IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2019 006741

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	AUDREY JAMIESON, Coroner
Deceased:	Daryl William Nioa
Date of birth:	13 May 1945
Date of death:	9 December 2019
Cause of death:	1(a) Pulmonary thromboembolism secondary to deep vein thrombosis in the setting of recent cervical spinal cord injury (operated)
Place of death:	Goulburn Valley Health, Shepparton Public Hospital, 2 Graham Street, Shepparton, Victoria, 3630

INTRODUCTION

1. On 9 December 2019, Daryl William Nioa (**Mr Nioa**) was 74 years old when he died in hospital following surgery for traumatic spinal fractures.

2. Prior to his death, Mr Nioa was living in Echuca with his partner, Pamela Schmedje (**Ms Schmedje**). The couple met about 40 years prior and were engaged for a few years but never married. Ms Schmedje described Mr Nioa as being involved in 'anything to do with horse training for all of his adult life'.[1]

3. Ms Schmedje also stated that Mr Nioa's health was always very good, and aside from requiring a medical assessment to obtain his trotting licence, he never went to see a doctor in the 40 years they were together until he was diagnosed with Parkinson's disease in about 2014. Mr Nioa was always very fit and active, he never looked his age, was a non-drinker and non-smoker.[2]

4. In August 2019, Mr Nioa was involved in a car accident when he crashed and rolled his car after falling asleep behind the wheel. Mr Nioa was the sole occupant and did not sustain any injuries. He was usually a very cautious driver and stopped driving from this day.[3]

5. From all accounts, Mr Nioa was a fiercely independent person who had no history of aggression. Reflecting on the events that led up to Mr Nioa's death, Ms Schmedje summarised that 'he was an ordinary person. I don't think he'd ever had a traffic fine…these things don't happen to ordinary people and I consider us ordinary.'[4]

THE CORONIAL INVESTIGATION

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

7. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The

[1] Coronial Brief (**CB**), Statement of Pamela Schmedje dated 3 January 2020, 12.
[2] Ibid.
[3] Ibid.
[4] CB, Transcript of Police Interview with Pamela Schmedje on 10 February 2021, 105.

purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

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

9. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Mr Nioa's death. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

10. This finding draws on the totality of the coronial investigation into the death of Mr Nioa including evidence contained in the coronial brief. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[5]

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

Circumstances in which the death occurred

First admission to Echuca Regional Health

11. In late 2019, Mr Nioa was having issues with a hernia and his General Practitioner (**GP**) referred him to see a surgeon in early December the same year. However, on 22 November 2019, Ms Schmedje called an ambulance for Mr Nioa as his hernia was very painful.[6]

12. Mr Nioa was admitted to Echuca Regional Health (**ERH**) on 22 November 2019 and discharged on 25 November 2019. During the admission, Mr Nioa had periods of extreme anxiety and agitation. On one occasion, he stated that he 'needed a doctor now' and queried why 'was no one doing anything about the pain because he is dying'. Half an hour later, when the pain subsided, Mr Nioa apologised to nursing staff for his outburst.[7]

---

[5] Subject to the principles enunciated in *Briginshaw v Briginshaw* (1938) 60 CLR 336. The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

[6] CB, Statement of Pamela Schmedje dated 3 January 2020, 12.

[7] Court Files (**CF**), Medical Records from Echuca Regional Health, 89.

13. Later in the afternoon, Mr Nioa stated he had a panic attack because he thought he heard a man in his room saying the 'they are going to tackle and chain him onto the bed and give him an enema'. Mr Nioa absconded from the hospital and had to be brought back by security. Staff took a collateral history from Ms Schmedje who disclosed that Mr Nioa had been 'lashing out' recently and was increasingly suspicious and paranoid.[8]

14. On 25 November 2019, Ms Schmedje returned to visit Mr Nioa in the hospital and was concerned about his mental state. She did not think that she would be able to manage at home if he were discharged but hospital staff outlined to her that home would be the safest place to manage Mr Nioa.[9]

15. Clinicians performed a delirium screen to explore possible organic causes for these new behavioural changes. No such cause was appreciated, but screening was limited by Mr Nioa refusing to have a computed tomography (**CT**) scan as five years prior he had a panic attack in the machine. The clinical notes document that Mr Nioa had no cognitive impairment or memory problems, had no visual or auditory hallucinations, and no current or historic suicidal or homicidal ideation. They also note that, according to Ms Schmedje, he was not coping with his recent medical issues as he had a very strong independent personality and did not like people to know about his medical issues or be dependent on others.[10]

