IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2019 3231

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 63(1)

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

INQUEST INTO THE DEATH OF DANIEL CHARLES RICHARDS

Findings of:	State Coroner, Judge John Cain
Delivered On:	6 December 2021
Delivered At:	65 Kavanagh Street Southbank, Victoria, 3006
Hearing Dates:	9 March 2021 to 12 March 2021; 22 March 2021 to 23 March 2021
Counsel Assisting the Coroner:	Ms Rachel Ellyard of counsel, instructed by Ms Ingrid Giles, Senior Legal Counsel
Representation:	Mr Gavin Silbert QC with Ms Stephanie Wallace and Mr Mitch Brogden, on behalf of the family of Daniel Richards, instructed by Mr Ali Besiroglu of Robinson Gill Lawyers Ms Roslyn Kaye, on behalf of Eastern Health, instructed by Ms Christina David of Lander & Rogers Ms Erin Gardner, on behalf of the Chief Commissioner of Police, instructed by Mr Dale McQualter of Maddocks Ms Naomi Hodgson, on behalf of Ambulance Victoria, instructed by Mr Jon Minter of K & L Gates

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SUMMARY[1]

1. Mr Daniel Charles Richards (**Danny**, as his family wish him to be known) was 48 years of age when he suffered a cardiac arrest and died at his home in Glen Waverley whilst in the custody of Victoria Police (**police**) who had attended his home to assist in the making and execution of an Assessment Order under the *Mental Health Act 2014* (Vic).

CORONIAL INVESTIGATION

Jurisdiction

2. Danny's death constituted a *'reportable death'* pursuant to section 4 of the *Coroners Act 2008* (Vic) (**Coroners Act** or **the Act**), as his death occurred in Victoria and was unexpected, unnatural, or violent and occurred while in police custody.

Purpose of the Coronial Jurisdiction

3. The jurisdiction of the Coroners Court of Victoria (**Coroners Court**) is inquisitorial.[2] The purpose of a coronial investigation is to independently investigate a reportable death to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which the death occurred.

4. The cause of death refers to the medical cause of death, incorporating where possible, the mode or mechanism of death.

5. The circumstances in which the death occurred refers to the context or background and surrounding circumstances of the death. It is confined to those circumstances that are sufficiently proximate and causally relevant to the death.

6. The broader purpose of coronial investigations is to contribute to a reduction in the number of preventable deaths, both through the observations made in the investigation findings and by the making of recommendations by coroners. This is generally referred to as the prevention role.

[1] This section is a summary of facts that were uncontentious and provides a context for those circumstances that were contentious, and that will be discussed in some detail below.
[2] *Coroners Act 2008* (Vic), s 89(4).

7. Coroners are empowered to:

   (a) report to the Attorney-General on a death;

   (b) comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice; and

   (c) make recommendations to any Minister or public statutory authority or entity on any matter connected with the death, including public health or safety or the administration of justice.

   These powers are the vehicles by which the prevention role may be advanced.

8. The power to comment, arises as a consequence of the obligation to make findings. It is not free ranging. It must be a comment '*on any matter connected with the death*'. The powers to comment and make recommendations are inextricably connected with, rather than independent of, the power to enquire into a death or for the purpose of making findings. They are not separate or distinct sources of power enabling a coroner to enquire for the sole or dominant reason of making comment or recommendation.[3]

9. It is not the role of the coroner to lay or apportion blame, but to establish the facts.[4] It is important to stress that coroners are unable to determine civil or criminal liability arising from the investigation of a reportable death and are specifically prohibited from including in a finding or comment or any statement that a person is, or may be, guilty of an offence.[5] However, as noted by Counsel Assisting at the Inquest into Danny's death, '*saying that something was missed or that a different decision might or could have been made or that a different approach was available is not the same as attributing blame or responsibilities. Those findings and comments are made for the purposes of preventing similar deaths in the future*'.[6]

10. Whilst it is sometimes necessary to examine whether a person's conduct falls short of acceptable or normal standards, or was in breach of a recognised duty, this is only to ascertain whether it was a causal factor or mere background circumstance. That is, an

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[3] *Harmsworth v The State Coroner* [1989] VR 989 at 996.
[4] *Keown v Khan* (1999) 1 VR 69.
[5] *Coroners Act 2008* (Vic), s 69(1). However, a coroner may include a statement relating to a notification to the Director of Public Prosecutions if they believe an indictable offence may have been committed in connection with the death. *See* sections 69(2) and 49(1) of the Act.
[6] Opening of Counsel Assisting, Inquest Transcript, p. 10.

act or omission will not usually be regarded as contributing to death unless it involves a departure from reasonable standards of behaviour or a recognised duty. If that were not the case many perfectly innocuous preceding acts or omissions would be considered causative, even though on a common-sense basis they have not contributed to death.

11. When assessing the actions of a professional person, regard must be had to the prevailing standards of his or her profession or specialty. For example, it would be unfair and unreasonable to expect a nurse to have the same skills and knowledge as an emergency-medicine physician.

12. It is also important to recognise the benefit of hindsight and to discount its influence on the determination of whether a person has acted appropriately. This is particularly important in this case because there might otherwise have been a temptation to impermissibly reason that because Danny died, the operation was necessarily flawed. I am conscious of the need to judge the actions of all involved free from the taint of hindsight bias, having regard to the information then known to them at the relevant time.

Standard of Proof

13. All coronial findings must be made based on proof of relevant facts on the balance of probabilities.[7] The strength of evidence necessary to prove relevant facts varies according to the nature of the facts and the circumstances in which they are sought to be proved.[8]

14. In determining these matters, I am guided by the principles enunciated in *Briginshaw v Briginshaw*.[9] The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals or entities, unless the evidence provides a comfortable level of satisfaction that they caused or contributed to the death.

15. Proof of facts underpinning a finding that would, or may, have an extremely deleterious effect on a party's character, reputation or employment prospects demand a weight of

[7] *Re State Coroner; ex parte Minister for Health* (2009) 261 ALR 152.
[8] *Qantas Airways Limited v Gama* (2008) 167 FCR 537 at [139] per Branson J (noting that His Honour was referring to the correct approach to the standard of proof in a civil proceeding in the Federal Court with reference to section 140 of the *Evidence Act 1995* (Cth); *Neat Holdings Pty Ltd v Karajan Holdings Pty Ltd* (1992) 67 ALJR 170 at 170-171 per Mason CJ, Brennan, Deane and Gaudron JJ.
[9] (1938) 60 CLR 336.

evidence commensurate with the gravity of the facts sought to be proved.[10] Facts should not be considered to have been proven on the balance of probabilities by inexact proofs, indefinite testimony, or indirect inferences. Rather, conclusions as to the evidence should be drawn from clear, cogent, or strict proof.[11]

Coronial Inquest

16. Section 52(2)(b) of the Coroners Act provides that a coroner must hold an inquest into a death if the death or cause of death occurred in Victoria and the deceased was, immediately before death, a person placed in custody or care.

17. Danny's death was reported to the Coroners Court on 24 June 2019. Professor Noel Woodford, Forensic Pathologist from the Victorian Institute of Forensic Medicine (**VIFM**) attended the scene of death in the early hours of the 25 June 2019. The Duty Coroner on 25 June 2019 made the direction for an immediate autopsy, which was performed that same day. I took carriage of the coronial investigation in December 2019. Detective Sergeant Solon Solomon was appointed coroner's investigator and compiled the coronial brief which underwent eight iterations.

18. The inquest proceeded on 9 March 2021 to 12 March 2021 and 22 March 2021 to 23 March 2021, six days in total. Ms Rachel Ellyard was appointed as Counsel Assisting the Coroner, and the Richards Family, Victoria Police, Ambulance Victoria, and Eastern Health were all represented. The inquest proceeded with minimal COVID-19 restrictions in place with interested parties physically attending court and some witnesses giving evidence remotely via WebEx.

Scope of Inquest

19. Although the coronial jurisdiction is inquisitorial rather than adversarial,[12] it should operate in a fair and efficient manner.[13] When exercising a function under the Act, coroners are to have regard, as far as possible in the circumstances, to the notion that

[10] *Anderson v Blashki* [1993] 2 VR 89, following *Briginshaw v Briginshaw* (1938) 60 CLR 336.
[11] *Briginshaw v Briginshaw* (1938) 60 CLR 336 at pp 362-3 per Dixon J: '*The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding, are considerations which must affect the answer to the question whether the issues had been proved to the reasonable satisfaction of the tribunal. In such matters "reasonable satisfaction" should not be produced by inexact proofs, indefinite testimony, or indirect inferences…*'.
[12] Second Reading Speech, *Legislative Assembly: 9 October 2008, Legislative Council: 13 November 2008*. *See also* ss 1(d) and 89(4) of the *Coroners Act 2008* (Vic).
[13] *Coroners Act 2008* (Vic), s 9.

unnecessarily lengthy or protracted coronial investigations may exacerbate the distress of family, friends and others affected by the death.[14]

20. In *Harmsworth v The State Coroner,*[15] Nathan J considered the extent of coroners' powers, noting they are not 'free ranging' and must be restricted to issues sufficiently connected with the death being investigated. His Honour observed that if not so constrained, an inquest could become wide, prolix, and indeterminate. His Honour stated the Act does *not* provide a general mechanism for an open-ended enquiry into the merits or otherwise of the performance of government agencies, private institutions, or individuals. Significantly, he added:

> *Such an inquest would never end, but worse it could never arrive at the coherent, let alone concise, findings required by the Act, which are the causes of death, etc. Such an inquest could certainly provide material for much comment. Such discursive investigations are not envisaged nor empowered by the Act. They are not within jurisdictional power.*[16]

21. In *Lucas-Smith v Coroners Court of the Australian Capital Territory*[17] the limits to the scope of a coroner's inquiry and the issues that may be considered at an inquest were also considered. As there is no rule that can be applied to clearly delineate those limits, 'common sense' should be applied. In this case, Chief Justice Higgins noted that:

> *It may be difficult in some instances to draw a line between relevant evidence and that which is too remote from the proper scope of the inquiry ...[i]t may also be necessary for a Coroner to receive evidence in order to determine if it is relevant to or falls in or out of the proper scope of the inquiry.*

22. Referring to *R v Doogan (No. 2),*[18] Chief Justice Higgins also provided a helpful example of the limits of a coroner's inquiry, suggesting that factual questions related to cause[19] will generally be within the scope of the inquest.

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[14] *Coroners Act 2008* (Vic), s 8(b).
[15] (1989) VR 989.
[16] Ibid, referring to the *Coroners Act 1985* (Vic), as then applied.
[17] [2009] ACTSC 40.
[18] [2005] ACTSC 74 (8 August 2005).
[19] I note that in that matter, Chief Justice Higgins was referring to the cause of a fire, however, I consider this analogous to the cause of death.

