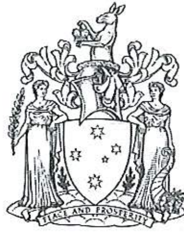

IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2017 3353

# FINDING INTO DEATH WITH INQUEST

*Form 37 Rule 63(1)*
*Section 67 of the Coroners Act 2008*

| | |
|---|---|
| Findings of: | **STATE CORONER JOHN CAIN** |
| Deceased: | JOELENE THERESE DOWDEN |
| Delivered on: | 1 May 2020 |
| Delivered at: | Coroners Court of Victoria<br>65 Kavanagh Street, Southbank, VIC |
| Hearing date: | 1 May 2020 |
| Counsel assisting the Coroner: | Lindsay Spence<br>Principal In-House Solicitor<br>In-House Legal Services |
| Representation: | |

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**HIS HONOUR:**

**BACKGROUND**

1. Joelene was born on 27 February 1980 in the New South Wales town of Wee Waa, the third youngest of four children to her mother, Debbie Hardman, and her father, Ronald Dowden. Joelene's paternal grandmother was Aboriginal with Joelene identifying herself as being Aboriginal throughout her life.

2. Joelene died on 12 July 2017, aged 37 years. On 9 July 2017 Joelene was arrested pursuant to s.351 *Mental Health Act* by Victoria Police after behaving extremely erratically around a number of trams at the Clarendon Junction Tram Stop 125, Southbank. At one stage Joelene had yelled at a Tram Driver to run her over before running into the path of a 'Yarra' Tram and colliding with it at low speed.

3. Victoria Police attended and after assessing Joelene, who was continually hitting her head on the concrete and kicking her arms and legs out, she was arrested under s.351 *Mental Health Act* and for safety reasons handcuffed with her hands behind her back and put on her left lateral side. Ambulance Victoria arrived to transport Joelene to hospital however whilst they were preparing to sedate Joelene, she went into cardiac arrest. Police immediately removed the handcuffs and resuscitation was commenced. Joelene was transported to the Alfred Hospital and admitted into the Intensive Care Unit however passed away three days later on 12 July 2017.

4. An Inquest in respect of Joelene's death is mandatory pursuant to Section 52(2)(b) *Coroners Act 2008*. Section 52(2)(b) *Coroners Act 2008* requires that "*A coroner must hold an inquest into a death if the death or cause of death occurred in Victoria and (b) the deceased was, immediately before death, a person placed in custody or care*". A "*person placed in custody or care*" includes "*(f) a person in the custody of a police officer*". There is no dispute on the available evidence that Joelene had been arrested pursuant to s.351 *Mental Health Act* and was therefore in the custody of LSC Wagner and First Constable Louch at the time of going into cardiac arrest.

5. An Inquest was held on 1 May 2020. The Inquest was a Summary Inquest without the calling of witnesses as there were no evidentiary conflicts or discrepancies in establishing the circumstances in which the deceased died that would justify the calling of any witnesses at Inquest.

6. I am also satisfied that there are no identified systemic issues that would justify the calling of evidence at Inquest. Finally I am satisfied that the conduct of LSC Wagner, First Constable Louch or any other Emergency Services Personnel immediately preceding the death does not require further investigation, and does not justify the calling of witnesses by the Coroner under the Act.

## THE PURPOSE OF A CORONIAL INVESTIGATION

7. Joelene's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (Vic) (**the Act**). Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury.

8. Coroners independently investigate reportable deaths to find, if possible, identity, medical cause of death and with some exceptions, surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. Coroners make findings on the balance of probabilities, not proof beyond reasonable doubt.[1]

9. The law is clear that coroners establish facts; they do not cast blame or determine criminal or civil liability.

10. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.