16. Clinicians consulted the psychiatry registrar at Austin Health who gave an impression of possible panic attack, anxiety, and possible adjustment disorder. They gave a plan to increase clonazepam to 1mg twice daily, for Ms Schmedje to be given emergency mental health contact numbers, and for follow up with Mr Nioa's regular GP to consider referral to psychological services and to consider other anti-psychotic medications.[11]

17. Ms Schmedje recalled that Mr Nioa was becoming increasingly agitated while waiting to be discharged but as soon as he was out of the hospital, he was fine. However, the following day, Mr Nioa became unsettled again. When asked, Mr Nioa stated that he was going to drive to his brother's house. Ms Schmedje got into the car to stop him from driving away. However, Mr Nioa physically removed Ms Schmedje from the car, got in, and drove away 'like a bat

[8] CF, Medical Records from Echuca Regional Health, 91.
[9] CB, Statement of Pamela Schmedje dated 3 January 2020, 13.
[10] CF, Medical Records from Echuca Regional Health, 80, 82.
[11] Ibid, 84.

out of hell' towards his brother's place. Ms Schmedje called the police because she was worried about his mental state.[12]

18. Meanwhile, Mr Nioa self-presented to the police station. Police made an assessment that he needed to go to the hospital and escorted him back to the emergency department (**ED**) at ERH for assessment. [13]

Readmission to Echuca Regional Health

19. On 28 November 2019, at 10.30pm, Mr Nioa was triaged at ERH and remained in the waiting area to be seen by clinicians. Mr Nioa was triaged as category 4 and documented as: *'patient presents with paranoid thoughts. Wanted to come to a "safe place". Denies suicidal ideation.'* The triage form had a tick next to security in the 'risks' section.[14]

20. Shortly after, Ms Schmedje attended and when she met Mr Nioa in the waiting room, 'he was talking as good as gold and sound of mind to [her].' A short time later, police issued Mr Nioa with an intervention order which meant that he couldn't come within 50 metres of Ms Schmedje.[15]

21. The Assistant Nurse Unit Manager (**ANUM**) commencing night shift recalled that the ED was busy and full, but everyone was seated waiting patiently in the waiting room. The ANUM observed Mr Nioa also sitting patiently and accompanied by Ms Schmedje, his brother, and his brother's wife.[16]

22. At about 1.20am on 29 November 2019, the ANUM went out to the waiting room and spoke to Mr Nioa and documented that he was *'sitting quietly with wife in waiting room co-operative + alert. States that he feels fine'*. It was a busy night, there were a few other patients waiting to be taken though the ED, which was full.[17]

23. At about 3am, the ANUM re-triaged Mr Nioa to ensure there were no significant changes as it had been a long wait time already. At this time, Ms Schmedje was leaving for home and warned staff that Mr Nioa would get up and leave if unaccompanied.[18] The plan was then for Mr Nioa to be moved to cubicle 3 in the presence of the two security guards in the hospital.

[12] CB, Statement of Pamela Schmedje dated 3 January 2020, 14.
[13] CB, Transcript of Police Interview with Pamela Schmedje on 10 February 2021, 93.
[14] CF, Medical Records from Echuca Regional Health, 11.
[15] CB, Statement of Pamela Schmedje dated 3 January 2020, 14.
[16] CB, Statement of Tracey Crawford ud, 22.
[17] Ibid, 23.
[18] CB, Transcript of Police Interview with Pamela Schmedje on 10 February 2021, 96.

The ANUM recalled Mr Nioa having a hot drink and eating sandwiches. There were no signs of agitation or of escalating behaviour. At about 3.45am, Mr Nioa asked if he could walk around as he becomes stiff from his Parkinson's disease. Again, there were no signs of agitation or escalation at this time.[19]

Physical Restraint by Security Guards

24. At about 4am, the two security guards were required to physically restrain another patient while getting an injection. Immediately afterwards, one of the guards approached Mr Nioa again and asked if he wanted a coffee or a sandwich to which he replied, 'I don't want an injection'. The guard walked away for about 30 seconds before returning to find Mr Nioa brandishing a fire extinguisher that he had taken off the wall from cubicle 3 and repeating, 'I don't want an injection'.[20]

