IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: **COR 2017 299**

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)
Section 67 of the Coroners Act 2008

Findings of:	**MR PHILLIP BYRNE, CORONER**
Deceased:	**TREVOR WILLIAM BROWN**
Date of birth:	**16 FEBRUARY 1967**
Date of death:	**18 JANUARY 2017**
Cause of death:	**I (a) HYPOXIC BRAIN INJURY FOLLOWING CARDIAC ARREST DUE TO MYOCARDIAL INFARCTION WITH RIGHT CORONARY ARTERY THROMBOSIS**
Place of death:	**KOORI INPATIENT PSYCHIATRIC UNIT, ST VINCENT'S HOSPITAL, 41 VICTORIA PARADE, FITZROY, VICTORIA, 3065**

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

I, PHILLIP BYRNE, Coroner having investigated the death of TREVOR WILLIAM BROWN without holding an inquest:
find that the identity of the deceased was TREVOR WILLIAM BROWN
born on 16 February 1967
and the death occurred on 18 January 2017
at Koori Inpatient Psychiatric Unit, St Vincent's Hospital, 41 Victoria Parade, Fitzroy, Victoria 3065

from:

1 (a) **HYPOXIC BRAIN INJURY FOLLOWING CARDIAC ARREST DUE TO MYOCARDIAL INFARCTION WITH RIGHT CORONARY ARTERY THROMBOSIS**

Pursuant to section 67(1) of the **Coroners Act 2008** I make findings with respect to **the following circumstances**:

Background

1. Trevor William Brown, known as "Turbo" Brown due to the days he was a professional boxer, aged 49 years old at the time of his death, resided at 198 Victoria Street, Brunswick.
2. Mr Brown, an indigenous gentleman, suffered from chronic schizophrenia and an acquired brain injury presumably due to his boxing career. He was managed by Dr Georgiou of the Victorian Aboriginal Health Service.
3. In this finding I propose to focus on events proximate to Mr Brown's death, rather than historical matters.
4. Mr Brown's death constituted a '*reportable death*' under the *Coroners Act 2008* (the Act) as immediately before death, he was a patient detained in a designated mental health service

within the meaning of the *Mental Health Act 2014*.[1] Ordinarily, a coroner must hold an inquest into a death if the death or cause of death occurred in Victoria and the deceased person was immediately before death a person placed in custody or care.[2] However, a coroner is not required to hold an inquest if the coroner considers that the death was due to natural causes.[3]

Events of 12 – 18 January 2017

5. On 12 January 2017 Mr Brown was referred to North Western Mental Health (NWMH) triage by Dr Georgiou due to Mr Brown's rapidly deteriorating mental health resulting in increasing agitation, aggression and auditory hallucinations. In this context Mr Brown, who had a significant criminal history, expressed a desire to kill someone.

6. The North West Community Mental Health Team/Clinicians experienced difficulty in assessing Mr Brown due to his combative and uncooperative presentation. Mr Brown was placed on an Assessment Order under the *Mental Health Act 2014* and transferred by ambulance to the Emergency Department (ED) at the Northern Hospital. To facilitate the transfer Mr Brown was medicated and required a level of restraint.

7. Mr Brown was admitted to the ED of Northern Hospital at 5:30p.m. on 12 January 2017. He was reviewed by the Emergency Mental Health clinician and noted to be sedated. Subsequently Mr Brown became agitated and was given injection Droperidol 10mg initially at about 10:10pm on 12 January 2017 and subsequently at 6:15am the next morning. Due to Mr Brown's challenging behaviour it was planned to admit him to the Koori Inpatient Psychiatric Unit at St Vincent's Hospital, Fitzroy.

8. Dr George Anthony, Consultant Psychiatrist reviewed Mr Brown at about 10:00a.m. on 13 January 2017. Being advised a bed was being organised at the Koori Inpatient Psychiatric Unit at St Vincent's Hospital, Dr Anthony provided a clinical handover of Mr Brown to his colleague at St Vincent's, Consultant Psychiatrist Associate Professor Peter Bosanac. Due to Mr Brown's presentation Dr Anthony varied the Inpatient Assessment Order to an Inpatient Temporary Treatment Order. Mr Brown was transferred to St Vincent's by ambulance shortly after 1:30p.m. on 13 January 2017.

9. Mr Brown arrived at Acute Inpatient Service (AIS) at St Vincent's shortly after 2:30p.m. on 13 January 2017. His demeanour was extremely threatening and combative resulting in him being placed in seclusion with physical restraint. Some short period later physical restraint

[1] Section 4, definition of 'Reportable death', *Coroners Act 2008;* Section 4, definition of 'Person placed in custody or care', *Coroners Act 2008.*
[2] Section 52(2)(b) *Coroners Act 2008.*
[3] Section 52(3A), *Coroners Act 2008.*

was ceased however Mr Brown again became highly agitated kicking the seclusion room door, defecating on the floor and smearing faeces on the walls and windows. After showering, during which he remained threatening, Mr Brown was again mechanically restrained (four point distal limbs) due to continuing immediate risk to himself and others. At 3:25p.m. Mr Brown was administered olanzapine 10mg and was continuously observed, one on one by a registered nurse.

10. Dr Bosanac, who was not on-site that afternoon, had his colleague Consultant Psychiatrist Dr Susan Ong review Mr Brown. Having reviewed Mr Brown at 3:45p.m. Dr Ong concluded continued mechanical restraint was necessary.

11. At 5:45p.m. Psychiatry Registrar Dr Amanda Young reviewed Mr Brown who remained verbally threatening and aggressive. At 6:05p.m. clonazepam 2mg was given intramuscularly and at 8:40p.m. Mr Brown was administrated olanzapine 10mg intramuscularly.