[1] In the coronial jurisdiction facts must be established on the balance of probabilities subject to the principles enunciated in *Briginshaw v Briginshaw* (1938) 60 CLR 336. The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

## MATTERS IN RELATION TO WHICH A FINDING MUST, IF POSSIBLE, BE MADE

### Identity of the Deceased pursuant to section 67(1)(a) of the *Coroners Act 2008*

11. On 12 July 2017, Joelene was visually identified by her Drug and Alcohol Counsellor, Karen Hall as per the Statement of Identification same dated.

12. Joelene's identity is not in dispute and therefore requires no further investigation.

### Cause of Death pursuant to section 67(1)(b) of the *Coroners Act 2008*

13. On 13 July 2017, Dr Victoria Francis, a Forensic Pathologist at the Victorian Institute of Forensic Medicine conducted an autopsy on Joelene's body. Dr Francis provided a written report, dated 26 February 2018, which concluded that the cause of death was

    1(a) HYPOXIC ISCHAEMIC BRAIN INJURY COMPLICATING ASPIRATION OF GASTRIC CONTENTS.

14. Dr Francis also made the following comments within her written report, which are highly relevant to understanding the circumstances in which Joelene's death occurred.

    2. Post mortem examination revealed a hypoxic ischaemic brain injury

    3. There was aspiration pneumonia throughout both lungs

    4. There was bruising over her forehead, wrists and both knees. There was a sternal body fracture with associated muscular/soft tissue haemorrhage. There was no evidence of injury sufficient to have caused her death.

    5. Toxicological analysis of antemortem blood samples dated from 9 July 2017 1430hrs detected doxylamine. No alcohol, morphine, gamma hydroxybutyrate, synthetic cannabinoids or synthetic cathinones were detected.

    9. Her 3-hydroxybutyrate level was significantly elevated, suggestive of alcoholic ketoacidosis.

12. The cause of Joelene Dowden's behaviour prior to her collapse was not identified during the post mortem examination. Whilst she was described as 'intoxicated', there was no alcohol or drugs of abuse identified on her hospital admission blood samples.

16. Ketoacidosis is a metabolic state associated with high concentrations of ketone bodies, formed by breakdown of fatty acids. 3-hydroxybutyrate is a form of ketone. The most common causes of increased ketones in the blood are alcoholic and diabetic ketoacidosis. Alcoholic ketoacidosis is typically seen in chronic alcoholics who binge, then stop drinking and have little or no oral food intake. Diabetic ketoacidosis was excluded due to a negative vitreous humour glucose level. Ordinarily, people with alcoholic ketoacidosis have a low level or no alcohol detected.

17. Alcoholic ketoacidosis often causes nausea, vomiting and abdominal pain as well as agitation, confusion, altered levels of alertness (sometimes leading to coma) and symptoms of dehydration. The metabolic acidosis may lead to the patient having a particular odour which may be confused for the smell of alcohol. Complications include coma, seizures, pancreatitis and pneumonia (usually after vomiting). This may explain Joelene Dowden's altered behaviour prior to and during the events leading to her death.

18. Other potential mechanisms of her cardiac arrest are a concussive head injury when she hit her head against the ground or the possibility that restraint contributed to her collapse. These two factors are considered unlikely to have had any significant contribution to these events.

15. I accept Dr Francis' opinion as to the medical cause of death.

**Circumstances in which the death occurred pursuant to section 67(1)(c) of the *Coroners Act***

**Background to the life of Joelene Dowden**

16. Joelene was born on 27 February 1980 in the New South Wales town of Wee Waa, the third youngest of four children to her mother, Debbie Hardman, and her father, Ronald Dowden. Joelene's paternal grandmother was Aboriginal with Joelene identifying herself as being Aboriginal throughout her life. Joelene attended primary school in Wee Waa prior to moving to Narrabri after her parents' relationship ended. Joelene continued her schooling at Narrabri Public School and then onto Narrabri High School where she successfully completed Year 10.

17. During that time Joelene was employed on a part-time basis at the Narrabri Chinese Restaurant however around the age of 15-16 Joelene became involved with alcohol and illicit drugs. Joelene commenced a relationship with Damien Robertson and became pregnant at the age of 18, giving birth to her first daughter Sharnie Dowden (Robertson) on 29 April 2000. A year later Joelene gave birth to her second child, Shae Dowden (Robertson) on 2 May 2001 however the relationship between Joelene and Damien then ended.