25. The guard approached, and Mr Nioa raised the extinguisher above his head before attempting to strike the officer with it. The guard attempted to move out the way but was struck on the right shoulder. Later, the guard required two operations and significant long-term management from this injury.[21]

26. As the guard was struck, he grabbed Mr Nioa with his left arm with Mr Nioa's head tucked up against his body, face down. The other security guard assisted bringing Mr Nioa into room 15, the department's secure room. No one else witnessed the incident, however, the ANUM observed Mr Nioa getting up from the floor and guided by the security guards to room 15.[22]

27. CCTV footage captured the interior of room 15 and shows the guards on either side of Mr Nioa entering the room and pressing him against the wall. Afterwards, they restrained Mr Nioa on the ground for a period before leaving the room again. Mr Nioa attempted to stand up but was unable to do so. The footage captured on CCTV is incomplete and is missing some of this attempt to stand. However, when footage resumes 90 seconds later, Mr Nioa was on the ground. Guards lifted Mr Nioa by the arms and ankles onto a mattress set up on the floor. Mr Nioa can be seen moving his legs while on the mattress.

28. At some point during the incident, Mr Nioa had faecal incontinence. With the assistance of another nurse, his treating nurse changed Mr Nioa's pants and washed him. At each step, the

[19] CB, Statement of Tracey Crawford ud, 23.
[20] CB, Statement of Barry Quinlan dated 12 March 2021, 17.
[21] Ibid, 18.
[22] CB, Statement of Tracey Crawford ud, 23.

nurse explained what they were doing and stated that they were 'conscious of not overwhelming' Mr Nioa, particularly in the context of his previous escalation. Throughout the rest of the admission, nurses did not go into the cubicle alone and were accompanied by security officers as a precaution against occupational violence.[23]

Initial Medical Response

29. At 5.15am, Mr Nioa was reviewed by the overnight ED Hospital Medical Officer (**HMO**). On examination, there was bilateral peripheral pain on palpation of the neck. Based on the history from Mr Nioa as well as the nursing staff and security guards, the HMO was not concerned about any head or spinal injury, and this was attributed to musculoskeletal pain from being restrained. Apart from a skin tear on the right elbow, there were no other injuries noted.[24]

30. When the HMO was getting Mr Nioa to stand as part of the examination, they noted faecal matter smeared on his pants and shoes. At this point, the HMO considered the faecal matter most likely the result of behavioural issues.[25]

31. The HMO called the overnight on call mental health triage and formulated a plan for Mr Nioa to remain in the department until mental health review in regular hours later in the morning. The plan was discussed with the consultant VMO who thought it was appropriate. The plan also included to consider a CT brain and repeat bloods. This was in reference to Mr Nioa's previous admission and original plan for a CT scan that he had refused, rather than from new concerns about a potential spinal injury.[26]

32. The HMO documented the examination, findings, and plan in a retrospective note at 9.10am.[27]

Subsequent Medical Care

33. At 8.30am, the nurse looking after Mr Nioa on the morning shift documented that he was given breakfast and 'remains cooperative'. At 9.52am, the nurse documented that Mr Nioa was unable to move his legs, had reduced grip strength in his upper limbs, and was 'sore all over'. The nurse asked for the Senior Medical Officer (**SMO**) to review the patient.[28] The

[23] CF, Statement of Jenny Newell ud, 3.
[24] CB, Statement of Oindrila Das ud, 30.
[25] Ibid
[26] Ibid.
[27] Ibid; CF, Medical Records from Echuca Regional Health, 17.
[28] CF, Medical Records from Echuca Regional Health, 18.

nurse also recalled that Mr Nioa had reduced sensation in his lower limbs and asked the security guards to watch for any movement in Mr Nioa's lower limbs.[29]

34. The SMO reviewed Mr Nioa and confirmed the nurse's findings and noted that Mr Nioa was difficult to assess from both being a poor historian and having paranoid thinking. The SMO thought that the findings could be a result of behavioural issues or related to missing a dose of medications for Parkinson's disease. The SMO asked for these medications to be administered, for nursing staff to closely observe and monitor Mr Nioa, and to notify him if there was no improvement or any concerns.[30]

35. Throughout the rest of the morning, Mr Nioa remained settled and compliant with observations but noted to be confused and making obscure comments. At 12.10pm, the nurse documented that Mr Nioa now had tingling in his arms and could still not move his legs despite administration of his regular medications.[31] The nurse escalated their concerns and asked the SMO to order a CT and to move Mr Nioa into the resuscitation bay for closer observation.[32]