23. Ultimately, however, the scope of each investigation must be decided on its facts and the authorities make it clear that there is no prescriptive standard that is universally applicable, beyond the general principles discussed above.[20]

24. The scope of the inquest was settled at a Directions Hearing held on 17 July 2020 and was expressed as follows:

> *1. Danny's state of mental health in the period leading to 24 June 2019 and on 24 June 2019.*
>
> *2. The family's request for assistance mental health services on 24 June 2019 and the information available to attending clinicians and other responders regarding*
>
> *2.1. Danny's mental and physical health; and*
> *2.2. Danny's likely response to attempts to assess and transport him to hospital.*
>
> *3. Planning by clinicians, police and paramedics for contact with Danny including*
>
> *3.1. risk assessments;*
> *3.2. the approach to be made to Danny;*
> *3.3. who was in control of the operation; and*
> *3.4. the respective roles to be played by clinicians, police, and paramedics.*
>
> *4. What happened inside the house on 24 June 2019?*
> *4.1. How was the approach to Danny made?*
> *4.2. How did Danny present?*
> *4.3. The decisions and actions of mental health clinicians in response to Danny.*
> *4.4. What was the sequence and duration of events up to and including Danny's being observed to be struggling to breathe;*
> *4.5. Decisions and actions of attending police regarding -*
> *(a) their role in managing Danny's behaviour during assessment; and*
> *(b) the use of force, including grappling, handcuffs and OC spray;*
> *4.6. Who was -*
> *(a) responsible for monitoring Danny's welfare during the interaction; and*
> *(b) in fact monitoring Danny's welfare during the struggle between him and police?*
>
> *4.7. Could the interaction between Danny, clinicians and police have been managed differently, having regard to relevant training, policies and practices?*

[20] *See* Ruling No. 2 in the 'Bourke Street' *Inquest into the deaths of Matthew Poh Chuan Si, Thalia Hakin, Yosuke Kanno, Jess Mudie, Zachary Matthew Bryant and Bhavita Patel* (COR 2017 0325 and Ors), Coroner Hawkins, 23 August 2019, para. 55.

Witnesses

25. The following witnesses were called to give *viva voce* evidence at Inquest:

    (a) Eileen Richards, Danny's mother

    (b) Vince Smethurst, Danny's friend

    (c) David Wright, a friend of the Family

    (d) Professor Noel Woodford, Forensic Pathologist, VIFM

    (e) Associate Professor Louis Irving, Director of Respiratory and Sleep Medicine at the Royal Melbourne Hospital

    (f) Gareth Jones, Crisis Assessment and Treatment Team, Eastern Health

    (g) Wayne Conron, Crisis Assessment and Treatment Team, Eastern Health

    (h) Catherine Wentworth, Paramedic, Ambulance Victoria

    (i) Vanessa Cross, Paramedic, Ambulance Victoria

    (j) Constable James Earle, Victoria Police[21]

    (k) Senior Constable Andrew Wooldridge, Victoria Police

    (l) Acting Sergeant Emma Rosevear, Victoria Police

    (m) Constable Ayla Gray, Victoria Police

    (n) Acting Sergeant Mark Carbone, Victoria Police

    (o) Senior Sergeant Matthew Hargreaves, Victoria Police

    (p) Dr Andrew Cheong, Eastern Health

26. As part of my investigation, I asked the Coroners Prevention Unit (**CPU**) to establish a panel of mental health experts to provide their perspectives on the prevention and

[21] I have referred to police members by their rank at the time of Danny's death, as of 24 June 2019, and as recorded in their statements.

management of behavioural concerns associated with psychiatric illness. The Clinical and Lived Experience Expert Panel (**Panel**) included Alfred Health Consultant Psychiatrist Associate Professor Ilan Rauchberger, Monash Health Community Services Manager and past PACER Clinician, Registered Nurse Mr Jeremy Sheppard, and Lived Experience Expert Ms Julie Anderson. The Panel provided written reports and gave evidence concurrently at the inquest.

Sources of Evidence

27. This Finding draws on the totality of the material produced for the purposes of the coronial investigation into Danny's death. That is, the court records maintained during the coronial investigation, the Coronial Brief and further material sought and obtained by the Court, the evidence adduced during the inquest and written submissions provided by Counsel Assisting and Counsel representing the Interested Parties.[22]

28. In writing this Finding, I do not purport to summarise all of the evidence but refer to it only in such detail as appears warranted by its forensic significance and the interests of narrative clarity. The absence of reference to any particular aspect of the evidence does not imply that it has not been considered.

BACKGROUND

Personal History

29. Danny completed secondary education to Year 12 and then completed a qualification in agriculture at Burnley College of Horticulture.

30. The Richards family owned and operated a business, Sports and Vintage Motoring, and Danny worked in that business initially part time whilst he was studying and then on a fulltime basis with his father. The business closed when his father died in 2000. Danny

[22] I am cognisant that further CCTV footage was provided to the Court after the formal close of evidence. I indicated to Interested Parties via my solicitor on 17 August 2021 that this CCTV footage was to be formally included in the coronial brief, along with the four statements referring to this footage, namely:

a. Statement of Detective Sergeant Sol Solomon dated 19 July 2021;
b. Statement of Robert Richards, dated 8 July 2021;
c. Statement of Gareth Jones, dated 13 August 2021; and
d. Statement of Wayne Conron, dated 16 August 2021.

then worked at Christie's auction house with his brother Robert Richards (**Robert**). Danny also worked as a security officer for a few years.[23]

31. Danny was very close to his father and his father's death in 2000 hit him very hard.[24]

32. Danny was a social person had a lot of friends and was popular. He liked to catch up with family and friends for coffee or a drink. Though was described as somewhat of a private and shy person, he really enjoyed company and was easy-going.[25] Robert described him as a gentle soul, extremely generous supportive and someone who always made himself available to help anyone who needed it.[26]

33. In approximately 2011, Danny's mental health began to decline. He started to exhibit paranoid and delusional ideation and became concerned with thoughts of being monitored by law enforcement and military agencies including the FBI. In 2015, his mental health had deteriorated to a level where a Crisis Assessment and Treatment (**CAT**) team was called to his home to make a mental health assessment. Danny was admitted to a mental health unit at Upton House at Box Hill Hospital as an involuntary patient where he remained for a period of approximately six weeks.[27]

34. In the months prior to his death, Danny's family and friends became increasingly concerned about his mental health.[28] Robert contacted Eastern Health telephone triage service on the 14 November 2018 raising concerns about Danny's erratic and concerning behaviour.[29] This contact did not result in any action being taken, with the plan being for the Family to contact '000' if required, and to re-contact the telephone triage service if needed. Facilitating help for Danny was complicated by the fact that he had no mobile phone and his whereabouts were at times unknown.[30]

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[23] Statement of Eileen Richards, Coronial Brief (**CB**) p. 390; Statement of Robert Richards, CB, pp. 378-9.
[24] Statement of Eileen Richards, CB, p. 389; Statement of Robert Richards, CB, p. 379; Statement of David Wright, CB, p. 196.
[25] Statement of Robert Richards, CB, p. 379; Statement of Eileen Richards, CB, p. 390; Statement of Vincent Smethurst, CB, p. 396.
[26] Reflections of the Richards Family, signed by Robert Richards, dated 30 March 2021.
[27] Statement of Robert Richards, CB, pp. 379-380; Statement of Eileen Richards, CB, p. 391; Statement of Vincent Smethurst, CB, p. 398; Statement of David Wright, CB, pp. 197-8. Eileen Richards also indicates that Danny was admitted as a voluntary patient to Upton House in 2011 (CB, p. 391, Inquest Transcript p. 36 and pp. 120-121).
[28] Statement of Eileen Richards, CB, p. 392; Statement of Vince Smethurst, CB, p. 398; Evidence of Vincent Smethurst, Inquest Transcript, p. 69.
[29] Screening Register Detail, CB, p.1404.
[30] Evidence of Eileen Richards, Inquest Transcript, p. 33.

35. In late December 2018, Mrs Richards was concerned that Danny was not complying with treatment plans and was concerned about his ongoing welfare. Mrs Richards and long-time family friend David Wright sought advice from police about how they could access support for Danny. A welfare check was instigated by police on Danny at the place where he was then living in Kooyong. The assessment made by police when they spoke to Danny on the 21st December 2018 was that he did not exhibit any apparent mental health issues and there were no apparent issues of concern from a welfare perspective, and Mrs Richards and Mr Wright were informed that there were insufficient grounds for police at that stage to take any action in relation to Danny's mental health.[31]

Danny's medical history

36. Danny did not attend doctors regularly. His paranoia and delusional behaviour made him uncomfortable engaging with doctors.[32]

37. Danny was admitted to Upton House Box Hill Hospital as an involuntary patient after an Assessment Order was made in 2015. He spent six weeks as an inpatient and was released on his undertaking to continue treatment and continue taking his medication. It appears that he did not follow his treatment plan which lead to a deterioration in his health.[33]

38. Dr Faro Hace (**Dr Hace**) of the Ballan Clinic had seen Danny in December 2018 in relation to recent testicular pain. Dr Hace referred Danny to a urologist David Cook. On 8 January 2019, Danny attended upon Dr Gailna Shvetsova for the same reason, and a further referral was made to urologist Peter Royce.[34]

39. Dr Zahin Ilahee (**Dr Ilahee**) provided a report dated the 16 September 2019 confirming that Danny had attended him for treatment on two occasions, the first occasion for urinary frequency and on the second occasion cholesterol and preventative health issues were discussed. Dr Ilahee did observe that on the first visit Danny did exhibit some paranoid ideation and concluded that it was likely that he likely suffered from

[31] Statement of Acting Sergeant Steve Popov, CB, pp. 159-160; Statement of SC Ben Sheldrake, CB, pp. 161-162; Statement of David Wright, CB, pp. 198-99; Statement of Eileen Richards, CB, p. 392; Statement of Robert Richards, CB, p. 381.
[32] Screening register detail, CB, p. 1287; Evidence of Vincent Smethurst, Inquest Transcript, p. 70.
[33] Statement of David Wright, CB, pp. 197-8; Evidence of David Wright, Inquest Transcript, p. 117.
[34] Statement of Dr Galina Shvetsova, CB, p. 193.

schizophrenia, though indicated that making this diagnosis was difficult due to the fact he had only seen Danny on two occasions. Following the second consultation Dr Ilahee stated that he wanted to follow Danny up regarding his blood pressure and cholesterol with a view to also keeping an eye on his mental health and allow him to open up further. Other than a letter that Danny sent to Vermont Health Care, Danny did not have any further contact with Dr Ilahee.[35]

IDENTITY OF DECEASED PURSUANT TO SECTION 67(1)(a) OF THE ACT

40. On 27 June 2019, Daniel Charles Richards, born 25 September 1970, was identified via fingerprint analysis.[36]

41. Identity is not in dispute and requires no further investigation.

MEDICAL CAUSE OF DEATH PURSUANT TO SECTION 67(1)(a) OF THE ACT

Autopsy Report

42. Professor Woodford, Forensic Pathologist and Director of VIFM, performed an autopsy on the body of Daniel Charles Richards and provided a written report of his findings dated 30 October 2019. Professor Woodford concluded that the medical cause of death was:

> *1(a) Ischaemic heart disease complicating restraint of an acutely agitated male.*

43. Professor Woodford provided the following comments:

> 1. *The cause of death in this 48 year old male most probably relates to significant cardiovascular disease complicating the physical and chemical restraint of an acutely agitated male.*
>
> 2. *External examination of the body showed bruising and abrasion over the chest in keeping with chest compressions performed during attempted resuscitation, linear marks around the wrists with features suggesting the placement of handcuffs, and relatively minor areas of blunt force injury (bruising and abrasion) in areas including the left forehead, the right side of the head anteriorly, and on the limbs. Two petechiae were present in the right eye but no generalised petechial haemorrhages were identified. Examination with ultraviolet light showed areas of*

[35] Statement of Dr Zahin Ilahee, CB, p. 191.
[36] Deceased (Fingerprint) Identification Report, CB, p. 302.

fluorescence over the lower half the face in keeping with the application of capsicum spray. Internally, there was some minor haemorrhage over the thyroid prominence but no strap muscle bruising. The laryngeal skeleton was intact. Oedema fluid and vomitus was present in the airways.