18. In 2003 Joelene was admitted to the Banksia Mental Health Unit, Tamworth Hospital where a Discharge Summary dated June 2003 recorded the following in respect of Joelene's Personal History '*Joelene is one of multiple children of her mother with multiple fathers. Joelene describes the partners as abusive and that the partners and her mother abused alcohol+++. Joelene claims that her mother physically abused her. She left her mother for a foster home aged 13 years. Joelene has 2 children by a previous partner who is alleged to have molested the children. The children have been in foster care since her last prison sentence. She currently has limited access to the children during the day and has the long term aim of detoxification from benzodiazepines to regain custody of the children. For the past 2 years Joelene has had a violent relationship with her de facto, Mark, who is alcohol dependent. Multiple bashings of Joelene by Mark have resulted in an AVO, charges of GBH and Mark's eviction from her flat*'.

19. As a consequence of Joelene's relationship with Mark Wilson she gave birth to two sons, . In 2004 Joelene moved to Hervey Bay, Queensland for a couple of years and returned to Narrabri in 2006. The NSW Department of Family and Community Services ultimately removed custody of all four of Joelene's children into foster care due to her excessive alcohol and illicit drug taking.

20. In August 2011, Joelene travelled to Adelaide and Mount Gambier for a short period of time before moving to Melbourne with Mark Wilson, who died from a drug overdose in a caravan park in November 2011. In 2012 Joelene moved to Mildura and then returned to the streets of Melbourne, homeless.

21. Whilst Joelene kept in constant contact with both her mother (Debbie Hardman) and her daughter (Sharnie Dowden), regrettably Debbie Hardman passed away on 13 July 2017, the day after Joelene's death and after being notified of her daughter's passing. Further no statement was able to be obtained from Joelene's eldest daughter, Sharnie Dowden. Much of Joelene's history within Melbourne has therefore been gained from medical and psychiatric records.

22. Approximately four-and-a-half years prior to her death, Joelene met Jeffrey Miller who gives evidence '*When I first met Jo she was around the St Kilda area living down the beach in a tent with her fellow whose name I can't remember. It was around this time that Jo was crook and had to go to hospital. While Jo was in hospital her fellow died from pneumonia. When Jo came out of hospital she came and lived with me on and off for about nine months in the St Kilda area. After this time she would go in and out of crisis accommodation, often she would become abusive towards staff and would get kicked out and stay with me for one to two months. She'd get another place and stuff it up*'.

23. In September 2014 Joelene met Karen Hall, a Drug and Alcohol Coordinator at Windana Drug and Alcohol Recovery in St Kilda. Karen gives evidence that '*I first met Jo in a rooming house in Queens Road, St Kilda. She was housed there for a couple of months. When I first met her she was drinking methylated spirits first thing in the morning. That house did not last very long as she continued to be bringing people back who were sleeping rough*'. Karen described her engagement with Joelene as *sporadic* however for the majority of time that Karen knew Joelene, she was homeless either living on the streets or couch-surfing.

24. In respect of Joelene's relationships, Karen gives evidence that '*Joelene usually had a partner. They were always violent, they were always in a domestic violence situation. A number of her partners died in horrible park type circumstances, so there was a lot of ongoing trauma*'.

25. Joelene would drink approximately 6-8 litres of wine daily. In Karen's opinion, whilst she was an alcoholic she didn't touch illicit drugs, other than minimal amounts of cannabis.

26. In January 2017 Joelene was admitted to the inpatient psychiatric unit at Alfred Health for a ten (10) day period. This admission occurred in the context of an episode of drug induced psychosis complicated by delirium, secondary to alcohol withdrawal. Joelene was referred back to her primary health care provider on discharge for ongoing care.