36. The SMO ordered a CT and requested spinal precautions for Mr Nioa but not a neck collar as the SMO was concerned that Mr Nioa would not tolerate this and likely escalate further. Mr Nioa was compliant with these precautions and there was no evidence to suggest that he struggled with the CT.[33]

37. At 2.20pm, the radiologist called to verbally advise that Mr Nioa had an unstable fracture at the level of C6-7 with likely ligamentous injury and haematoma causing canal stenosis and cord compression. The afternoon SMO took the call and communicated this result to nursing staff and stressed how important it was that he stay still. Nursing staff then placed Mr Nioa in a neck collar, which Mr Nioa tolerated.[34]

38. A bladder scan showed urinary retention and an indwelling catheter (**IDC**) was inserted before transfer to Alfred Health under the neurosurgery department for surgery.[35]

[29] CB, Statement of Ashleigh Reid ud, 34.
[30] CB, Statement of Dr Qasim Sahi dated 16 March 2021, 38.
[31] CF, Medical Records from Echuca Regional Health, 18.
[32] CB, Statement of Ashleigh Ried ud, 35.
[33] CF, Medical Records from Echuca Regional Health.
[34] CB, Statement of Ashleigh Ried ud, 35.
[35] CF, Medical Records from Echuca Regional Health, 19.

Transfer to Alfred Health

39. Mr Nioa was conveyed to Alfred Health via Ambulance Victoria's Helicopter Emergency Medical Service (**HEMS**) and arrived at 6pm. Shortly after arrival, Mr Nioa was intubated, and an MRI was performed. This confirmed the injuries seen on CT as an unstable three-column C6-7 fracture with high grade canal stenosis as well as confirming suspicions of various ligamentous injuries. It also highlighted concern for a possible right vertebral artery dissection.[36]

40. Surgeons operated on Mr Nioa that night, in the early hours of 30 November 2019, and performed a C6/7 discectomy and closed reduction of the fracture fixed with cage, plate, and screws. There were no complications and Mr Nioa was admitted to the ICU after the operation.[37]

41. That night, Mr Nioa had a fever and required increasing supports to maintain his blood pressure which raised a suspicion of an infection and possible sepsis. Clinicians prescribed broad spectrum antibiotics and changed the IDC to remove a possible source of the infection.[38]

42. On 2 December 2019, no further surgeries were recommended for Mr Nioa. The MRI had also shown a spinal fracture at the level of L2 which was planned to be treated conservatively with a brace rather than a further operation.[39]

43. Over the next few days, Mr Nioa continued to deteriorate. He had ongoing fevers and tachycardia (elevated heart rate) as well as reduced neurological function in his limbs. The spinal rehabilitation team provided an opinion that Mr Nioa would likely require high level care at best, with poor chances of any functional recovery. After discussion with Ms Schmedje, Mr Nioa was extubated on 5 December 2019. Staff and Ms Schmedje agreed that re-intubation or CPR in the case of further deterioration was inappropriate.

44. Throughout the admission, Mr Nioa was recognised as being at high risk of venous thromboembolism (**VTE**)[40] and was prescribed and administered enoxaparin daily as

[36] CB, Statement of Dr Nathan Hunter dated 30 December 2020, 43; CF, Medical Records from Alfred Health, 424-5.
[37] CB, Statement of Dr Nathan Hunter dated 30 December 2020, 44; CF, Medical Records from Alfred Health, 353-4.
[38] CB, Statement of Dr Nathan Hunter dated 30 December 2020, 44.
[39] Ibid.
[40] Blood clots in the veins.

pharmacological VTE prophylaxis as per hospital guidelines.[41] On 5 December, clinicians ceased enoxaparin following an episode of haematuria (blood in the urine).[42]

45. On 6 December 2019, the ICU consultant discussed Mr Nioa's progress and management with Ms Schmedje and her sister. The documentation notes that Ms Schmedje was 'very clear' that Mr Nioa 'would not want to end up in a nursing home, and that if he couldn't return to the same quality of life or level of function, he would want to let nature take its course'. The consultant stated that Mr Nioa would die at some stage as a result of this injury. They decided to stop treatment except for Parkinson's medications and pain relief to maintain comfort as well as to refer him to the palliative care team. At this time, Mr Nioa remained confused but was able to communicate with Ms Schmedje. At one stage he stated that 'he really enjoyed the helicopter ride' but did not know where he was or what had happened. [43]

