IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2020 001531

FINDING INTO DEATH FOLLOWING INQUEST

Form 37 Rule 63(1)

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

Inquest into the Death of Daylon John Roeton

Findings of:	Coroner Kate Despot
Delivered on:	15 September 2023
Inquest hearing date:	5 September 2023
Appearances:	Mr Gordon Chisholm, Counsel Assisting the Coroner, Ms Ingrid Brent of Counsel, for South West Healthcare
Keywords:	Mental health inpatient facility, involuntary patient, seclusion room

BACKGROUND

1. Mr Daylon John Roeton (Daylon) was 28 years old at the time of his death. Daylon lived in a unit behind his mother, Ms Jennifer Tilley's (Ms Tilley) property in Derrinallum, having moved there about a year ago.[1]

2. Daylon is also survived by his older sister, Jaice. Daylon's father tragically died when Daylon was 2 years of age.[2]

3. Daylon attended Hampton Primary School and Highett High School. Daylon later obtained employment in Colac. Daylon had a history of using alcohol and cannabis since his early adolescence. Ms Tilley stated that while Daylon worked in Colac, she observed that his illicit substance use escalated.

4. Daylon's medical history included insomnia, depression, anxiety, spondyloarthropathy and back pain, for which he was prescribed tramadol.

5. In 2017, Daylon's grandmother passed away, which had a profound impact on Daylon's wellbeing. He later sustained a back injury while at work and experienced discord and estrangement from his friendship group.

6. In 2018, Daylon left his job in Colac and returned to stay with Ms Tilley. She recounted that her son was not drinking at that time but continued using cannabis. The available evidence suggests Daylon made concerted attempts to improve his physical and mental wellbeing with the assistance and support of his. Ms Tilley stated her son's mental health appeared to improve towards the end of 2018, and he was noticeably "*happier and was regularly exercising*".

7. Daylon's wellbeing declined approximately three months before his passing. According to Ms Tilley*, "things went downhill again when [Daylon] went back on Tramadol [painkiller]"* in early 2020. He expressed suicidal ideations and stopped attending his psychologist and other mental health services, reporting a fear that he would be *"locked up."*

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[1] Coronial Brief of Evidence (**CB**), Statement of Mr Allan Woodward, page 44.
[2] CB, Statement of Ms Jennifer Tiller, page 29.

THE CORONIAL INVESTIGATION

Jurisdiction

8. Daylon's death was a *'reportable death'* under section 4 of the Act because it occurred in Victoria, and was considered *'unexpected, unnatural or to have resulted, directly or indirectly, from an accident or injury'*. In addition, immediately before his death, Daylon was a patient within the meaning of the *Mental Health Act 2014* ('**MHA**') and was a *'person placed in custody or care'* as defined by section 3 of the Act immediately before his death.

9. Section 52(2) of the Act provides that a Coroner must hold an inquest into a death if the death or cause of death occurred in Victoria and a Coroner suspects the death was a result of homicide or the deceased was, immediately before death, a person placed in custody or care, or the identity of the deceased is unknown. Given Daylon was a person placed in care – a patient detained in a designated mental health service and subjected to a Temporary Treatment Order, an inquest into his death was mandatory.

Purpose of a coronial investigation

10. The purpose of a coronial investigation of a reportable death[3] is to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.[4] The cause of death refers to the medical cause of death, incorporating where possible the mode or mechanism of death. The circumstances in which a death occurred refers to the context or background and surrounding circumstances but are confined to those circumstances sufficiently proximate and relevant to the death, and not all those circumstances which might form part of a narrative culminating in death.[5]

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[3] The term is exhaustively defined in section 4 of the *Coroners Act 2008* (Vic) ('the Act'). Apart from a jurisdictional nexus with the State of Victoria, a reportable death includes deaths that appear to have been unexpected, unnatural or violent or to have resulted, directly or indirectly, from an accident or injury; and, deaths that occur during or following a medical procedure where the death is or may be causally related to the medical procedure and a registered medical practitioner would not, immediately before the procedure, have reasonably expected the death (section 4(2)(a) and (b) of the Act).

[4] Section 67(1) of the Act.

[5] This is the effect of the authorities – see for example, *Harmsworth v The State Coroner* [1989] VR 989 (***Harmsworth***); *Clancy* v *West* (Unreported 17/08/1994, Supreme Court of Victoria, Harper J).