27. In February 2017 Karen referred Joelene for a psychiatric consultation via the Homeless Outreach Psychiatric Service (HOPS), Alfred Health. A review of Joelene's psychiatric history prior to this assessment revealed documented diagnoses of alcohol use disorder and drug induced psychosis, with differential diagnosis of alcoholic hallucinosis.

28. On 14 February 2017 Joelene attended a psychiatric consultation with Dr Viola Luk, Ms Laura Hales (occupational therapist) and Karen Hall during which Joelene expressed concerns about her experiences of "voices", nightmares and ongoing state of homelessness. At the time of the assessment Joelene reported drinking up to 8L of cask wine per day, commencing on waking. Joelene reported consistently experiencing significant withdrawal complications, and she had last experienced an alcohol withdrawal induced seizure three months prior to her assessment.

29. Dr Luk assessed Joelene as presenting with alcohol use disorder and although it was difficult to comprehensively assess Joelene due to her being alcohol intoxicated, it appeared that her presentation was more consistent with that of trauma, in accordance with her developmental history and her experience as a victim of severe domestic violence. As a result of this assessment Joelene was encouraged to return to her primary health care provider to discuss the option of prescription of a regular anti-psychotic. Whilst recommended, Joelene at the time declined admission to a detoxification/rehabilitation unit as well as declined pharmacological options in the management of her alcohol use disorder.

30. On 11 May 2017 Joelene attended GP Dr Paul Blatt. Dr Blatt gives evidence that Joelene '*came in and stated she was "paranoid", couldn't stop vomiting, complaining of abdominal distension. She said she was drinking 6 to 8 litres of wine per day. She was intoxicated. I advised her to go to Alfred Emergency Department. Referral provided*'.

**Events of Sunday 9 July 2017**

31. On Friday 7 July 2017, nothing appeared amiss with Joelene, she was according to Jeffrey Miller '*normal, drinking wine with me at home*'. However the following day Miller gives evidence that '*she didn't eat or drink wine as she was throwing up a lot, bringing up fluid and she wasn't feeling well and was in bed for most of that day. I saw her vomit at least half a dozen times during that day*'. In either the late afternoon or early evening, between 5-7pm, Joelene became agitated by the ongoing arguing that had been occurring between Miller and his flatmate, and she therefore left Miller's residence, saying she couldn't live there anymore because she was sick of all the arguing. Joelene's movements are unknown between this time and Sunday morning.

32. Approximately 9.30am on Sunday 9 July 2017, Joelene attended the Alfred Hospital Emergency Department and approached the triage desk and spoke with the Triage Clerk. Joelene was registered however upon being called by the Triage Nurse was unable to be located. Triage Nurse Clare Skafte checked the toilets however was unable to locate Joelene and was then informed by a member of the public that Joelene had left. Clare continued to search for Joelene and checked the main hallway of the hospital and located Joelene walking out the doors. Clare managed to convince Joelene to return to be triaged however on the way back to triage, two Security Guards were walking out of the Department. As soon as Joelene sighted Security she ran out and decamped and left the hospital. Clare contacted the Emergency Psychiatric Service to check if they knew of Joelene needing psychiatric treatment however they indicated there were no current alerts in respect of Joelene.

33. At 11.53am Joelene attended the front reception of Launch Housing, 52 Haigh Street, Southbank and requested a blanket that was provided. Support Worker Naomi Redmayne attempted to engage with Joelene and Naomi gives evidence that '*Joelene appeared somewhat paranoid ... ... expressed her frustration with the Salvos in Bourke Street. She kept claiming that people were withholding information from her*'. Naomi asked Joelene about her housing options and suggested that she talk with the St Kilda Crisis Centre. Joelene agreed and made contact however upon hanging up the phone said '*That was pointless*'. Joelene then started vomiting and vomited a number of times before leaving approximately 12.38pm.