3. *The heart was enlarged and showed evidence of biventricular dilatation. There was left ventricular hypertrophy (thickening of the wall of the main pumping chamber) and areas of fibrosis (scarring) indicative of previous myocardial infarction (old heart attacks). The coronary arteries showed focally severe atheromatous narrowing and focal intraplaque haemorrhage. Cardiac enlargement, myocardial fibrosis, and coronary artery narrowing. Cardiac enlargement, myocardial fibrosis, and coronary artery narrowing can all predispose to the relatively sudden onset of cardiac rhythm disturbance and arrest (heart attack). Physiological stressors such as strenuous resistance or struggling against restraint (with significantly elevated raised pulse and blood pressure) can place an excessive demand on a diseased and vulnerable cardiovascular system.*

4. *Toxicological examination showed the presence of ethanol (alcohol) in the blood at a concentration of 0.05g/100mL. No other commonly encountered drugs or toxins were identified.*

5. *Evidence from the scene and temperature determinations indicate that deceased was not suffering from the syndrome of excited delirium at the time of his arrest and death […].*[37]

Associate Professor Louis Irving's Expert Opinion

44. Associate Professor Louis Irving was engaged by the Richards family and provided an expert report dated 4 December 2020. In preparing this report, Associate Professor noted that he reviewed version 5 of the Inquest Brief (excluding the summary at pages 2 to 8), Proposed Scope, DHHS-Victoria Police protocol for mental health and certain audio files. Associate Professor states that his report is based on his 'knowledge and experience, quoted literature, and advice about coronary artery disease from cardiological colleagues at RMH'.[38] He gave evidence at the inquest concurrently with Professor Woodford.

45. Associate Professor Irving concluded that Danny likely died because of an arrhythmia and subsequent cardiac arrest in the setting of pre-existing heart disease and strenuous exertion whilst being restrained. He stated that:

[37] Medical Examination Report of Professor Woodford, CB, pp. 360-361.
[38] Expert Report of Associate Professor Irving, CB, p. 1006.

> *it is quite likely that his agitated state, the extreme exertion to resist restraint, and possibly effects of the OC spray caused two of the atheromatous plaques to become unstable and further obstruct his coronary arteries. Although there was significant pre-existing heart disease, he had not complained of cardiac symptoms previously and his activities of daily living were not impaired. Therefore, the strenuous exertion whilst being restrained, and possibly other factors related to the restraint are important. It is also clear that the reason that he so vigorously resisted restraint by Police Officers was that he had a pathological terror of being restrained by police. It is notable that he continued to resist restraint even though he would have been at least as exhausted and as breathless as the Police Officers, and even though the restraint and his resistance to it was inflicting soft tissue injuries. This on-going resistance to restraint is likely explained by his absolute terror of being restrained, and was probably, given his psychosis, involuntary*.[39]

46. When questioned about the possibility of positional asphyxia, Associate Professor Irving in his evidence stated that he did not find any evidence of asphyxiation, that is complete lack of ventilation, because this was blocked or because breathing was stopped. He states that '*in trying to restrain someone who is exercising at the level that he appeared to be exercising at any form of a restraint would have reduced breathing capacity*'.[40]

Conclusion in relation to cause of death

47. Professor Woodford in his evidence summarised the various contributing factors:

> *And it's really important to realise I think that there's a lot of complicated things going on at the one time and we're trying to, as you say, unpack some of those. But since he didn't die attached to monitoring equipment, we don't really know what was the major operative factor. So, it's possibly a degree of low blood oxygen, it's possibly a degree of impaired movement of his respiration, it's possibly, you know, the fact that at that critical time and with the pre-existing narrowing of his coronary arteries that his heart really needed oxygen at a time it couldn't get it, and that was what[caused] this fatal arrhythmia in the end, which I think we both believe is the ultimate mechanism of death.*[41]

48. While there were some nuances to their respective conclusions in relation to Danny's cause of death, I do not consider that there is significant disagreement between Associate Professor Irving and Professor Woodford as to the medical cause of death and I accept the cause of death proposed by Professor Woodford, namely '*1(a)*

[39] Expert Report of Associate Professor Irving, CB, p. 1008.
[40] Evidence of Associate Professor Irving, Inquest Transcript, p. 100.
[41] Evidence of Professor Woodford, Inquest Transcript, p. 101.

Ischaemic heart disease complicating restraint of an acutely agitated male'. I will now proceed to detail the circumstances in which Danny died.

CIRCUMSTANCES OF DEATH PURSUANT TO SECTION 67(1)(a) OF THE ACT

Events of 24 June 2019

49. On 24 June 2019, Vincent Smethurst (**Mr Smethurst**), a friend of the Richards family, made a telephone call to the Eastern Health Telephone Triage Service and spoke to a staff member, 'Olga', in relation to what he considered was Danny's deteriorating mental health condition. The call was made at 2:27 pm on the 24 June 2019 according to the telephone triage service records.[42]

50. Mr Smethurst had not informed Mrs Richards that he was going to make the call, but he was aware that the Mrs Richards and Robert were seeking assistance and support for Danny and that past attempts to engage any mental health services had been unsuccessful.[43]

51. Mr Smethurst gave a history of Danny's condition to Olga as he wanted to ensure that the level of concern that the family had for Danny's wellbeing was understood. The notes of the conversation with Mr Smethurst record that he was concerned that Danny's condition was deteriorating and that there was an increase in level of conviction of his delusional beliefs placing his family and potentially himself at risk. Danny had a belief that he was an undercover spy working for the Navy and Air Force special forces and was of the belief that the police were aware of this and making efforts to try and stop him and eliminate him. It was noted that Danny had a strong fixation in relation to police, and that if he saw police cars or cars that he thought were undercover police vehicles, he would look inside the cars and 'stalk the person in the car'. In his evidence, Mr Smethurst, having reviewed the notes held by Eastern Health, confirmed that they constitute an accurate summary of what he had told Olga.[44]

52. Olga advised Mr Smethurst that from the records held by the service she could see that Mrs Richards had been the contact person on previous occasions (specifically the 2015 admission to Upton House) and that she should be the contact person again, which

[42] Screening Register Detail, CB, p. 1286.
[43] Statement of Vincent Smethurst, CB, p. 398.
[44] Screening Register Detail, CB, pp. 1286-7; Evidence of Vincent Smethurst, Inquest Transcript, pp. 43-44.

would also assist in maintaining the relationship of trust between Danny and Mr Smethurst as friends. Olga recorded a plan that Mr Smethurst would arrange to speak with Mrs Richards to identify her as referrer and then arrange for her to ring triage for further information.[45]

53. Following this conversation with Olga, Mr Smethurst attempted to contact Mrs Richards to advise her that he had contacted Eastern Health telephone triage service and that they were willing to assist. He was unable to immediately make contact with Mrs Richards but did speak with Robert and updated him on his contact with the Eastern Health telephone triage service and that he needed to speak to Mrs Richards.[46]

54. Robert contacted his mother and arranged for Mr Smethurst to meet Mrs Richards at her home at approximately 5 pm on the 24 June 2019. When they met Mr Smethurst was not able to speak with her about his contact with Eastern Health telephone triage service as Danny was present. He did however pass her a handwritten note. The content of the note was:

> - *Call 1300721927 (CATT Team Triage).*
>
> *Then press 3 on your phone number pad*
>
> *- You can speak with anyone. But if Alga [sic] is available ask to talk to her.*
>
> **They may ask some questions but main reason is they want to know if its OK that you are the REFERRER on there system as I've organised for the CATT Team to come to assess Danny. (in other words you called them worried about Danny).*
>
> *- I'm nothing to do with it, but will be around.*[47]

55. Mrs Richards spoke to a staff member from the telephone triage team at 6:26pm, a 'Ms H Child RPN' and in that discussion provided additional information about Danny's condition. Mrs Richards advised that the house was now full of new electronic equipment for monitoring and security, and that Danny got very agitated with her if she did not follow all his rules related to house security. It was noted that Danny's issues

[45] Screening Register Detail, CB, p. 1286-7; Evidence of Vincent Smethurst, Inquest Transcript, pp. 43-44; Statement of Vincent Smethurst, CB, p. 399.
[46] Statement of Vincent Smethurst, CB, p. 399.
[47] Note from Vincent Smethurst, CB, p. 409.

were chronic but had deteriorated of late and he was more agitated and paranoid. The notes recorded that Mrs Richards reported feeling fearful of Danny, not because he would be physically aggressive but because she felt like a prisoner in her own home. It was also noted that Danny had never been violent but could be verbally abusive.[48]

56. On the basis of the information received from Mr Smethurst and Mrs Richards, Ms Child referred the matter to the CAT Team and telephoned CAT team member Gareth Jones (**Mr Jones**) at 6:36pm to make the referral.[49]

57. Mrs Richards and Mr Smethurst agreed to meet to discuss this further. Mrs Richards was then contacted by Wayne Conron (**Mr Conron**) from CAT team at 6:44 pm and he advised her that he and a colleague (Mr Jones) were on their way to assess Danny at her home. This surprised Mrs Richards as she was expecting that the contact would be the following day.[50]

Arrival of CAT Team

58. At 7:20pm CAT team clinicians, Mr Conron and Mr Jones, arrived at the house but could not gain access as the front gates were locked. Mr Conron called Mrs Richards to obtain the landline telephone number for the house so he could call Danny. The purpose of the call was to determine if Danny would co-operate with the CAT team in conducting the assessment. Mr Conron also advised Mrs Richards that police may be required to assist in the attempt to conduct the assessment.[51]

59. Mr Jones called the house identified himself as CAT team clinician and that he would like to assess him as people were concerned about his welfare.[52] The call was terminated, presumably by Danny as he was the only occupant of the house at the time. A second call was made but the phone was not answered.

60. When Mrs Richards arrived home shortly after 7:30 pm, Danny told her that he had received a strange telephone call. Mrs Richards advised him that she was worried about

[48] Screening Register Detail, CB, p. 1287.
[49] Screening Register Detail, CB, p. 1287; Statement of Wayne Conron, CB, p. 204.
[50] Evidence of Eileen Richards, Inquest Transcript, p. 16; Statement of Eileen Richards, CB, p. 392.
[51] Statement of Wayne Conron, CB, p. 204.
[52] Statement of Wayne Conron, CB, p. 205; Statement of Gareth Jones, CB, p. 209; Evidence of Wayne Conron, Inquest Transcript, p. 224.

him and that she had contacted the CAT team. Danny become quite upset and agitated.[53]

61. At 7:35 pm Mr Conron, having been unable to gain Danny's agreement to be assessed, called triple zero to arrange for police and Ambulance Victoria (**ambulance**) to attend. The police were to assist with entry to the house and the ambulance was for the purposes of transporting Danny to hospital for assessment if required.[54] Whilst waiting for police to arrive Mr Conron and Mr Jones remained in their vehicle. Mr Smethurst made himself known to them and he was invited to join them in their car where they discussed Danny's mental health condition and were provided further information from Mr Smethurst about, *inter alia*, Danny's 'paranoia traits'.[55]

Police and Ambulance attendance

62. Acting Sergeant Carbone (**A/Sgt Carbone**) and his driver Constable Earle were dispatched to the scene and arrived at 8:13 pm and parked down the street with the waiting ambulance. A/Sgt Carbone spoke to the paramedics briefly and ascertained that they did not have any additional information in relation to Danny. A/Sgt Carbone and Constable Earle waited at that location until a second police unit arrived.[56]

63. At 8.15pm, police members Senior Constable Wooldridge (**SC Wooldridge**) and Constable Gray arrived at Madeline St, identified the CAT team members, and had a brief discussion with them. Mr Jones and Mr Conron advised that Danny wasn't violent, just paranoid and that his mother and friend were present at the house. They were also advised that the Mrs Richards had contacted the mental health triage service.[57]

64. A/Sgt Carbone and Constable Earle having been informed that SC Wooldridge and Constable Gray were in Madeline St with the CAT team members, drove to their location. Both police units had separately accessed IRIS/LEAP records to obtain