11. The broader purpose of any coronial investigation is to contribute to the reduction of the number of preventable deaths through the findings of the investigation and the making of recommendations by Coroners, generally referred to as the prevention role.[6]

12. The Coroners Court of Victoria is an inquisitorial jurisdiction.[7] Coroners are not empowered to determine the civil or criminal liability arising from the investigation of a reportable death and are specifically prohibited from including in a finding or comment on any statement that a person is, or may be, guilty of an offence.[8]

13. Coroners are empowered to report to the Attorney-General in relation to a death; to comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice; and to make recommendations to any Minister or public statutory authority on any matter connected with the death, including public health or safety or the administration of justice.[9] These are effectively the vehicles by which the Coroner's prevention role can be advanced.[10]

Standard of proof

14. All coronial findings must be made based on proof of relevant facts on the balance of probabilities. 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.

15. In determining these matters, I am guided by the principles enunciated in *Briginshaw v Briginshaw*. 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.

[6] The 'prevention' role is now explicitly articulated in the Preamble and purposes of the Act, compared with the *Coroners Act 1985* where this role was generally accepted as 'implicit'.
[7] Section 89(4) of the Act.
[8] Section 69(1) of the Act. 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.
[9] *See* sections 72(1), 67(3) and 72(2) of the Act regarding reports, comments and recommendations, respectively.
[10] *See also* sections 73(1) and 72(5), which requires publication of coronial findings, comments and recommendations and responses respectively; sections 72(3) and 72(4), which oblige the recipient of a coronial recommendation to respond within three months, specifying a statement of action which has or will be taken in relation to the recommendation.

16. Proof of facts underpinning a finding that would, or may, have an extremely deleterious effect on a party's character, reputation or employment prospects demands a weight of evidence commensurate with the gravity of the facts sought to be proved. Facts should not be considered to have been proven on the balance of probabilities by inexact proofs, indefinite testimony, or indirect inferences. Rather, such proof should be the result of clear, cogent, or strict proof in the context of a presumption of innocence.

Inquest

17. On 25 November 2022, a Directions Hearing was held in relation this matter. Representatives for Ms Tilley, the Chief Commissioner of Police and South West Healthcare (**SWH**) attended that hearing. Parties were invited to make submissions following the Directions Hearing in relation to the proposed scope of inquest[11]. Submissions were received by the parties and a further Directions Hearing was held on 18 April 2023. I don't propose to summarise all of the submissions received over the course of this matter, however, on 14 June 2023, SWH provided further correspondence to the Court in which they conceded that there were areas of deficiency in Daylon's care and that those deficiencies were causally related to Daylon's passing. SWH further confirmed the remedial and preventative actions which had been implemented as a result of Daylon's passing.

18. Having regard to these matters including the important concessions regarding the deficiencies in Daylon's care made by SWH, I was satisfied that there was sufficient material before me to make findings pursuant to the Act and that the matter could proceed by way of summary inquest and without the calling of witnesses.

19. The summary inquest was conducted on 5 September 2023 with the South West Healthcare[12] (**SWH**) represented by Ms Ingrid Brent of MinterEllison. Daylon's mother, Ms Tilley and Daylon's sister Jaice, attended the inquest in person. Ms Tilley was represented by Ms Ann Cunningham of Grit Legal. Legal representatives for the Chief Commissioner of Victoria Police did not attend the inquest; I excused Victoria Police from attendance on the basis that

[11]The proposed scope for inquest did not include examination at inquest regarding the actions of Victoria Police in apprehending and conveying Daylon to hospital pursuant to section 351 of the MHA on the basis that the available evidence clearly demonstrated that the response of Victoria Police was reasonable, proportionate and appropriate based on the available information and Daylon's presentation at the time of their engagement with him.
[12] Warrnambool Base Hospital is operated by of South West Healthcare.

there was no suggestion that the actions of Victoria Police in respect of their interaction with Daylon in the period proximate to his passing required further inquiry or indeed warranted any criticism.

20. Ms Tilley made a Coronial Impact Statement which was read by her legal representative at the conclusion of the hearing. This statement was deeply moving and emphasised the significant and ongoing impact Daylon's tragic death has had on her and Jaice. I respectfully acknowledge Ms Tilley's courage in preparing this statement and agreeing to having her own words shared in open court. Despite her personal, profound and immeasurable loss, Ms Tilley also compassionately acknowledged in her Coronial Impact Statement the impact Daylon's death would have had on police members and hospital staff.

Sources of evidence

21. This finding draws on the totality of the material obtained in the coronial investigation of Daylon's death: the coronial brief prepared by the nominated Coroner's Investigator, Detective Acting Sergeant Derek Verity[13]; further material obtained by the Court; the transcript of inquest; and the written submissions of filed on behalf of legal representatives for SWH, Ms Tilley and the Chief Commissioner of Police prior to the inquest; as well as closing submissions from the Counsel Assisting.