34. Approximately 1.00pm Steven Anderson, Tram Driver for Yarra Trams was driving the Restaurant Tram and pulled into the tram stop located at Normanby and Clarendon Streets, Southbank. Anderson noticed Joelene sitting at the tram stop acting erratically saying to Anderson '*Run me over, I am not moving until you run me over*'.

35. A few minutes later the Number 96 Tram arrived and as it pulled into the tram stop, Joelene tried to run in front of it however the tram had come to a stop before Joelene reached it. Anderson and a number of other employees assisted her back to the tram stop and offered Joelene some water. Ingrid Marshall, an employee on the Restaurant Tram noticed that Joelene's movements were disjointed, her speech was slurred, on approach she smelt like methylated spirits, and that Joelene kept punching her stomach and said she wanted to die.

36. Soon after, the Number 109 Tram was approaching and Joelene ran away from Anderson and tried to run in front of it however miscalculated and ended up hitting the front right hand side near the driver's cabin. The tram immediately stopped and Joelene fell to the tracks in front of the tram and started banging her head on the roadway with force. Yarra Tram employees had previously called Operations Centre and requested the attendance of Police and Ambulance.

37. At 1.12pm LSC David Wagner and First Constable Karly Louch arrived at the tram stop and observed Joelene laying on the ground under the front of tram Number 109. Upon sighting Police Joelene attempted to crawl further underneath the tram. LSC Wagner then reached underneath the tram and grabbed onto Joelene's top and pulled her out fearing that if she crawled any further underneath the tram she may be electrocuted. At this time Joelene was still continuing to hurt herself by smashing her head against the ground.

38. Joelene then began to resist Police and a number of bystanders assisted in restraining Joelene by the legs and in carrying her away from the tram and to the rear of the Police Divisional Van. LSC Wagner then proceeded to handcuff Joelene both for police safety and her safety. Once Joelene was handcuffed she was rolled onto her side and LSC Wagner kept observations of her. LSC Wagner arrested Joelene pursuant to s.351 *Mental Health Act*.

39. At 1.18pm Ambulance Victoria Paramedics James Tehan and Melissa Gledhill attended the Normanby Rd Tram Stop. Upon arrival they observed Joelene lying on the tram tracks in the left lateral position with her arms handcuffed behind her back and the hooded jumper pulled up over her head. Joelene refused to engage with the Ambulance Paramedics and after repeated questioning with no answers, she suddenly became more agitated and attempted to bite the hands of Paramedic Tehan as well as kicking and attempting to headbutt the roadway surface. Paramedic Gledhill placed a pillow between the patient's head and the asphalt to protect Joelene as she was continuing to headbutt the roadway surface.

40. The Paramedics initially drew up 10mg midazolam to sedate Joelene, however prior to administration they observed Joelene to vomit whilst on her side, with her clearing and spitting the vomit out. Administration of the sedative was withheld out of concerns for the patient's airway. Almost immediately after vomiting Paramedics witnessed that Joelene had stopped breathing. They immediately requested LSC Wagner remove the handcuffs and resuscitation was commenced whilst requesting the assistance of MICA Paramedics & MFB.

41. At 2.02pm Joelene was transported by ambulance to the Alfred Hospital arriving at 2.17pm. Joelene was admitted into the Intensive Care Unit however never regained consciousness. Joelene passed away three days later on 12 July 2017 approximately 6.55pm.

42. Later that evening LSC David Wagner, First Constable Carly Louch and First Constable Emma Skewes were directed to undergo Drug and Alcohol Testing on the grounds it was believed that they had been involved in a critical incident. All three members underwent Drug and Alcohol testing and the results returned negative readings for all three members.

43. At a later date enquiries were made by the Coroner's Investigator with the Operational Safety Training Unit at the Victoria Police Academy who advised that all of the police members involved were qualified to carry out operational duties and carry their OSTT equipment, required to perform their duties.