12. At 11:30p.m. Dr Young again reviewed Mr Brown. At 1:30a.m. on 14 January 2017 Mr Brown was reviewed by the on-call medical resident Dr Fink. It was planned that there would be a further medical review within the 4-hour mandatory minimum for patients mechanically restrained.

13. However events overtook that plan as at 4:10a.m. the nurse monitoring Mr Brown became concerned about his breathing and summoned Associate Nurse Unit Manager Ms Tara Lantry. Upon attendance in a timely manner, Ms Lantry noted Mr Brown to be unresponsive, not breathing. A Code Blue was called.

14. After full resuscitation measures after approximately 12 minutes, spontaneous circulation was restored and Mr Brown was transferred to the Intensive Care Unit (ICU). He did not however regain consciousness. Subsequent investigations demonstrated that as a result of the "downtime" prior to resuscitation Mr Brown had suffered an hypoxic brain injury.

15. Mr Brown remained in the ICU. On the afternoon of 16 January 2017 the AIS manager Dr Bosanac, the Aboriginal Health Liaison Officer and Mr Brown's carer Mr Chessels and a friend "Max" met to discuss Mr Brown's management and prognosis. Intensivist Dr Croswell later joined the discussion.

16. On 18 January 2017 Mr Brown's family met with the Intensive Care Team where it was conveyed that Mr Brown's condition was unsalvageable. After consultation Mr Brown was extubated and he died later that evening.

POST-MORTEM EXAMINATION AND REPORT

17. The matter was appropriately reported to the coroner. Having considered the circumstances, and having conferred with a forensic pathologist, I concluded it was imperative that an autopsy be performed to establish the precise cause of death.

18. In accordance with my direction an autopsy was undertaken by Forensic Pathology Registrar Dr Khamis Almazrooei supervised by Forensic Pathologist Dr Gregory Young of the Victorian Institute of Forensic Medicine (VIFM). Subsequently, a comprehensive 16-page autopsy report, together with a 4-page neuropathology report under the hand of the Head of Pathology at the VIFM, Dr Linda Iles, was provided.

19. As a result of the investigations I was advised Mr Brown died due to *I (a) hypoxic brain injury following cardiac arrest due to myocardial infarction with right coronary artery thrombosis.*

    Dr Almazrooei reported Mr Brown had significant coronary artery disease and suggested immediate family members be assessed in regards to their cardiovascular health, I am satisfied Mr Brown died due to natural causes.

The evidence

20. Having regard to the circumstances, and bearing in mind Mr Brown was an involuntary patient in a mental health service, "in care" within the meaning of the act, I sought statements from both Northern Hospital and St Vincent's Hospital as to their management of Mr Brown. The first point I make is Mr Brown presented a significant challenge to those seeking to treat him.

21. On behalf of Northern Area Mental Health Service (NAMHS) Consultant Psychiatrist Dr George Anthony provided a statement. Having examined the statement it became clear the transfer to St Vincent's specialist unit was necessary to manage Mr Brown. One could not reasonably be critical of Mr Brown's management at the Northern Hospital; his transfer was arranged in a timely manner.

22. Lander & Rogers, solicitors for St Vincent's Health, provided a comprehensive statement and annexures on behalf of their client. The author of the report, Associate Professor Peter Bosanac, Director of Clinical Services at St Vincent's Mental Health (SVMH) described the course of treatment provided to Mr Brown.

23. Dr Bosanac specifically described in detail the policies and guidelines adopted by SVMH in accordance with the provisions of the *Mental Health Act 2014*. While generally treatment is

required to be provided in the least restrictive environment, the *Mental Health Act 2014* recognises that from time to time it will be necessary, as a last resort, to employ restrictive measures. The *Mental Health Act 2014* dictates when seclusion, bodily mechanical restraint, and pharmacological management is permitted. Appropriately such management is required to be authorised by quite senior personnel. When these measures are applied the patient is required to be subject to high levels of monitoring/observation.

24. I am entirely satisfied the restrictive measures utilised at St Vincent's met the strict legislation criteria required by the *Mental Health Act 2014*. Furthermore, I am satisfied the intensive monitoring was appropriate.

25. As Mr Brown died due to natural causes, and noting the relatively recent amendments to section 52 of the Act, I propose to proceed to finalisation of my investigation without inquest.

26. Not only have I satisfied myself that the relevant SVMH policies and guidelines were complied with, but importantly I am further satisfied that those policies and guidelines provide an appropriate regime to treat a patient with Mr Brown's challenging presentation.

27. Prior to finalising my investigation I had my registrar enquire of the Office of Chief Psychiatrist if they were aware of the circumstances of Mr Brown's death and whether the Chief Psychiatrist wanted any input. I was advised the Chief Psychiatrist was cognisant of the circumstances and did not propose input.

FINDING

28. I formally find Trevor ("Turbo") William Brown died at the Koori Inpatient Psychiatric Unit at St Vincent's Hospital on 18 January 2017 due to a hypoxic brain injury following cardiac arrest due to myocardial infarction with right coronary artery thrombosis.

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

    Mr Wilfred Brown, Senior Next of Kin;

    Dr Neil Coventry, Office of the Chief Psychiatrist;

    St Vincent's Acute Inpatient Service;

    North Western Mental Health Service (Northern Hospital); and

    Detective Senior Constable Rachael Knight, Coroner's Investigator, Victoria Police.

30. Pursuant to section 73(1B) of the *Coroners Act 2008*, I also direct the finding be published on the Coroners Court of Victoria website in accordance with the rules of the Coroners Court.

Signature:

PHILLIP BYRNE
CORONER

Date: 15 July 2011