22. In writing this finding, I do not purport to summarise all the material evidence but refer to it only in such detail as appears warranted by its forensic significance and the interests of narrative clarity. It should not be inferred from the absence of reference to any aspect of the evidence that it has not been considered.

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

Identity of the deceased – Section 67(1)(a) of the Act

23. On 20 March 2020, Daylon was identified via fingerprint identification.

24. Coroner Gebert made a determination pursuant to section 24 of the Act and identified the deceased as Daylon John Roeton, born 3 June 1991.

[13] His rank was Detective Senior Constable at the time of the investigation. I will refer to him as his current rank in this finding.

25. Identity was not in dispute and required no additional investigation.

Cause of death – Section 67(1)(b) of the Act

26. On 19 March 2020, Forensic Pathologist Dr Michael Burke at the Victorian Institute of Forensic Medicine performed an external examination of the body of Daylon John Roeton. Dr Burke reported that the findings were consistent with the reported history as contained in the Victoria Police Report of Death (Form 83), noting that the abraded injury on the neck was consistent with some form of ligature.

27. Routine toxicology analysis of the blood samples revealed the presence of lorazepam, paracetamol, delta-9-tetrahydrocannabinol (**THC**), diazepam and its metabolite, nordiazepam.

28. Taking into account all information available to him, Dr Burke provided an opinion that a reasonable formulation for the cause of death was "1 (a) hanging".

29. I accept and adopt Dr Burke's opinion.

Circumstances in which the death occurred – Section 67(1)(c) of the Act

30. On 16 March 2020 Ms Tilley had become increasingly concerned regarding her son's mental health. She sought advice from Camperdown Mental Health Service (**CMHS**) and was advised to encourage Daylon to present to CMHS for assessment. A verbal disagreement occurred between Ms Tilley and Daylon pertaining to him attending CMHS for assessment.

31. At approximately 10.50am, Daylon left in his vehicle, and Ms Tilley concerned for her son's wellbeing immediately called Victoria Police.

32. Following a job being dispatched via Police Communications at approximately 10:50am, Leading Senior Constable Justin Rasmussen (L/S/C Rasmussen), who was on divisional van duties in the Mortlake area, attended Ms Tilley's home address. L/S/C Rasmussen spoke briefly with Daylon over Ms Tilley's phone and then located Daylon at Derrinallum Park Recreational Reserve.[14]

33. L/S/C Rasmussen observed that Daylon was alone in his car and appeared extremely upset and aggressive. He proceeded to converse with Daylon to determine why he was upset.

[14] Court File (**CF**), Mr Bilal Katar of Moray & Agnew Lawyers dated 11 September 2023.

During their conversation, Daylon expressed suicidal ideations. He also indicated that he had ingested a large amount of paracetamol with alcohol the night before.

34. A second police member attended shortly after to assist L/S/C Rasmussen and they conveyed Daylon under section 351 of the MHA to the Warrnambool Base Hospital ('the hospital') Emergency Department (**ED**) due to his suicidal ideation. While on their way to the hospital, Daylon was depicted in the closed-circuit television (**CCTV**) in the rear of the van removing his shoelaces and trying to place them around his neck. This was immediately responded to by L/S/C Rasmussen.

35. Daylon arrived at the ED and was triaged and was reviewed by a nurse, Ms Chantelle Herbert, at approximately 2.30pm.[15] On review by Ms Herbert, Daylon continued to behave aggressively, and she was unable to establish a rapport with him to engage in further assessment.

36. Ms Herbert consulted psychiatrist Dr Zoran Radovic (Dr Radovic) and noted her plan at the time was to liaise with Camperdown Mental Health Services and Ms Tilley to obtain collateral information.

37. At approximately 4.20pm, Dr Radovic authorised Ms Herbert to place Daylon on an Assessment Order under the MHA due to his significant suicidal risk and in light of his attempt to overdose with paracetamol.

38. At approximately 5.12pm, Daylon was placed on an n-acetylcysteine (**NAC**) infusion to treat paracetamol poisoning. Shortly after, he was examined by medical officer, Dr Ali Haroon. Daylon was observed to be "*on edge and excitable*." Dr Haroon noted Daylon had recently been using methamphetamine and had a recent history of attempting suicide without further plans to do so. Dr Haroon's clinical impression was that Daylon had a paracetamol overdose. The treatment plan was for Daylon to remain in the general ward with one-to-one nursing supervision while waiting for a psychiatric review and undergoing the infusion.