Transfer to Goulbourn Valley Health

46. On 7 December 2019, Mr Nioa was transferred to Shepparton Hospital for continuation of palliative care closer to home to make it easier for Ms Schmedje to visit. Mr Nioa remained comfortable and was able to communicate that he was not in pain.[44]

47. Ms Schmedje was able to talk with Mr Nioa a fair bit but noted that his 'mental state wasn't so good so I didn't go into what had happened to injure him. He was more just needing comfort and peace'.[45]

48. On 9 December 2019, Mr Nioa developed difficulty breathing and had reduced responsiveness. Hospital staff sat Mr Nioa up in bed with the assistance of family members and he eventually stopped breathing and passed away.[46]

Identity of the deceased

49. On 9 December 2019, Daryl William Nioa, born 13 May 1945, was visually identified by his partner, Pamela Schmedje.

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

[41] CF, Medical Records from Alfred Health, 137, 141, 144, 149.
[42] Ibid, 364.
[43] CF, Medical Records from Alfred Health, 326.
[44] CF, Medical Records from Goulburn Valley Health, 47.
[45] CB, Statement of Pamela Schmedje dated 3 Janaury 2020, 15.
[46] CF, Medical Records from Goulburn Valley Health, 47; CB, Statement of Pamela Schmedje, 16.

Medical cause of death

51. Forensic Pathologist Dr Melanie Archer (**Dr Archer**) from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an autopsy on 11 December 2019 and provided a written report of the findings. Dr Archer also reviewed a post-mortem computed tomography (**CT**) scan with accompanying specialist radiology report from Dr Christopher O'Donnell (**Dr O'Donnell**) and referred to the Victoria Police Report of Death (Form 83), e-Medical deposition form, and medical records from Alfred Health, Echuca Regional Health, and Goulburn Valley Health.

52. The autopsy showed pulmonary thromboembolism (**PE**) (blood clot in the lungs) with associated deep vein thrombosis (**DVT**) (blood clot in the deep veins of the legs). The fracture at the level of the 6th and 7th cervical vertebrae was also appreciated at autopsy with evidence of the discectomy and cage fixation.

53. There was no evidence of any other trauma that caused or contributed to death. There was also no evidence of any direct surgical complication relating to operation to stabilise the neck fractures.

54. According to Dr O'Donnell, the mechanism of the neck injury was marked hyperflexion which could have occurred in two ways. First, the head pushed forward from behind causing the neck to bend forwards. Second, impact to the top of the head forcing the neck to bend forwards.

55. Toxicological analysis of a hair specimen detected the presence of 7-aminoclonazepam (a metabolite of the benzodiazepine sedative clonazepam).

56. Dr Archer commented that the main risk factors in this case for PE were a combination of recent trauma and surgery. Dr Archer explained that immobility, trauma, and surgery increase the risk of blood clots and resulted in DVT. When these clots dislodge, they can travel to the lungs causing PE and produce symptoms of chest pain and shortness of breath. In severe cases, as in this case, this results in death due to cardiac and respiratory compromise.

57. Dr Archer provided an opinion that the medical cause of death was 1 (a) pulmonary thromboembolism secondary to deep vein thrombosis in the setting of recent cervical spinal cord injury (operated).

FURTHER INVESTIGATION

Coroners Prevention Unit (CPU) Review[47]

58. In light of the circumstances surrounding Mr Nioa's death, I requested the CPU to review the medical care and treatment provided to Mr Nioa, particularly in the context of the timeliness of the medical response following the incident with the security guards. The CPU reviewed the medical records and CCTV footage from Echuca Hospital as well as the relevant statements in the coronial brief of evidence.

59. The CPU provided an opinion that there was an apparent delay in fully assessing Mr Nioa and then obtaining a CT scan. The CPU commented that it is not possible to know if this contributed to the outcome and that the 'difficult scenario, rural setting, and the limited skills and resources available' may have also contributed to this delay.

60. The CPU noted that the scenario of a trauma patient in a rural health service with a potential cervical spine injury in addition to a behavioural disturbance or altered mental state and a difficult or unreliable examination would make assessment and safe patient management or spinal immobilisation a very challenging scenario, even for senior, experienced ED doctors. The CPU outlined some alternative management choices but ultimately accepted that the ED doctor was best placed to judge this in the circumstances and was not critical of the management choice.

