evidence, in the circumstances described above:

140. I find that Michael John Darmody born on 14 February 1963, died on 12 May 2014 of Combined Drug Toxicity (Methadone and Benzodiazepines) in a man with Coronary and Cerebrovascular Disease.
141. In respect to the 1st and 2nd call, I am satisfied that neither Ms Hollenback nor Sgt Mayne had formed the view during Michael's incarceration that his condition posed a medical emergency.
142. I am satisfied that Ms Hollenback formed a view, which she conveyed to Sgt Mayne in their earliest conversation, that Michael did not require an ambulance. I find that upon Sgt Mayne informing Ms Hollenback that Michael's best response was a grunt she should have

²²⁰ Transcript of Inquest, dated 22 April 2016, at page 550, lines 15-31.

²²¹ Coronial Brief of Evidence, Supplementary statement of Timothy Dorey, dated 13 April 2016, at page 535[9] (Exhibit 24).

²²² Transcript of Inquest, dated 22 April 2016, at pages 574-575, lines 1-8.

immediately directed him to ascertain Michael's conscious state. In not doing so I find her response was not reasonable or appropriate.

143. I find Ms Hollenback, in not ascertaining Michael's conscious state, denied Michael the opportunity of receiving immediate hospital transfer and straightforward medical intervention.
144. I find Michael's death was preventable.
145. I find, based on the evidence of A/Prof Gerditz' evidence, that Ms Hollenback's training for the CHAL role did not reflect best practise.
146. I find however, that my conclusion regarding the inadequacies of Ms Hollenback's response (referred to in paragraph 143) was not a result of any training deficits.
147. I offer all members of Michael's family my sincere condolences – their dignity and love of Michael has been apparent throughout the inquest. The complexity facing all custodial staff, entrusted with prisoner welfare, cannot be overstated. It is essential that staff training, and the system in which they work, reflect best practice and undergoes rigorous regular scrutiny. Having said that, I say to the family that all parties appearing before me, have expressed a genuine determination to continue to learn and improve the system of prisoner welfare in police custody, thereby reducing the likelihood of similar tragedies occurring.

RECOMMENDATIONS

Pursuant to section 72(2) of the Coroners Act 2008, I make the following recommendations:

Recommendation 1

That Victoria Police introduce training for Custody Sergeants and Custody Staff regarding identifying and communicating signs and symptoms of life-threatening conditions. Such training ought to include the practicalities of understanding aspects of the medical checklist and ought to train on using the ISBAR philosophy to communicate concerns.

Recommendation 2

That Victoria Police review the medical checklist to incorporate difficulty of rousability into the checklist. Exactly how this is done is a matter for further medical opinion and advice, although it is submitted that as a starting point, if a person is not orientated to time and space (i.e. is on the scale anything lower than a 5) and is difficult to rouse then this should arguably lead to the need for an ambulance to be called.

Recommendation 3

That Victoria Police consider the viability of introducing web camera or similar device into the CHAL system (one roving camera per police gazetted cell block facility) to be live-streamed to the CHAL nurses.

Recommendation 4

That Victoria Police develop a formal training module for CHAL nurses along the lines proposed by Associate Professor Gerdtz and ensure that they undergo training and appropriate support/review of their work prior to undertaking the role of providing telephone advice regarding the health of detainees in police custody.

Recommendation 5

That CHAL protocols be amended as suggested by Associate Professor Gerdtz to include a basic primary survey structure and appropriate physiological descriptors.

Recommendation 6

That Victoria Police redevelop a training package which highlights the mandatory requirement that medical checklists are always referred to when concerns for prisoner welfare are held. In addition, whether there is a more appropriate tool to assess the need for urgent medical treatment.

To enable compliance with section 73(1) of the Coroners Act 2008 (Vic), I direct that the Findings will be published on the internet.

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

The family of Michael Darmody

The Chief Commissioner of Police

Ms Karyn Hollenback

Signature:

JOHN O'LE
CORONER
Date 10 April 2017