39. Daylon remained in the ED overnight with one-on-one security supervision. While he was reportedly more settled, and cooperative with nursing staff, Daylon was noted to be very

[15] CF, South West Healthcare Clinical Notes, page 1 of 14, page 67.

restless while sleeping. He reportedly told nurse Margaret Smart at midnight that "*he has no wish to continue living*."

40. On 17 March 2020, at approximately 1.00pm, Dr Radovic reviewed and conducted a mental state examination of Daylon. Dr Radovic reported that Daylon was in *"an acutely emotionally disturbed state, with mixed features of depression, anger, irritability, impulsivity [and] anxiety."* Dr Radovic concluded that while *"there were no psychotic features, [Daylon] had reported suicidal ideation on an acute and long term basis."*

41. Dr Radovic formed the diagnostic impression that on top of Cluster B personality traits, Daylon was also facing a situational crisis in the setting of substance abuse and exhibiting post-traumatic stress disorder (**PTSD**) features of unclear origin.

42. Given Daylon's persistent refusal to attend community mental health services, Dr Radovic's treatment plan was to admit him to the hospital's Mental Health Adult Inpatient Unit (**MHAIU**) under the provisions of an Inpatient Temporary Treatment Order[16] (**ITTO**), with an initial admission to the High Dependency Unit (**HDU**) for further assessments.[17]

43. At approximately 5.30pm, while being transferred to the MHAIU, Daylon's behaviour escalated. He became agitated and tore off the intravenous drip on his arm and began verbally abusing security guards and ward staff. A security guard then escorted him to a seclusion room with the company of a nurse.[18] He became more agitated while being physically restrained, requiring the assistance of two additional security guards and two nursing staff to assist. One of the registered nurses (**RNs**), David Carter, administered 10mg of olanzapine orally.

44. During one of his 15-minute intermittent observations, RN Carter reported Daylon remained unsettled and aggressive after he was left alone in the room.

45. According to RN Carter, the two seclusion rooms in the MHAIU are located in the HDU section, nursing staff rostered to work in the HDU would perform an hourly rotation. During

[16] A Temporary Treatment Order (TTO) enables an authorised psychiatrist to provide compulsory treatment to a person to whom the treatment criteria apply. It also enables a patient to be taken and detained and treated in a designated mental health service.
[17] The Assessment Order (AO) would have been revoked at the time as it was officially revoked at 4.20pm on 17 March 2023, which was 24 hours after the AO was made.
[18] According to the available evidence, the seclusion officially commenced at 3:45pm.

those rotations, they must also perform observations at least 15-minute intervals on the patients.

46. The seclusion rooms have a window allowing nursing staff to observe the patient in the seclusion room. There was also a convex mirror in each room to intended to give nursing staff visibility of the rooms and in particular any areas where a patient could not be seen.

47. Upon completing his handover from RN Kaylene Gleeson, who was on the rotation from 6.00pm to 7.00pm, RN Carter completed a visual observation of Daylon at 7.10pm. RN Carter stated:

    At about 19.10 hours [7.10pm] when I became aware that Mr Roeton was standing behind the door in the seclusion room, I was immediately suspicious about what he was doing inside the room. I am always suspicious of patients when they stand near the door because this is a challenging area in the seclusion room to visualise from the outside.

    About 1915 hours [7.15pm], my suspicious about what Mr Roeton was doing escalated as I observed that there had been a change in Mr Roeton's position since my observations of him at 1910 hours. He had moved to the hardest part of the room to see.

    At about 1920 hours [7.20pm] my suspicions about what Mr Roeton was doing escalated to concern for his wellbeing because there was another change in Mr Roeton's position and he did not respond to any of my verbal ques (sic) for a response.

48. RN Carter did not consider calling a Code Grey at this time because he did not consider that calling a Code Grey was the correct option to address the situation at hand: "*I would call a Code Grey in circumstances where a patient was very agitated or violent*." Accordingly, RN Carter contacted the clinical coordinator to request an additional security guard.

49. RN Carter called the clinical coordinator at the main hospital at about 7.22pm and wanted an additional security guard. According to RN Carter the additional security guard came across from the emergency department "arriving in two to three minutes." We had one security guard already, but I did not think that one guard was sufficient to enter the seclusion room given Daylon's previous behaviour."

50. At about 7.28pm RN Carter, RN Lenehan and Security Guards Mr Ahu and Mr Meeks entered the seclusion room.

51. Upon entering the room, RN Carter found Daylon hanging from the door hinge below head height with the edging from a blanket around his neck. A Code Blue was called, and cardiopulmonary resuscitation (**CPR**) was commenced. Unfortunately, Daylon could not be revived. Resuscitation efforts were ceased, and he was declared deceased at 7.55pm.