61. On review of the CCTV footage, the CPU notes that there was significant physical interaction between the two security officers and Mr Nioa. While it is difficult to assess the degree of force, the security officers' actions could be the mechanism of Nr Nioa's injuries.

62. The CPU could not comment on the techniques and skills of the security officers but highlighted that in metropolitan centres, a significantly larger team is involved in such incidents to allow for safer immobilisation and restraint when other de-escalation techniques fail. However, the CPU concluded that 'clearly a security team of six or eight members is not an option in a relatively small rural health service'.

[47] The Coroners Prevention Unit (CPU) was established in 2008 to strengthen the prevention role of the coroner. The unit assists the Coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations. The CPU also reviews medical care and treatment in cases referred by the coroner. The CPU is comprised of health professionals with training in a range of areas including medicine, nursing, public health and mental health.

Echuca Regional Health Review

63. ERH performed a Root Cause Analysis (**RCA**) and reported to Safer Care Victoria (**SCV**) as a sentinel event.[48] The findings of the RCA were summarised in a letter to the court dated 3 May 2022 and were:

    a) Demand escalation process triggers were not met which contributed to Mr Nioa not having a medical assessment before the incident with the fire extinguisher; and

    b) A focus on Mr Nioa's mental health assessment and treatment plan and no recognition of his pre-existing vulnerable neck which led to a delay in diagnosis of his spinal injury.

64. The RCA also noted that the position of the fire extinguisher was not ideal and upskilling of security staff around the risks of restraint in elderly or physically vulnerable patients would be of value.

65. The recommendations from the RCA included updating the Demand Escalation Record, reviewing the location of the fire extinguisher, having the fire extinguisher behind a locked cabinet with the key in possession of the duty ANUM at each shift, and providing training for all staff and additional training for security staff on addressing occupational violence, particularly in the context of vulnerable patients.

66. The letter also addressed the missing CCTV footage; the cameras only record when there is motion detected. After consultation with the IT manager, the only explanation was that the movement sensor associated with the camera did not detect movement at these times. The cameras were replaced in mid-2020 and are now configured to record continuously.

Security training

67. During the investigation, one of the security guards expressed concerns about several incidents at ERH that occurred because of a lack of procedures, training, and guidelines for security staff to manage mentally unwell members of the public.[49]

[48] Safer Care Victoria advised the Court via email dated 31 March 2022 that a senior project officer determined that the review of Mr Nioa's case did not meet the criteria for a full Quality Assessment and was therefore not conducted.
[49] CB, Statement of Barry Quinlan dated 12 March 2021, 18.

68. ERH were given the opportunity to respond to these allegations and addressed these concerns in a separate letter dated 5 November 2021.

69. ERH advised that in December 2018, a Security Risk Assessment (**SRA**) was undertaken hospital-wide and following the SRA, an overall Occupational Violence Action Plan for ERH was developed to implement the control measures to minimise or mitigate against all risks. This was supported by separate action plans for specific areas such as the ED. These action plans were made available to all staff.

70. ERH further advised that all new security guards were provided with training including a Job Safety Analysis with competency assessment, shadow shifts with experienced security personnel and training regarding ERH's policies and procedures. All new employees are also provided with task lists for each shift. The ERH also maintains a relationship with Ballarat Health Security to allow for information sharing as to how issues are best managed at other health facilities.

COMMENTS

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

1. The standard of proof for coronial findings of fact is the civil standard of proof on the balance of probabilities, with the Briginshaw gloss or explications.[50]

2. With respect to adverse comments or findings, the effect of the authorities is that they should not be made unless the evidence provides a comfortable level of satisfaction that an individual (or institution) caused or contributed to the death, and in the case of individuals acting in a professional capacity, that they departed materially from the standards of their profession.

3. While I note the CPU's understanding and generous assessment of the medical response, I remain concerned about the lack of consideration for alternative causes that were initially attributed to 'behavioural concerns' as well as the initial apparent heavy-handed response of the security guards.

[50] *Briginshaw v Briginshaw* (1938) 60 CLR 336 at 362-363: '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…'.

4. The evidence suggests that clinicians were 'closed off' to alternatives which impacted physical examination and timely diagnosis. There were several indications that something was not quite right with Mr Nioa after the incident which should have been more fulsomely explored, particularly following review of the footage, and not immediately attributed to 'behavioural concerns.' Many of these indications were documented and escalated by nursing staff throughout the day which did eventually lead to senior medical staff review and investigation.