[53] Statement of Eileen Richards, CB p. 393; Evidence of Eileen Richards, Inquest Transcript, pp. 20-21.
[54] Statement of Wayne Conron, CB, p. 205; Statement of Gareth Jones, CB, p. 209.
[55] Statement of Wayne Conron, CB, p. 206; Statement of Gareth Jones, CB, p. 209; Evidence of Vincent Smethurst, Inquest Transcript, pp. 50-51; Statement of Vincent Smethurst, CB, pp. 400-401.
[56] Statement of A/Sergeant Carbone, CB, p. 44; Statement of Constable Earle, CB, pp. 69-70.
[57] Statement of SC Wooldridge, CB, pp. 59-60; Statement of Constable Gray, CB, p. 52.

information about Danny. The IRIS/LEAP records showed that Danny did not have any violent prior convictions but did indicate that Danny was concerned about police.[58]

65. The CAT team members Mr Jones and Mr Conron, and police members A/Sgt Carbone, SC Wooldridge and Constables Earle and Gray, all met for a briefing at approximately 8:30pm. A/Sgt Carbone was the senior member in charge from the police perspective and decided that SC Wooldridge would be the primary communicator along with the clinician Mr Jones and that he would observe from the rear and have OC foam should the need arise.[59] Situation and clinical information was provided by Mr Jones and Mr Conron to police.[60] This discussion included safety briefing to ensure risk was minimised and that everybody was on the same page and kept safe.[61]

66. A/Sgt Carbone understood that this was an operation led by the CAT team and that police were there as an assisting agency to ensure the safety of the CAT team members and, if necessary, facilitate the conversation so that the CAT team could conduct the assessment of Danny. It was A/Sgt Carbone's expectation that SC Wooldridge would take the lead in the discussion with Danny in terms of introductions and then allow Mr Jones to make his assessment. A/Sgt Carbone wanted to have SC Wooldridge's perspective on the scene as a senior officer.[62] The evidence of other police members differs on this point as both Constable Earle and Constable Gray both thought that Mr Jones would take the lead in engaging with Danny with police intervening if required.[63]

67. The briefing is described by A/Sgt Carbone as occurring outside the premises with the four police members and the two CAT team members in attendance. There is no direct evidence about the duration of the meeting although it is described by A/Sgt Carbone as a *'quick'* meeting.[64] Paramedics had also briefly conversed with police through their vehicle window upon arrival at 20:17, and a later conversation had also occurred

[58] Statement of A/Sergeant Carbone, CB, p. 44; Statement of Constable Gray, CB, p. 51; Statement of SC Wooldridge, CB, p. 59; Statement of Constable Earle, CB, p. 70.
[59] Statement of A/Sergeant Carbone, CB, p. 44; Statement of Constable Gray, CB, p. 52; Statement of SC Wooldridge, CB, p. 60; Statement of Constable Earle, CB, p. 70.
[60] Statement of Wayne Conron, CB, p. 205; Statement of Gareth Jones, CB, p. 210.
[61] Evidence of A/Sergeant Carbone, Inquest Transcript, pp. 437-438.
[62] Evidence of A/Sergeant Carbone, Inquest Transcript, pp. 437-438.
[63] Evidence of Constable Earle, Inquest Transcript, pp. 296-297; Evidence of Constable Gray, Inquest Transcript, p. 409.
[64] Evidence of A/Sergeant Carbone, Inquest Transcript, p. 437.

between ambulance staff and Wayne Conron of the CAT team shortly after police members and Gareth Jones entered the house.[65]

68. Some weeks after the conclusion of the hearing and after submissions had been filed, the representatives of the Family advised in their submissions in reply that there was additional CCTV footage of the scene (**Additional CCTV**), depicting the arrival of police at the scene and their entry with CAT team members to the house. This footage shows, from a different angle to the CCTV tendered during inquest, the various vehicles arriving at the scene and members walking to the front gate. It does not show police and CAT team members gathering for a meeting or discussion but rather shows them walking from their cars to the front gate and into the front yard area. From viewing the CCTV footage, it appears that the discussion or briefing referred to likely took place while they were walking to the front gate.[66]

69. While the Additional CCTV appears at first blush to depict that the safety briefing was somewhat cursory, the available evidence is that there were other discussions that occurred between various members, the CAT team and paramedics prior to their arrival at the front gate of [redacted] Madeline St Glen Waverley. A/Sgt Carbone, for example, gives evidence of an initial conversation with Wooldridge whilst in the vehicle followed by a discussion with members and the mental health team down the road at an intersection on Madeline Street.[67] The supplementary statements of Wayne Conron and Gareth Jones confirm that the Additional CCTV does not capture the briefing that occurred between the two CAT team members and police down the road near the corner of Madeline Street and Angus Drive.[68]

70. There is CCTV footage from [redacted] Madeline Street[69] of the four police members A/Sgt Carbone, SC Wooldridge, Constable Gray and Constable Earle together with CAT Team member Mr Jones entering the property. This CCTV footage shows the four police officers led by A/Sgt Carbone walking down the path with Mr Jones at the rear. CAT team member Mr Conron remained outside the property as it was considered that

[65] Statement of Catherine Wentworth, CB, p.171; Evidence of Catherine Wentworth, Inquest Transcript, pp. 250-251; Statement of Vanesa Cross, CB, p. 174; Evidence of Vanessa Cross, Inquest Transcript, pp. 274-275; Statement of Wayne Conron, CB, p. 205.
[66] CCTV footage from [redacted] Madeline Street.
[67] Statement of A/Sergeant Carbone, CB, p. 44; Evidence of A/Sergeant Carbone, Inquest Transcript, pp. 436-438.
[68] Statement of Gareth Jones, dated 13 August 2021; Statement of Wayne Conron, dated 16 August 2021.
[69] This was tendered at Inquest as Exhibit 7.

as he had been involved in the Assessment Order made in 2015 that Danny may respond badly to his presence.[70]

71. As they were walking down the path, the police officers and Mr Jones met Mr Smethurst who was walking towards the gate. They also met Mrs Richards as she was walking up the path towards the front gate. Police did not engage with or seek updated or additional information from either Mr Smethurst or Mrs Richards other than being informed that Danny was in the kitchen area of the house.[71]

72. Upon arrival at the front door Danny was observed through the kitchen window standing near the island bench. No attempt was made to engage with Danny from outside the house.[72] SC Wooldridge was the first person to enter the house and advised Danny that CAT team member Mr Jones wanted to speak with him. Danny moved into the kitchen area away from the entrance. He was followed by SC Wooldridge and Constable Earle. SC Wooldridge continued to try and encourage Danny to engage with Mr Jones. Danny did not engage. While SC Wooldridge and Mr Jones continued attempts to speak with Danny, he ignored them and picked up the phone that was attached to the wall in the kitchen and made a call.[73]

73. Mr Jones tried to speak with Danny but had difficulty engaging with him. Danny was speaking on the phone to emergency services reporting that he had police in his house but was concerned that they were not who they claimed to be.[74] In his evidence Mr Jones described his attempts to engage Danny and this included using a non-threatening approach, namely '*quite gentle tones […] using open ended questions, that kind of thing, non-threatening kind of stances in our demeanour*', and explaining his role and the process openly and honestly.[75] Having made attempts to engage with Danny without success Mr Jones proceeded to conduct the assessment and concluded that Danny should be served with an Assessment Order because he appeared acutely unwell, paranoid, was thought to be a potential danger to himself and would not submit to

[70] Evidence of Gareth Jones, Inquest Transcript, p. 156.
[71] Evidence of Vincent Smethurst, Inquest Transcript, p. 54.
[72] Evidence of A/Sergeant Carbone, Inquest Transcript, p. 446.
[73] Statement of SC Wooldridge, CB, p. 61; Statement of Gareth Jones, CB, p. 210; Evidence of Gareth Jones, Inquest Transcript, pp. 140-141; Evidence of Constable Gray, Inquest Transcript, p. 410.
[74] Statement of Gareth Jones, CB, p. 210.
[75] Evidence of Gareth Jones, Inquest Transcript, pp. 140-141 and pp. 169-171.

voluntary assessment. He then completed the required paperwork to give effect to the order.[76]

74. At about the same time that Mr Jones was completing the paperwork, a D24 dispatcher advised A/Sgt Carbone via the police radio that Danny was talking to a triple zero call taker.[77] Attempts were made by SC Wooldridge and A/Sgt Carbone to engage with Danny, but he would not engage and remained on the telephone call. SC Wooldridge gave evidence that he used an empathetic approach in attempting to communicate with Danny.[78] By that time Mr Jones had completed the paperwork and the order was made.

75. Constable Earle ended the phone call by pressing the button on the phone wall unit ending the call while Danny still had the handset in his hand and then police officers went to physically take hold of Danny.[79] The situation was described as dynamic and the way in which this transpired is not wholly clear on the evidence. Two police officers described their initial physical contact with Danny as being a response to a sudden movement from him or a perception that he was posing a heightened risk to another police officer.[80] The other two officers recalled that they placed hands on him after forming a view that negotiations had taken enough time and that it was necessary for action to be taken to give effect to the Assessment Order.[81] Mr Jones indicated that he did not see the commencement of police physically restraining Danny.[82]

76. Once police had taken hold of him, Danny resisted efforts to restrain him very strenuously and according to the evidence of all police he was very strong and resisted vigorously.[83] There was a struggle of approximately 4 to 6 minutes in the kitchen area of the house involving Danny and four police officers. Police eventually managed to get Danny onto the floor of the kitchen but continued to have difficulty getting the handcuffs on him. A/Sgt Carbone called for further assistance via his police radio as he was concerned that the police members were tiring and struggling to restrain Danny.

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[76] Statement of Gareth Jones, CB, p. 210; Evidence of Gareth Jones, Inquest Transcript, pp. 140-143 and pp. 169-172.
[77] Statement of A/Sergeant Carbone, CB, p. 45-46.
[78] Evidence of SC Wooldridge, Inquest Transcript, p. 357.
[79] Evidence of Constable Gray, Inquest Transcript, p. 410.
[80] Evidence of A/Sergeant Carbone, Inquest Transcript, p. 451; Statement of Constable Gray, CB, p. 53.
[81] Evidence of Constable Earle, Inquest Transcript, pp. 307-308; Evidence of SC Wooldridge, Inquest Transcript, p. 359.
[82] Evidence of Gareth Jones, Inquest Transcript, p. 144.
[83] Evidence of Constable Earle, Inquest Transcript, pp. 322-323; Evidence of A/Sgt Carbone, Inquest Transcript, p. 453; Evidence of Constable Gray, Inquest Transcript, pp. 404-405; Statement of SC Wooldridge, pp. 364.

77. During the struggle Acting Sergeant Carbone did remind police to be careful and mindful of the risk of positional asphyxia. He gave evidence that he did this as he wanted to be sure that police members were aware of the risk and were actively considering it.[84]

78. Attempts were made by all four police members to control Danny's movements, but it took some time for that to eventuate. A/Sgt Carbone deployed OC foam twice on Danny, without apparent effect. A warning was given to Danny by A/Sgt Carbone prior to releasing the OC foam. Eventually police abandoned attempts to handcuff him with his hands behind his back and instead used two sets of handcuffs to handcuff his hand to the front. He was eventually handcuffed on the floor of the kitchen.

79. Although Danny was handcuffed, he was still struggling, and paramedic assistance was sought to sedate Danny so he could be transported to hospital. While paramedics were in the process of preparing the sedation medication, and while he was still being held by police on the floor, SC Wooldridge advised that Danny was struggling to breathe. Police then observed that Danny had stopped resisting and was turning a shade of blue or purple. A/Sgt Carbone told Mr Jones to get paramedics urgently.[85] Police commenced CPR around the arrival time of paramedics.