## COMMENTS

### The Decision by LSC Wagner and First Constable Louch to arrest Joelene

44. There is no direct CCTV or Body Worn Video evidence in respect of the arrest of Joelene by LSC Wagner and First Constable Louch. This matter pre-dated the rollout of Body Worn Video within Victoria Police and the Coroner's Investigator confirmed that a CCTV canvass failed to identify any relevant CCTV footage. Ingrid Marshall, Yarra Trams employee took a short iPhone video pre-incident that showed Joelene wandering onto the tram tracks and appearing to be largely disorientated. CCTV is available from Camera 12 of a Yarra Tram but the actual incident is obscured by the Police vehicle of LSC Wagner and First Constable Louch, with the relevant incident occurring at the rear of the vehicle, and out of sight of the CCTV.

45. Ingrid Marshall, Yarra Trams also took a number of photographs that are of significant probative value in confirming the versions provided by all of the attending Emergency Services personnel.

46. As Yarra Trams employee Steven Anderson approached Joelene she was saying '*Run me over, I am not moving until you run me over*'. Joelene was standing in the way of the Tramcar on the tram tracks and at one stage sat down on the tracks and started punching her stomach saying that she wanted to die. Joelene then ran towards the 109 Tram, impacting with the front right-hand side near the driver's cabin, falling to the ground upon which she started banging her head on the ground with force.

47. Upon the arrival of LSC Wagner and First Constable Louch, it was observed that Joelene had managed to crawl underneath the tram. LSC Wagner observed Joelene had cuts to her hands and was bleeding from her head as a result of her bashing her head onto the concrete multiple times. LSC Wagner reached in and grabbed onto Joelene's top and attempted to pull her out as he feared if she crawled further under the tram she may be electrocuted. As LSC Wagner pulled Joelene out from underneath the tram in the foetal position, she continued to hurt herself by smashing her head against the ground. Joelene was subsequently placed under arrest pursuant to s.351 *Mental Health Act.*

48. The decision by LSC Wagner to arrest Joelene pursuant to s.351 *Mental Health Act* was entirely reasonable and justifiable. Joelene had clearly expressed a suicidal intention followed by her standing/sitting/running in front of a number of Yarra Trams including her low speed impact with Tram 109. Further Joelene's self-harming behaviour continued following her impact with Tram 109, lying on the ground repeatedly hitting her head into the roadway surface with force.

49. The requisite s.351 thresholds were clearly satisfied, that is Joelene appeared to have a mental illness AND needed to be apprehended to prevent serious and imminent harm to herself.

**The Decision by LSC Wagner and First Constable Louch to apply handcuff restraints**

50. Following Joelene being extracted from underneath the tram, she was carried to the back of the Police divisional van by LSC Wagner, First Constable Louch and a number of bystanders. LSC Wagner gave evidence that '*I then proceeded to handcuff the female for police safety and her safety. Once the female was in handcuffs I rolled her onto her side and kept observations of her*'. First Constable Louch gave further evidence that at the time of being handcuffed, '*the female was still resisting, she was still kicking out with her legs and moving her arms and again it was more like she was trying to break free ... ... she was eventually cuffed behind her back. It would only have taken about 30 seconds from the time we placed her on the ground at the back of the divisional van until she was handcuffed'*.

51. Attending Victoria Ambulance Paramedics James Tehan and Melissa Gledhill made similar observations of Joelene. James Tehan gave evidence that '*after repeated questioning with nil verbal answers the patient became more agitated and attempted to bite my hands as well as kicking and attempting to head-butt the road again. Assessment of the patient was difficult and I was unable to find any other injuries*'. Melissa Gledhill gave similar evidence, that '*verbal de-escalation attempts by James were unsuccessful and soon the patient's lack of compliance escalated into physical aggression including attempting to bite/kick AV and VicPol staff and headbutting the asphalt. James and I agreed sedation of the patient was necessary before moving her to the stretcher to ensure the safety of herself and all emergency services staff*'.