5. Further, there appears to be an assumption that Mr Nioa would not tolerate a neck collar when a potential cervical spine injury was eventually considered. If there was something more behind the decision to not attempt to place a collar on Mr Nioa, it should have been documented but was not. Whilst acknowledging the benefit of hindsight and the difficulties of the clinical scenario generally, it is important for clinicians to attempt to complete a full examination when the circumstances warrant one, rather than assume that it will not be tolerated or cause escalation in behaviours of concern. The evidence indicates that an earlier full neurological assessment may well have been successful—nursing staff notes clearly document patient concordance with examination and there is no documentation to suggest that there were any difficulties in performing the CT scan or when a neck collar was applied later in the afternoon.

6. Regarding the response from ERH, I caution against having fire extinguishers behind a locked cabinet without a key also attached behind an emergency break glass panel. The balance of allowing immediate access to firefighting equipment and the risk of patients using equipment inappropriately is difficult to strike and I suggest further exploration of this issue.

7. I am satisfied that the explanation for the missing CCTV footage is plausible. The subsequent change from motion sensor activated recording to continuous recording is also beneficial and negates the need for any further recommendations.

8. Many of the pertinent details in the case and clinical reasoning were only appreciable on review of statements from clinical staff and were not included in the clinical notes. It is always worth emphasising the importance of adequate and contemporaneous clinical documentation.

9. Finally, as noted in the Royal Commission into Victoria's Mental Health System (**Royal Commission**), emergency departments can sometimes be less than ideal places for those experiencing mental health issues. Had Mr Nioa been in a low-stimulus environment and separate area, as recommended by the Royal Commission, and not overheard another patients'

distress, then his behaviour may not have escalated leading to him brandishing the fire extinguisher. Unfortunately, a low-stimulus environment was not an option in this case and thus the escalating factor unavoidable.

FINDINGS AND CONCLUSION

1. Pursuant to section 67(1) of the Act I make the following findings:

   a) the identity of the deceased was Daryl William Nioa, born 13 May 1945;

   b) the death occurred on 9 December 2019 at Goulburn Valley Health, Shepparton Public Hospital, 2 Graham Street, Shepparton, Victoria, 3630; and

   c) I accept and adopt the medical cause of death ascribed by Dr Archer and I find that Daryl William Nioa died from pulmonary thromboembolism secondary to deep vein thrombosis in the setting of recent cervical spinal cord injury (operated).

2. Having considered all the evidence, I find that the security guards caused the spinal fractures and other spinal injuries while physically restraining Daryl William Nioa and these injuries are directly related to his subsequent death. Although Daryl William Nioa had mental health problems and had seriously injured one of the security officers, their response appeared to be disproportionate, particularly towards an elderly man of slight build. However, in making this finding I acknowledge that the security guards involved may not have been supported by sufficient training and the benefit of being located at a better equipped metropolitan hospital.

3. I am unable to make a definitive finding on whether the delay in assessment and diagnosis of the cervical spine injuries contributed to the death of Daryl William Nioa. It is possible that the delay resulted in further damage to the spinal cord from further movement of the neck which may have impacted recovery post-surgery. However, it is also possible that this delay made no difference to the outcome at all as the trauma alone may have been sufficient to lead to the death of Daryl William Nioa.

4. I further find that the risk of pulmonary embolism from VTE was adequately managed and the cessation of enoxaparin consistent with best practice and clinical guidelines as well as patient wishes to withdraw medical care.

5. I commend the restorative and preventative measures which Echuca Regional Health has implemented after Daryl William Nioa's death. However, having investigated the circumstances, I find that the weight of the available evidence indicates that Daryl William

Nioa's death in the circumstances of his attendance at the emergency department for issues unrelated to his cause of death, was preventable.

I convey my sincere condolences to Mr Nioa's family for their loss.

Pursuant to section 73(1B) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

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

Pamela Schmedje, Senior Next of Kin

Rose Hopkins, Legal representation for Echuca Hospital

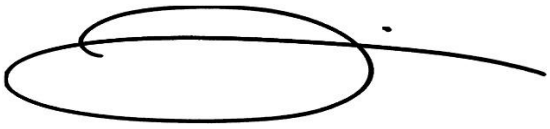
The Alfred Hospital

Goulburn Valley Health

Safer Care Victoria

Leading Senior Constable Jason Hare, Coroner's Investigator

Signature:



AUDREY JAMIESON

CORONER

Date: 19 July 2023

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.