80. Additional paramedics and the fire brigade arrived and assisted with the resuscitation efforts for about 50 minutes. Danny was moved from the small confines of the kitchen area to the lounge room to assist in allowing sufficient room for resuscitation efforts. However, Danny was unable to be revived and was pronounced deceased at 9:41pm.[86]

THE CORONIAL INQUEST

81. Particular aspects of the aforementioned events leading up to and including 24 June 2019 were explored at Inquest with the view of determining, *inter alia*, whether Danny's death was in any way preventable, whether the actions of attending police members, CAT team members and paramedics adhered to relevant policies and procedures, and whether there were any missed opportunities to engage Danny in a way that didn't entail the use of force. These and further issues were explored through the

[84] Statement of A/Sergeant Carbone, CB, p. 47; Evidence of A/Sergeant Carbone, Inquest Transcript, p. 472-473.
[85] Statement of A/Sergeant Carbone, CB, p. 49.
[86] Statement of Vanessa Cross, CB, p. 175; Statement of Catherine Wentworth, CB, p. 177-178; Ambulance Victoria Patient Care Records, CB, pp. 1109-1119.

questioning of the 16 witnesses at Inquest, including via the Panel, which discussed best practice approaches for engaging people with mental health issues presenting as Danny did.

82. I will address these issues under discrete headings and make the following further findings pursuant to section 67(1)(c) of the Act as to the circumstances of Danny's death.

Information provided to the triage service and appropriateness of the resulting referral to the CAT Team

83. As noted above, Mr Smethurst made contact with Eastern Health Psychiatric Triage service at 2.27 pm on the 24 June 2019 and in a discussion with staff member Olga described his concerns about Danny's deteriorating mental health. Danny had been observed by family and friends to have been becoming more unwell in the weeks and months prior to the 24 June 2019. The descriptions offered to the triage service by Mr Smethurst and Mrs Richards, as contained in the Eastern Health Screening Register detail[87] are consistent with the evidence from family and friends at inquest and on the brief. They state that they considered that Danny's condition was deteriorating, and the family were very concerned. Danny believed that he was an undercover spy working for the army and the air force special forces in relation to Brexit and that police are aware of this and trying to stop him. It is noted that he was described as having a strong paranoia and fixation regarding police.[88] In the conversation that Mrs Richards had with the triage service at approximately 6:30 pm she confirmed that Danny appeared unwell and agreed to be the referrer.

84. Danny's declining mental health had been a topic of conversation between Mrs Richards and her son Robert and with Mr Smethurst on many occasions. Mrs Richards had observed that Danny was more withdrawn and was not going out very much and had become very concerned about security and wanted to place additional locks on the house.[89]

85. It does not appear from the evidence of Mrs Richards or Mr Smethurst that on 24 June 2019 that Danny's condition had become more acute or deteriorated particularly rapidly

[87] Screening Register Detail, CB, p. 1286-1287.
[88] *See for example* Evidence of Vincent Smethurst, Inquest Transcript, p. 61; Screening Register Detail, CB, pp. 1286-1287.
[89] *See for example* Evidence of Eileen Richards, Inquest Transcript, p. 13.

as compared to the day or week before, though Mr Smethurst agreed that there had been a 'recent decline'. His mental health as assessed by family and friends had been deteriorating for some months and all were deeply concerned and wanted to get assistance for Danny.[90]

86. On 24 of June 2019 based on the information provided to Eastern Health Telephone Triage Team by Mrs Richards and Mr Smethurst, as recorded in the Screening Register Detail and confirmed Mrs Richards and Mr Smethurst, together with the information that was already known from the previous referral of Danny to the triage service, I find that it was reasonable for the triage team to conclude that Danny was unwell enough to require assessment by mental health clinicians. The referral to the CAT Team was in the circumstances reasonable and appropriate.

Response by CAT Team

87. The referral to the CAT team occurred at 6:36 pm on the 24 June 2019. Mr Jones described the referral as a '*clear cut case*'.[91] He and Mr Conron had the referral information and access to records of Danny's past inpatient care. Mr Conron had in fact been the clinician who had assessed Danny in 2015.

88. Mr Jones and Mr Conron took up the referral immediately. They attended at the premises at [redacted] Madeline Avenue, but noted that the front gates were locked.[92] Had the gates been open, they would have potentially knocked on the door and spoken to with Danny without police being called.[93]

89. A telephone call was placed to Mrs Richards and they obtained the landline telephone number for the house so they could attempt to speak with Danny. Mr Jones called the landline and when the phone was answered explained that he was from the CAT Team and that they wanted to speak with him. The phone was hung up. A follow up call was made that was not answered. Danny's family in their written submissions assert that it was not established that Danny was the person that answered the phone and submit that further attempts through Mrs Richards should have been made to speak to Danny

[90] Evidence of Eileen Richards, Inquest Transcript, p. 36; Evidence of Vincent Smethurst, Inquest Transcript, pp. 69-70.
[91] Evidence of Gareth Jones, Inquest Transcript, p. 128. For completeness, it is noted that Mr Jones was answering a question put by Counsel Assisting as to whether this was a 'clear cut case' but the transcript refers to Mr Jones stating it was a '*clean cut case'*.
[92] Evidence of Gareth Jones, Inquest Transcript, p.129.
[93] Evidence of Gareth Jones, Inquest Transcript, p.129.

directly before calling for assistance from police. There is no suggestion that there was anyone else at the property who could have otherwise answered the phone. In their evidence Mr Conron and Mr Jones considered that the answerer of the phone call to be Danny, and that Danny's refusal to speak to them on the phone was likely indicative, in combination with other collateral information known, that he would not go willingly to hospital and that police assistance would be required.[94]

90. They accordingly sought police attendance and waited for police to arrive, making no attempt to approach Danny directly even once the gate was unlocked and a direct approach would have been possible. Mr Jones evidence was that it would not have been appropriate to make further attempts once the gate was open in his evidence stating, '*I think it was beyond us by that point*'.[95]

91. Danny's apparent refusal to speak on the phone led the CAT Team members to conclude that he was unlikely to engage with them and that police should be involved to assist them in making their assessment. It was reasonable for Mr Jones to assume that it was Danny who ended the call when he had phoned. The decision by the CAT Team members to request police assistance was based on their professional judgment about the likelihood of Danny engaging with them and agreeing to attend for assessment voluntarily, which in turn was based on consideration of collateral information as to his current state of declining mental health, leading to a conclusion that an approach with police was needed for safety reasons.[96] In the circumstances I consider their actions were reasonable.

Could the assessment have been delayed?

92. It is relevant to consider whether the assessment could have waited until the next day when there may have been an opportunity for the CAT team members to make a direct approach to Danny. Mr Conron, when asked about this in his evidence opined that it couldn't wait until the next day - '*Mrs Richards was saying that she was feeling like she was a prisoner in her own home that she was walking on eggshells. Vince [Mr Smethurst] told us things are getting worse and worse. When we get these referrals, we*

[94] Evidence of Gareth Jones, Inquest Transcript, p. 136; Evidence of Wayne Conron, Inquest Transcript, p. 200.
[95] Evidence of Gareth Jones, Inquest Transcript, p. 166.
[96] Evidence of Wayne Conron, Inquest Transcript, pp. 201-202.

want to get those referrals done as soon as possible.'[97] Both CAT Team members considered that it was urgent. This approach is supported by Mr Sheppard in his evidence as part of the Panel where he identified the risk of absconding, interactions with members of the public, prior police involvement and the level of paranoia and delusions as possible relevant factors in determining how time-critical a response is in a given situation, and agreed that CAT Teams are by definition a crisis response service.[98] Further, Dr Andrew Cheong of Eastern Health explained, by acting on delusional beliefs, or behaving in a manner consistent with them, Mr Richards was potentially placing himself and others in danger, which did give rise to a sense of emergency.[99]

93. In the circumstances, the decision to proceed with the assessment on the night and to call for police and paramedic assistance was reasonable and appropriate notwithstanding that it meant that instead of providing a later opportunity for a potential direct approach by 2 clinicians, one with a history of assessing Danny, four armed police officers were required to assist the two clinicians conduct the assessment. However, it cannot be known whether the situation would have been different the following day, and the evidence available to the CAT clinicians was that the need for assessment was urgent. As Jeremy Sheppard noted as part of the Panel in commenting hypothetically on optimal approaches in such situations, *'[l]eaving somebody in the community who is potentially at risk to themselves or to others or who may deteriorate over that period is not a sound clinical decision'*.[100]

Planning by CAT team, police officers and ambulance paramedics

94. Mr Conron and Mr Jones were working with a strong presumption that Danny would be made subject to an Assessment Order[101] and that, though they needed to engage him in conversation to make the final assessment, they anticipated and planned for Danny's needing to go to hospital. This is reflected in the triple zero call to seek the attendance

[97] Evidence of Wayne Conron, Inquest Transcript, p. 203. *See also* Evidence of Gareth Jones, Inquest Transcript, p. 135.
[98] Evidence of Jeremy Sheppard, Inquest Transcript, pp. 554-555. *See also* Evidence of Wayne Conron, Inquest Transcript, p. 222.
[99] Evidence of Dr Andrew Cheong, Inquest Transcript, p.596.
[100] Evidence of Jeremy Sheppard, Inquest Transcript, p. 527.
[101] Evidence of Gareth Jones, Inquest Transcript, p. 132 and p. 165; *See also* Evidence of Wayne Conron, Inquest Transcript, p. 226-229.

of Ambulance Victoria and in the evidence of police who were briefed by the CAT Team about the likely outcome of the assessment.[102]

95. On behalf of Danny's family, it was suggested that police planning was poorly conceived and executed and as a result the entry and implementation of the plan was rushed. They identified the following issues of concern:[103]

(a) failure to include input from Danny's friends and family, who were either physically present at the scene or available via telephone;

(b) failure to include Ambulance Victoria. As a result, police were unable to incorporate their services and equipment such as pre-preparing sedation and restraints;

(c) failure to give appropriate consideration to the following information about Danny's lack of violent priors and that he had concerns about police;

(d) failure to clearly identify who was the lead agency and who would be the initial point of contact with Danny upon entry into the house;

(e) failure to articulate the level of force that was permitted to be utilised by police under the *Mental Health Act 2014* should Danny be placed on a valid Assessment Order.

(f) that the plan consequently failed to consider all 'reasonable and less restrictive options' prior to utilising bodily restraint;

(g) failure to develop a 'Plan B' should communications fail, and a physical struggle arise;

(h) failure to give any consideration to returning the next morning, thereby utilising the 72-hour duration of an Assessment Order under section 34[1](b)(ii) of the *Mental Health Act 2014;*

(i) failure to reconsider options when they arrived at the front door such as; speaking through the kitchen window, calling out, showing identification; and

[102] Statement of Wayne Conron, CB, p. 205.
[103] Summarised from the Closing Submissions made on behalf of the Richards Family, filed on 30 June 2021, p. 6.

(j) failure to consider the foreseeable risks of entry with four police and a CATT practitioner, into the tiny space of the kitchen where Danny was standing.