52. The *Victoria Police Manual | Operational Safety Equipment* states that '*Members are expected to protect themselves and the public while fulfilling their duties. To do this effectively, they may need to use force. The use of force, including the use of OSE, must be in accordance with specific legal requirements'*. Specifically with respect to Handcuffs the VPM states '*Any person arrested or taken into custody should be handcuffed if it is reasonably believed to be necessary in the circumstances*'. The VPM also requires that '*keep any person who is physically restrained under close observation. Take care to ensure the person is placed in and maintains a position that allows unrestricted breathing ... ... when using handcuffs prevent the possibility of positional asphyxia by ensuring subjects (i) do not have their face covered and (ii) are not left lying face down with their hands restrained behind their back*'.

53. The decision by LSC Wagner to apply handcuff restraints to Joelene was entirely reasonable and justifiable and in accordance with Victoria Police Policy and Procedure. At the time of her arrest Joelene was non-compliant, resisting Police, repeatedly kicking out and repeatedly headbutting the roadway surface. The decision to handcuff Joelene was reasonable and justifiable both for her own safety as well as for the safety of the attending Police Officers, Ambulance Paramedics and the general public. I note that LSC Wagner minimised the possibility of positional asphyxia by placing Joelene on her side in the left lateral position.

54. Finally I note the comments of Forensic Pathologist Dr Victoria Francis following the autopsy that '*Other potential mechanisms of her cardiac arrest are a concussive head injury when she hit her head against the ground or the possibility that restraint contributed to her collapse. These two factors are considered unlikely to have had any significant contribution to these events*'.

**Assessment of the Medical Treatment Rendered**

55. I referred this matter to the Coroners Prevention Unit for an advising in respect of the management of Joelene by Victoria Police and Ambulance Victoria.

56. The Coroners Prevention Unit advised that '*The management by police and paramedics at the scene to which they were called was reasonable. They attempted to prevent further injury (Ms Dowden was banging her head on the concrete) by placing a pillow under her head. She was handcuffed but not physically restrained in any other way. She was lying in the left lateral position, the position most likely to prevent aspiration if vomiting occurred. Resuscitative efforts were immediate and maximal. Management in the MMC ED and ICU was reasonable. Dr Francis, Forensic Pathologist, identified possible alcoholic ketoacidosis at autopsy as a possible cause of Ms Dowden's condition prior to her collapse. The biochemical abnormalities associated with this condition were adequately managed in ICU. The care provided by emergency services and MMC were reasonable and there were no opportunities for prevention identified*'.

**FINDINGS AND CONCLUSION**

57. Having investigated the death of Ms Joelene Therese Dowden and having held an Inquest in relation to her death on 1 May 2020, at Melbourne, I make the following findings and conclusions, pursuant to section 67(1) of the *Coroners Act 2008*:

(a) that the identity of the deceased was Ms Joelene Therese Dowden, born 27 February 1980; and

(b) that Ms Joelene Therese Dowden died on 12 July 2017, at the Alfred Hospital, from 1(a) HYPOXIC ISCHAEMIC BRAIN INJURY COMPLICATING ASPIRATION OF GASTRIC CONTENTS, in the circumstances set out above; and

(c) the decision by LSC Wagner to arrest Joelene pursuant to s.351 *Mental Health Act* was entirely reasonable and justifiable to prevent serious and imminent harm to herself; and

(d) the decision to handcuff Joelene was reasonably necessary in the circumstances AND LSC Wagner minimised the possibility of positional asphyxia arising by placing Joelene on her side in the left lateral position; and

(e) that the care and management of Joelene by Victoria Police, Ambulance Victoria and the Alfred Hospital was reasonable and appropriate in the circumstances.

58. I convey my sincerest sympathy to Joelene's family and friends. I acknowledge the grief and devastation that you have endured as a result of your loss.

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

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

    a. The family of Joelene Dowden;

    b. Coroner's Investigator, D/S/Sgt Stephen Sheahan, Victoria Police;

    c. Professional Standards Command, D/Sgt Dean Richards, Victoria Police;

    d. Ambulance Victoria;

Signature:

**JOHN CAIN**

**STATE CORONER**

Date: 1 May 2020