Best practice planning for responding to CAT Team referrals in the community

96. The Panel considered the issues of planning and preparation. The Panel did not specify a best practice approach to an emergency mental health response in a community setting but agreed it should include thorough information-gathering, including from friends or family members, an assessment of environmental risks, risks to the patient and risks to others, that critical decisions about timing are clinical decisions based on clinical judgement, that police have the responsibility to do an initial safety check of the physical environment and that each situation is different. Associate Professor Rauchberger noted the importance of proactively preventing and de-escalating behaviours of concern rather than being reactive, with a need for clarification of roles and a mutual understanding as part of planning.[104]

97. In his expert report Mr Sheppard describes (in the context of a Police and CAT Early Response (**PACER**) program) the information that may be available from a number of sources and which can inform planning – the LEAP database that is available to police, information from the mental health service database, environmental risk assessments by talking to those who reside at the premises including family, friends, or co-tenants.[105]

98. Associate Professor Irving also expressed a view about planning:

> *The CAT team and Police and Ambulance Officers do not seem to have been fully alert to the possibility that "Plan A" might fail and that a safe and effective "Plan B" might be required. Furthermore, it may not have been fully appreciated that Mr Richards had a pathological fear of being restrained by police and that he was unlikely to respond to rational requests, making it likely that "Plan A" would be problematic.*[106]

99. This suggests there is a recognised Plan A / Plan B approach to the circumstances of assessing a person in the community, however as the Panel have opined there is no apparent best practice approach, rather clinicians, paramedics and police working

[104] Evidence of Associate Professor Rauchberger, Inquest Transcript, pp. 518-519.
[105] Expert report of Jeremy Sheppard, CB, p. 1337.
[106] Expert Report of Associate Professor Louis Irving, CB, p. 1011. While making such observations from a medical perspective, Associate Professor Irving noted during Inquest that his specialty lies in respiratory and sleep medicine rather than decisions about planning and the methodology of getting mental health patients into psychiatric care (Evidence of Associate Professor Irving, Inquest Transcript, p. 105).

toward a goal with different skills, perspectives and workplace guidance, which is supported by Mr Conron's comments about having a 'continuum of response'.[107]

The planning in relation to the approach to Danny

100. Both CAT Team members Mr Conron and Mr Jones had access to information about Danny's past mental health issues, and the referral from the triage service gave them the background and history of Danny's recent presentation to family and friends. Mr Smethurst had spent time in the car with the CAT Team members whilst waiting for police to arrive. They discussed Danny's condition.[108] At the inquest, police witnesses gave evidence of what was discussed and how the approach was to be made to Danny. SC Wooldridge was to be the contact or lead officer and A/Sgt Carbone to be 'cover'.[109] A safety briefing was conducted by A/Sgt Carbone with other police members, and there were separate discussions between police and paramedics and between police and CAT Team clinicians about Danny's history as known to them. The safety briefing on the available evidence was described by A/Sgt Carbone as 'quick' and this is I think a correct characterisation. While there is evidence of a briefing between CAT Team members and police on the corner of Madeline Street and Angus Drive, at least some discussions appear to occur as police members and CAT Team members were walking from their cars to the entrance to the property.[110]

101. Paramedics were present for the transport of Danny to hospital. Their role was a very narrow scope and CAT team clinicians and police were clear about this.

102. There were differing degrees of understanding of the nature of Danny's condition and attitude towards police,[111] however the evidence suggests that all were aware that Danny was experiencing paranoia or delusions and that he might respond poorly to police presence.

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[107] Evidence of Gareth Jones, Inquest Transcript, p. 188.
[108] Statement of Wayne Conron, CB, p. 206; Statement of Gareth Jones, CB, p. 209; Evidence of Vincent Smethurst, Inquest Transcript, pp. 50-51; Statement of Vincent Smethurst, CB, pp. 400-401.
[109] Evidence of SC Wooldridge, CB, p.354; Evidence of A/Sergeant Carbone, CB, p. 446.
[110] Statement of Gareth Jones dated 13 August 2021; Statement of Wayne Conron, dated 16 August 2021, Additional CCTV Footage.
[111] Evidence of A/Sgt Carbone, Inquest Transcript, p. 438; Evidence of Constable Gray, Inquest Transcript, pp. 396-398; Evidence of SC Wooldridge, Inquest Transcript, pp. 353-354; Evidence of Constable Earle, CB, pp. 339-340.

103. The CAT team clinicians were the lead agency whose role it was to undertake an assessment of whether Danny should be made subject to an Assessment Order. They were in formal control and this was accepted by police.

104. Police were present as a support agency for the CAT Team members, but in practice police members entered the house first and Mr Jones entered last. The CCTV of [redacted] Madeline Street depicts the four armed police members leading the way down the path at the side of the house to the front door, and they were the first to interact with Danny. This was done so that the police could assess the scene and ensure that it was safe. Only then could the assessment by Mr Jones take place.[112]

105. SC Wooldridge made the first communication with Danny in the kitchen area. The evidence differs as to whether the plan was for the CAT Team member Mr Jones to make the initial communication, or police. Danny's reaction when police members and Mr Jones first entered the house it appears prompted SC Wooldridge to make the first communication.[113]

106. The family suggest police escalated the situation by entering the house first and if the CAT team member Mr Jones or a paramedic had entered first then the situation may have been different.[114] The evidence of both CAT Team clinicians and paramedics is that where there are issues of safety then it is for police to lead and ensure that the site is safe. This is also consistent with the evidence of Mr Sheppard of the Panel of usual practice in a PACER context, whereby '*the police unit usually attends ahead of the [clinicians] and the idea was always that police have a responsibility to ensure the situation is safe […]*'.[115]

107. I must be careful not to assess the actions with the benefit of hindsight and to discount the influence of it. The evidence of the Panel is relevant, as they identified the importance of including in the planning process assessments of environment risks, risk to patient and risk to others. The Panel also noted that critical decisions about timing are clinical decisions based on clinical judgement, that police have responsibility for safety of the physical environment, and that each situation is different, fluid, and that a

[112] Evidence of Gareth Jones, Inquest Transcript, p. 186.
[113] Statement of SC Wooldridge, CB, p. 61; Evidence of SC Wooldridge, Inquest Transcript, p. 357-358.
[114] Closing Submissions made on behalf of the Richards Family, filed on 30 June 2021, p. 7.
[115] Evidence of Jeremy Sheppard, Inquest Transcript, pp. 506-507.

degree of flexibility is required.[116] The evidence of the planning and preparation from the police and CAT Team members is not neatly packaged and recorded. It reflects the dynamic nature of the events; information was gathered from a variety of sources and shared. Not everybody gave evidence to the same level of detail on all matters, however I find that on the key issues there is consistency. They made appropriate assessments of risk, obtained relevant information and understood their respective roles and responsibilities.

108. In the circumstances I consider that the planning by police paramedics and CAT team was adequate.

What happened inside the house on 24 June 2019?

Was the approach to Danny appropriately made?

109. Although the CAT team clinicians were the primary agency, the first approach to Danny was made by police, all four of whom entered the house and took up positions near Danny; SC Wooldridge and Constable Gray at the kitchen entrance and A/Sgt Carbone and Constable Earle on the hallway side of the kitchen bench along with Mr Jones. As noted above, it was SC Wooldridge that first spoke to Danny

110. SC Wooldridge explained in evidence the tone of voice he used and the style of communication he adopted would have been an '*empathetic tone*', '*to the point but not too assertive*'[117]. The inquest heard evidence from the Panel on communication approaches and style.[118] The approach adopted by SC Wooldridge does appear to be consistent with the Panel's view on how this communication should occur.

111. Mr Jones in his evidence describes how he attempted to interact with Danny in 'non-threatening and engaging way' but Danny did not engage with him.[119] The approach described by Mr Jones appears to be consistent with the approach suggested by the Panel.[120]

[116] *See for example* Evidence of Jeremy Sheppard, Inquest Transcript, pp. 559-560.
[117] Evidence of SC Wooldridge, Inquest Transcript, p. 357.
[118] Evidence of Associate Professor Rauchberger, Inquest Transcript, pp. 503-504; Evidence of Julie Anderson, Inquest Transcript, pp. 504-505.
[119] Evidence of Gareth Jones, Inquest Transcript, pp. 169-171.
[120] Evidence of Associate Professor Rauchberger, Inquest Transcript, pp. 503-504; Evidence of Julie Anderson, Inquest Transcript, pp. 504-505.

112. The kitchen area is not a large area and this number of police present in the kitchen and hall area was significant. There is nothing to suggest that police were confrontational or aggressive in their approach. The CCTV shows the police approach to the house occurred 'in a fairly slow and relaxed fashion'.[121] However, in all likelihood, even with careful and non-aggressive body language, four armed police officers and a CAT Team member in the kitchen would have been very confronting for Danny.

How did Danny present?

113. When the police members and Mr Jones entered the house, Danny did not initially present as aggressive. However, it appears Danny believed police were at the house unlawfully and that this precipitated him to make his own call to 'triple zero' to complain of police presence. It is very likely that Danny's reluctance or refusal to engage was motivated by his belief that police were unlawfully at the premises and he had not been provided with the paperwork that he thought should have been provided to him.[122] The triple zero call that Danny made provides some insight to Danny's concerns. At this time, there may have been an opportunity when Constable Earle hung up the triple zero call that Danny was making,[123] as well as in A/Sgt Rosevear's approach with Danny on that triple zero call,[124] to have better reflected the principles of empathy, de-escalation and use of soft tones and language that are considered best practice in dealing with members of the public with mental health issues.

114. Notwithstanding, I find that Danny's reluctance to engage with SC Wooldridge and Mr Jones during this time was a reasonable basis for the conclusion that Danny would not go voluntarily to the ambulance and hospital for assessment.

The decisions and actions of mental health clinicians in response to Danny

115. In his statement and in evidence at inquest Mr Jones described the steps he took to complete the assessment of Danny. This included having a good understanding of his history of mental illness, and knowledge of the current information that had been provided to the triage service prior to his referral to CAT Team, including a verbal

[121] Exhibit 7, referred to during evidence of Vincent Smethurst, Inquest Brief, pp. 77-78.
[122] Exhibit 29, Transcript of 000 Recording made by Daniel Richards, CB, pp. 1060-1064.
[123] Statement of Constable Earle, CB, p. 74; Evidence of Constable Earle, Inquest Transcript, p. 321; Exhibit 29, 000 Recording made by Daniel Richards, CB, pp. 1060-1064.
[124] Evidence of A/Sgt Rosevear, Inquest Transcript. p. 378. See also p. 382: '*I was trying to be stern without, you know, being too over the top I suppose*'.

briefing from 'Hannah' of the triage service.[125] Mr Jones was not the first person to enter the house and speak to Danny, however he did try to engage Danny in conversation and was able to observe and assess him. In his evidence Mr Jones described how he introduced himself and explained his role in as non-threatening way as possible to try and engage with Danny He asked him about why he was calling the police and his concerns about the police who were present. He also talked about Danny's options and if he was willing to attend the hospital voluntarily.[126]

116. The family in their submissions assert that Mr Jones did not fulfill the requirements of the *Mental Health Act 2014* in completing his assessment and that the order is therefore not valid.[127] Having reviewed all the evidence and carefully considered the actions of Mr Jones I am satisfied that Danny's presentation to Mr Jones inside the house made it clear that he was unwell enough to require assessment, and that the criteria for the making of the Assessment Order was therefore met.

<u>What was the sequence and duration of events up to and including Danny's being observed to be struggling to breathe?</u>

117. There was no physical contact with Danny until after the Assessment Order had been made.

118. The available evidence suggests that it was police who instigated physical contact by taking hold of Danny's arms in an attempt to escort him from the house. Danny responded with significant resistance and police were surprised by his strength and capacity to resist their attempts to control him.[128] The evidence of SC Wooldridge and Constable Earle makes it clear that Danny resisted with significant strength and that they we struggling to contain him.[129] Even with the assistance of Constable Gray it was requiring all their efforts to get Danny to the floor and attempt to apply the handcuffs. It was difficult to move Danny from a standing position to the floor. Efforts to hand cuff him with hands behind his back were abandoned and instead he was handcuffed to the

[125] Evidence of Gareth Jones, Inquest Transcript. pp. 158-159.
[126] Evidence of Gareth Jones, Inquest Transcript, p.171.
[127] Closing Submissions made on behalf of the Richards Family, filed on 30 June 2021, pp. 4-5.
[128] Evidence of Constable Earle, Inquest Transcript, pp. 322-323; Evidence of A/Sergeant Carbone, Inquest Transcript, p. 453; Evidence of Constable Gray, Inquest Transcript, pp. 404-405; Statement of SC Wooldridge, p. 63.
[129] Evidence of Constable Earle, Inquest Transcript, p. 309; Statement of SC Wooldridge, p. 63.

front and then using two sets of handcuffs.[130] Even after being handcuffed he continued to struggle and to require a degree of physical control from police members.

119. The use of OC foam on two occasions by A/Sgt Carbone did not lesson Danny's resistance. During the struggle police members had been reminded of the risk of positional asphyxia.[131]

120. The evidence of Mr Smethurst was that he heard Danny say that he could not breathe.[132] The evidence from the other police is that it was not possible to understand what Danny was saying as it was indecipherable. Mr Jones did not hear this either. SC Wooldridge gave evidence that he did say that Danny was having trouble breathing.[133] Mr Smethurst was asked whether it was possible that he heard SC Wooldridge say that Danny was not breathing, and he thought that it was Danny. Mr Smethurst rejects this and maintains that he heard Danny say that he could not breathe.[134] I accept the evidence of police members and Mr Jones that they did not hear Danny complain of being unable to breathe. It is possible that what Mr Smethurst heard was SC Wooldridge saying that Danny was not breathing. However, the available evidence does not allow me to determine this conclusively.[135]

Use of OC foam[136]

121. Associate Professor Irving raised the question as to whether the use of OC foam may have increased the risk to Danny.[137] Danny's family in their submissions assert that the use of OC foam was excessive and ineffective.[138] Associate Professor Irving states, *'[g]iven Mr Richards' pre-existing coronary artery disease, it is quite possible that the*

[130] Evidence of SC Woolridge, Inquest Transcript, p. 362.
[131] Statement of A/Sergeant Carbone, CB, p. 47; Evidence of A/Sergeant Carbone, Inquest Transcript, p. 472-473; Evidence of SC Wooldridge, Inquest Transcript, pp. 363-365; Evidence of Constable Gray, Inquest Transcript, p. 416; Evidence of Constable Earle, Inquest Transcript, pp. 327-328.
[132] Evidence of Vincent Smethurst, Inquest Transcript, pp. 75-76. Statement of Vincent Smethurst, CB, p. 403.
[133] Statement of SC Wooldridge, CB, p. 65; Evidence of SC Wooldridge, Inquest Transcript, p. 362.
[134] Evidence of Vincent Smethurst, Inquest Transcript, pp. 75-76.
[135] Evidence of Vincent Smethurst, Inquest Transcript, pp. 75-76; pp. 89-90; Evidence of Constable Earl, Inquest Transcript, p. 327; Evidence of SC Wooldridge, Inquest Transcript, p. 363; Evidence of Constable Gray, Inquest Transcript, p. 405.
[136] This was referred to interchangeably at Inquest as 'OC foam' and 'OC spray'. The Closing Submissions on behalf of the Chief Commissioner of Police dated 4 June 2021 indicate the appropriate term in this case is 'OC foam', though the distinction between the two was not explored in the evidence. For consistency, the term 'OC foam' has been used throughout this Finding unless used in a direct quotation.
[137] Expert report of Associate Professor Irving, CB, p. 1008.
[138] Closing Submissions made on behalf of the Richards Family, filed on 30 June 2021, p. 8.

use of OC spray had an aggravating effect', noting that OC spray may induce panic, agitation, elevated blood pressure, tachycardia, and hyperventilation in some people.[139]

122. Danny was clearly agitated and highly anxious about the presence of police and his physical output in resisting efforts by police to take him into custody placed him at greater risk given the underlying coronary artery disease. The use of OC foam on Danny is likely to have had an aggravating affect but was one of several aggravating factors. Nevertheless, and noting in particular that police were unaware of Danny's underlying medical condition, I consider that the decision to use OC foam was reasonable in the circumstances of a continuing struggle between Danny and police which needed to be brought to an end.

Conclusions in relation to police actions

123. I have conducted a careful review of the evidence, including that of Mr Smethurst, of all police officers and the evidence of Mr Jones regarding: (i) the way police attempted to engage with Danny; (ii) what occurred prior to the physical confrontation beginning; and (iii) their response when Danny resisted their initial attempt to have him leave the premises to be assessed. I am satisfied that:

    (a) though there is some evidence that suggests that certain aspects of the police approach to Danny could have been more empathetic, police made reasonable and sufficient attempts to communicate with Danny before taking hold of him in an attempt to escort him out of the house;

    (b) the ensuing struggle represented police officers trying to control Danny's movements using standard police techniques;

    (c) the decision to use handcuffs was reasonable;

    (d) the use of force was at all times in response to Danny's actions in resisting police efforts to control and handcuff him; and

    (e) the use of OC foam on two occasions was not excessive.

[139] Expert report of Associate Professor Irving, CB, p. 1008.

Who was (a) responsible for monitoring Danny's welfare during the interaction; and (b) in fact monitoring Danny's welfare during the struggle between him and police?

124. From the time police first took hold of Danny, he was in their custody and they were responsible for his welfare. This was appropriately acknowledged by police witnesses.[140]

125. A/Sgt Carbone was aware of the risks posed by the ensuing struggle, particularly the risks posed by positional asphyxia, and he was giving directions to those police who were struggling with Danny to guard against that risk – a risk of which they were themselves already aware and was addressed in A/Sgt Carbone's safety briefing.[141]

126. No one was monitoring Danny for other medical issues, including any cardiac issues of the kind which ultimately caused his death. Neither the police nor the CAT Team clinicians had any information to suggest that Danny had a heart condition, or any other health issue which placed him at increased risk. Mr Jones, a registered nurse, rejected the suggestion at Inquest that CAT clinicians ought to have a role in monitoring the health of those in police custody as impractical and noted his qualifications are in mental rather than physical health, and Mr Conron noted that his qualifications are in social work.[142] I do not consider that the CAT team ought to have had a formal role in monitoring Danny's medical wellbeing during the struggle with police.

FINDINGS

127. Having investigated the death of Daniel Charles Richards, and having held an inquest in relation to Danny's death from 9 March 2021 to 12 March 2021 and 22 March 2021 to 23 March 2021 at Melbourne, I make the following findings, pursuant to section 67(1) of the *Coroners Act 2008*:

    (a) that the identity of the deceased was Daniel Charles Richards, born on 25 September 1970;

[140] *See for example* Evidence of SC Wooldridge, Inquest Transcript, pp. 361-362; Evidence of Constable Earle, Inquest Transcript, pp. 312-313.; Evidence of Acting Sergeant Carbone, p. 454.
[141] Statement of A/Sgt Carbone, CB, p. 47; Evidence of A/Sgt Carbone, Inquest Transcript, p. 472-473; Evidence of SC Wooldridge, Inquest Transcript, pp. 363-365; Evidence of Constable Gray, Inquest Transcript, p. 416; Evidence of Constable Earle, Inquest Transcript, pp. 327-328.
[142] Evidence of Gareth Jones, Inquest Transcript, p. 149 and p. 190; Evidence of Wayne Conron, Inquest Transcript, p. 198 and p. 240.

(b) that Daniel Charles Richards died at [redacted] Madeline Street, Glen Waverley on 24 June 2019 from ischaemic heart disease complicating restraint of an acutely agitated male;

(c) in the circumstances described above.

128. I convey my sincerest sympathy to Danny's family and friends. I acknowledge the grief and devastation that you have endured as a result of your loss. I read carefully and was greatly assisted by the personal reflections made by Mrs Richards, Robert Richards, David Wright and Vince Smethurst submitted to me, and I thank the Family for their active participation and assistance in these proceedings.

129. I thank Counsel Assisting Ms Ellyard and the counsel and solicitors who represented the interested parties for their assistance and comprehensive submissions. I also acknowledge and thank Ms Ingrid Giles Senior Legal Counsel at the Coroners Court for her invaluable assistance in this investigation, along with Ms Elizabeth Morris, formerly of the Coroners Court. I also thank my investigator, Detective Sergeant Sol Solomon, for his able assistance in preparing the coronial brief and throughout inquest.

COMMENTS

Pursuant to section 67(3) of the Act, I make the following comments connected with the death.

Royal Commission into Victoria's Mental Health System

130. Danny's family and friend were acutely aware that his mental health was deteriorating. Mrs Richards and David Wright reported their concerns to police in December 2018 and police had conducted a welfare check.[143] There is also evidence of other calls being made to mental health services seeking assistance. The fact of Danny's deteriorating condition made it less likely that he would engage voluntarily. Panel member Julie Anderson an expert in lived experience provides helpful insight:

> *In my experience sometimes the trauma in engaging with mental health services means that people's response to facing the experience again can create new and more painful trauma. It can prevent us from processing*

[143] Statement of First Constable Bronte Bate, CB, pp. 168-169.

> *the event encourage us to suppress it or teach us to internalise self-blame and shame for what happened.*
>
> *Trauma of engagement with mental health services can lead to a fearful, frightened, and even angry reaction to the prospect of entering the mental health system again. Being approached by others can trigger a traumatised response.*[144]

131. Danny was fearful of police and his response to Mrs Richards upon being informed that the referral to the CAT team had been made (crying out '*like a wounded animal*'[145]) also demonstrates that he may have been fearful of re-entering the mental health system. Although his condition was deteriorating, the risk of physical violence on available evidence was low. Danny would not voluntarily participate in treatment and in those circumstances an Assessment Order was the only option available to Danny's family to have him access treatment.

132. The decision to refer a family member to a mental health service knowing that it is likely that they may resist assessment is extremely challenging and confronting for the family and friends. Unfortunately, other options are presently not available. Family members, police, paramedics, and mental health services would be assisted by a broader range of options to support those suffering from mental health conditions.

133. Section 7 of the Coroners Act requires that I avoid unnecessary duplication of inquiries and investigations. To that end the Royal Commission into Victoria's Mental Health System (**RCVMHS**) delivered its final report on 3 February 2021 and it was tabled in Parliament by the Victorian Government on 2 March 2021 (**Final Report**).[146] I am of the opinion that there are a number of recommendations highly relevant to the circumstances of this case.

134. The RCVMHS did consider these issues and Chapter 9 of the final report deals with the complexity of these situations. In the final report, at least three recommendations are made that are highly relevant to the circumstances of Danny's death. These recommendations are:

i. Recommendation 8 (1): Responding to Mental Health Crises

[144] Expert report of Ms Julie Anderson, CB, p. 1332.
[145] Evidence of Eileen Richards, Inquest Transcript, p. 20.
[146] Final Report of RCVMHS available: https://finalreport.rcvmhs.vic.gov.au/download-report/.

ii. Recommendation 9(1): Developing 'safe spaces' and crisis respite facilities

iii. Recommendation 10: Supporting responses from emergency services to mental health crises.

135. In respect of responding to mental health crises the RCVMHS recommended in **Recommendation 8(1)**:

> *ensure each Adult and Older Adult Area Mental Health and Wellbeing Service delivers a centrally coordinated 24-hours-a-day telephone/telehealth crisis response service accessible to both service providers and to members of the community of all ages that provides:*
>
> *a. crisis assessment and immediate support.*
>
> *b. mobilisation of a crisis outreach team or emergency service response where necessary; and*
>
> *c. referral for follow-up by mental health and wellbeing services and/or other appropriate services.*

136. In respect of developing 'safe spaces' and crisis respite facilities, the Royal Commission recommended in **Recommendation 9(1)**:

> *invest in diverse and innovative 'safe spaces' and crisis respite facilities for the resolution of mental health and suicidal cases which are consumer led and, where appropriate, delivered in partnership with non-government organisations.*

137. In respect of supporting responses from emergency services to mental health crises, the Royal Commission recommended in **Recommendation 10**:

> *1. ensure that, wherever possible, emergency services' responses to people experiencing time-critical mental health crises are led by health professionals rather than police.*
>
> *2. support Ambulance Victoria, Victoria Police and the Emergency Services Telecommunications Authority to work together to revise current protocols and practices such that, wherever possible and safe:*
>
> *a. Triple Zero (000) calls concerning mental health crises are diverted to Ambulance Victoria rather than Victoria Police; and*
>
> *b. Responses to mental health crises requiring the attendance of both ambulance and police are led by paramedics (with support*

from mental health clinicians where required).

3. *Ensure that mental health clinical assistance is available to ambulance and police via:*

    a. *24-hours-a-day telehealth consultation systems for officers responding to mental health crises;*
    b. *in-person co-responders in high-volume areas and time periods; and*
    c. *diversion secondary triage and referral services for Triple Zero callers who do not require a police or ambulance dispatch.*

138. The RCVMHS Recommendation 8 recommends crisis assessment and immediate support, mobilisation of crisis outreach teams or an emergency response if needed. Had this service been available in 2018 and 2019 it would have provided another option for engagement for family and friends to get support for Danny. There is no certainty that Danny would have engaged but it would have been another treatment option for family and friends and possibly less confronting for Danny.

139. The RCVMHS Recommendation 9 provides for 'safe spaces' which, if they had been available in 2018 or 2019, may have offered Danny a safe place to seek help, or a safe place for family and friends to encourage Danny to go to for assistance. It cannot be assumed that Danny would have attended such a space voluntarily, but it would have provided alternative that family and friends may have been able to persuade Danny to attend.

140. The RCVMHS Final Report also includes comments on police training and on the proposed paramedic-led emergency responses.[147] The focus of the discussion and of recommendation 10 is on paramedics rather than police being the first responders to a community mental health request, and that paramedics can if required liaise with mental health services.[148]

141. The circumstances of Danny's death involved the CAT Team being called to make the approach to Danny, and who in turn called police and ambulance for back-up assistance, and it is not clear in the RCVMHS Final Report if these circumstances will require a different approach to the first-responder model, because police and paramedics were not the first responders.

[147] RCVMHS Final Report, Volume 1, p. 519 and 576-8.
[148] RCVMHS Final Report, Volume 1, pp. 560-564.

142. The Panel in considering these recommendations concluded that any change to compulsory treatment at this stage was aspirational and that without resourcing, the goals of the recommendations may not be achieved even with a new Mental Health and Wellbeing Act. The Panel observed that Victoria, compared to other states and territories, and Australia, compared to other countries, have the highest rates of compulsory treatment in the world and there is continued debate as to what this means, but the Panel believed that deeper thought needs to occur at a societal level for any meaningful change.[149]

143. The Panel endorsed the planned paramedic led first-responder approach to community mental health requests including its normalising of mental illness, with Julie Anderson of the Clinical and Lived Experience Panel strongly endorsing an ambulance-led response, stating that '*if anyone was sick in the community you'd ring an ambulance, you'd ring the paramedics. I think it normalises the face of mental health in our society*'.[150] However, along with Ambulance Victoria, issues were identified by the Panel related to training, role definition, resourcing and what will change in how services will work together as significant.

144. Paramedics are quite obviously not trained in any tactical options for circumstances where there are warning flags or the potential that someone may become aggressive or violent in the way that police are. As a matter of policy, paramedics rely upon police members, who have such training to ensure scene safety prior to entering such a scene. It is also not unreasonable for paramedics to be provided with both a safe workplace and the reassurance that their workplace will be safe before entering it, by utilising the police who are specifically trained for such circumstances.[151]

145. Police are relied upon to secure sites and make it safe for other services, in this case paramedics and CAT Team clinicians to work safely. The RCVMHS Final Report does not include a specific discussion about the reliance on police for this role nor offer any alternatives.

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[149] Evidence of Associate Professor Ilan Rauchberger, Inquest Transcript, pp. 537-538. *See also* p. 540 – '*as a society we would need to go on a journey around the philosophy of whether compulsory treatment for mental health conditions is a good practice or it's not a good practice'*.

[150] Evidence of Julie Anderson, Inquest Transcript, p. 532.

[151] Closing submissions of Ambulance Victoria filed on 4 June 2021, referring to Evidence of Catherine Wentworth, Inquest Transcript, pp. 264-265.

146. The RCVMHS Recommendation 10 does trigger a review of current systems and processes across mental health services, police and paramedics in community emergency situations and provides an opportunity to establish a best practice inter-service response. Such a review is critical to explore how treatment may be provided with an Assessment Order and forceable removal to a medical facility for assessment being the last resort after a range of other options have been considered.

147. On the issue of training of police, I note that I was apprised at inquest of details of the specialist mental health training that police are now required to undertake in the form of the PRIME Training package (an acronym referring to 'Police Responding in Mental Health Events').[152] Given the focus of the PRIME training on issues such as de-escalation and best practice communication, the full roll-out of this training (which I understand has been affected by the exigencies of the COVID-19 pandemic) would appear to be a prudent step to ensuring all police members have the opportunity to be well-skilled in communicating and understanding members of the community who may be facing a mental illness, noting that Sessions 5-7 of the PRIME training are dedicated to communication skills, which '*teach police to listen, pause and respond, with communication strategies focussed on empathy, reflection, validation and building rapport*'[153] – strategies that mirror those that were broadly endorsed by the Panel.

Mental illness and physical illness

148. The cause of death of Danny Richards was ischaemic heart disease, complicating restraint of an acutely agitated male. Danny's BMI was 34, which is in the obese range, and he had cardiovascular disease[154] although his general practitioner records did not include any serious medical illness.[155] The CAT Team had access to Danny's previous medical history however it contained very limited information about his physical health history.

149. According to the 2016 National Mental Health Commission Physical Health Consensus Statement, four out of every five people living with mental illness have a co-existing physical illness and compared to the general population are, amongst other things, two times more likely to have cardiovascular disease, respiratory disease, metabolic

[152] Statement of Senior Sergeant Andrew Wise, CB, pp. 502-505, referred to in the Evidence of Senior Sergeant Matthew Hargreaves, Inquest Transcript, p. 630 and pp. 643-647.
[153] Statement of Senior Sergeant Andrew Wise, CB, p. 504.
[154] Medical Examiners Report of Professor Woodford, CB, p. 360.
[155] Expert report of Associate Professor Louis Irving, CB, p. 1007.

syndrome, diabetes, and osteoporosis. Further, people with a serious mental illness, are six times more likely to die from cardiovascular disease and four times more likely to die from respiratory disease.[156] Approximately 66% of people living with mental illness and a coexisting physical health condition are overweight or obese and half of males and almost two-thirds of females with psychosis are obese.[157]

150. The prevalence of cardiovascular, respiratory, and metabolic diseases in people with a mental illness suggests the presence of these diseases can be assumed in the absence of contradictory information.[158] Therefore, a different approach to a planned emergency contact with a patient with a mental illness by a mental health service which involves police and paramedics is worthy of consideration, especially in circumstances where the use of restraint is a possibility. Collateral information gathering by the mental health service, who may be able to access medical information about the person, should include efforts to establish the presence or not of diseases that would increase the risks associated with restraint, for example from family, a general practitioner and previous mental health records, which is then communicated to police and reflected in the planning for the use of restraint. It is not possible to say with any certainty that had this been in place then it would have led to a different outcome in Danny's case, however if the starting point is to assume that underlying disease may be present then it provides the best opportunity to reduce the risk of harm.

RECOMMENDATIONS

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

1. To the Secretary of the Department of Health, through the Mental Health and Wellbeing Division:

156 Mental Health Commission Equally Well Consensus Statement: Improving the physical health and wellbeing of people living with mental illness in Australia. Sydney NMHC, 2016., p. 10. Available: https://www.equallywell.org.au/wp-content/uploads/2018/12/Equally-Well-National-Consensus-Booklet-47537.pdf.

157 Roberts, R. The physical health of people living with mental illness: A narrative literature review. NSW: Charles Sturt University; 2019, p. 19. Available: https://www.equallywell.org.au/wp-content/uploads/2019/10/Literature-review-EquallyWell-2a.pdf.

158 Expert report of Associate Professor Louis Irving, CB, p. 1010 – '*it cannot be assumed that people with mental illness are physically well*'.

i. Consistent with the recommendation I made in the finding into the death of Adam Laufer,[159] recommendations 8, 9 and 10 arising from the Royal Commission into Victoria's Mental Health System be prioritised and implemented in their entirety as recommended by the Royal Commission.

ii. That in implementing Recommendation 10 of the RCVMHS Final Report that where a person is being assessed in the community by a mental health service and police and paramedics are involved, that specific consideration be given to:

a. The circumstances in which the mental health service had instigated the involvement of police and paramedics.
b. Inter-service planning that ensures a mutual understanding of the onsite response across all onsite services.
c. The principles of trauma-informed care.
d. Identification of best practice.
e. Practical guidance to all onsite services.

2. To the Secretary of the Department of Health, via the Chief Psychiatrist, that:

i. The Chief Psychiatrist alert Area Mental Health Services to the risks associated with restraint of people with a mental illness and cardiovascular, respiratory, and metabolic diseases that in circumstances where a community mental health service involves police and paramedics and where restraint could possibly be used, that an assumption of physical disease is reasonable. In response, mental health services include in their planned response:

a. Where possible, identification of physical health risks as part of collateral information gathering, including from family members.

b. Communication to police and paramedics prior to engagement with the person any established physical illness risks or if it remains unknown.

[159] Finding of State Coroner Judge John Cain in the Inquest into the death of Adam Laufer, 26 July 2021, p. 35, available: https://www.coronerscourt.vic.gov.au/sites/default/files/Form%2037%20COR%202016%205581%20LAUFER%20Adam.pdf. While my recommendation in that Finding was directed to Mental Health Reform Victoria, I appreciate that Mental Health Reform Victoria has now ceased operations, and its staff and functions moved to the new mental Health and Wellbeing Division in the Department of Health, which is tasked with implementing the RCVMHS recommendations.

c. Consideration be given to mitigating strategies by all onsite services if physical illness risks are identified or remain unknown.

3. I note for the benefit of the Family and Interested Parties that, pursuant to the requirements in section 72(3) and (4) of the Act, a written response is to be provided by the Secretary of the Department of Health to the Coroners Court within 3 months of the date of this Finding, specifying the action (if any) that has or will be taken in response to these recommendations.

ORDERS AND DIRECTIONS

I order that this finding be published on the Coroners Court of Victoria website in accordance with the *Coroners Court Rules 2019*.

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

The family of Daniel Charles Richards, c/ Mr Ali Besiroglu, Robinson Gill Lawyers

Chief Commissioner of Police, c/ Mr Dale McQualter, Maddocks

Eastern Health, c/ Ms Christina David, Lander & Rogers

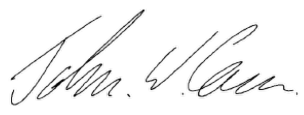
Ambulance Victoria, c/ Mr Jon Minter, K&L Gates

Professor Euan Wallace, Secretary, Department of Health

Dr Neil Coventry, the Chief Psychiatrist

Detective Sergeant Sol Solomon, Coroner's Investigator

Signature:



JUDGE JOHN CAIN
State Coroner

Date: 6 December 2021

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an investigation. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.