52. Victoria Police attended the scene and found no suspicious circumstances following their investigation concerning the cause or circumstances leading to Daylon's passing.

SUBSEQUENT ACTIONS

53. Dr Radovic provided a statement to the Court. He stated that the blanket, which was available to Daylon in the seclusion room, was purchased by the hospital on 21 February 2017. The hospital was unable to identify any specific reason as to why it sourced this particular type of blanket. Dr Radovic further advised that the hospital was unable to locate evidence of risk assessments undertaken in relation to the blankets used in the HOU, and the seclusion room.

54. Following Daylon's death, the hospital undertook an investigation and prepared a Root Cause Analysis (**RCA**). Dr Radovic reported that the RCA, identified four root causes as follows:

   a) when additional blankets for use in the seclusion rooms were sourced in 2017, it was not appreciated that the additional blankets had a binding edge (as visually they appeared the same as the original blankets already in use). This resulted in blankets with edge binding being used in the seclusion room. The edge binding on one of these blankets was removed and used as a ligature by Daylon;

   b) multiple modifications had occurred in the MHAIU, including the seclusion rooms, over the preceding years to remove or reduce ligature risks. However, the 'narrow edge' door hinges had not been identified as a potential ligature point in previous ligature audits;

   c) the size and condition of the convex mirror, the location and size of the viewing window, combined with the warm lighting in the seclusion room, affected the clear visibility of the patient in the left corner of the seclusion room. This led to staff being unclear of Daylon's activity and condition; and

d) the delay in interrupting seclusion was based on the need for additional staff to enter the room safely. Factors considered in this decision included Daylon's previous aggression and threatening behaviour and his ongoing agitation displayed whilst in seclusion.

55. According to Dr Radovic, the findings from the RCA resulted in the following recommendations:

a) inspect all blankets used in the MHAIU seclusion rooms to ensure that they are all without edge binding and are in good order;
b) remove and replace internal door hinges in the seclusion rooms;
c) increase visibility from outside the seclusion rooms to maintain a constant clear view of patients in seclusion; and
d) communicate and train medical staff in open disclosure.

EXPERT OPINION

56. Associate Professor Ilan Rauchberger (A/Prof Rauchberger) was engaged by the Court to provide an expert opinion in relation to Daylon's medical management following his admission to Southwest Healthcare Warrnambool Hospital. A/Prof Rauchberger provided a report of his opinion dated 3 June 2021, which included the following opinions:

The appropriateness of the decision to place Daylon into seclusion.

57. A/Prof Rauchberger considered that the decision to place Daylon into seclusion was reasonable based on Daylon's behaviour in that Daylon presented an imminent and serious risk of harm to others at that time, and the use of seclusion was to prevent this imminent risk.

58. A/Prof Rauchberger noted that it was not clear whether less restrictive alternate interventions were considered at the point of seclusion. However, in his opinion, less restrictive interventions were not likely to have been effective and would not be likely to have reduced the imminent risk to others at that point in time.

The quality of the reviews, including the planned medical review and observations.

59. A/Prof Rauchberger reported that the seclusion observations were reasonable in that there was documentation of nursing observation every 15 minutes from 5:45pm to 7:15pm. A/Prof Rauchberger further noted that Daylon continued to present as either aroused or threatening on observations at 6.00pm, 6.15pm and 6.30pm.

60. Having regard to Mr Carter's reported concerns about Daylon's behaviour during seclusion observation at 7.15pm. It was appropriate for him to return to check on Daylon earlier than the planned 15-minute observation at 7.20pm, and the decision to escalate his concern about Daylon's behaviour was reasonable.

61. Further, A/Prof Rauchberger considered that the decision to call for extra security prior to entering the seclusion room was reasonable, given Daylon's presentation that resulted in the use of the seclusion and his behaviour during nursing observations leading up to that point.

The reliance on security guards to enable access to Daylon while in seclusion

62. A/Prof Rauchberger stated that it is reasonable to rely on security guards to support staff in providing clinical care for a patient if there is concern about imminent risk of harm to others. Daylon had presented with significant agitation and aggression in the form of verbal and physical aggression in his encounters with staff prior to and following the use of seclusion. Accordingly, A/Prof Rauchberger considered that it was reasonable for staff to have anticipated that Daylon may continue to present in that manner during the seclusion review. The use of security guards would have potentially mitigated the risk of harm to staff during Daylon's seclusion review.

63. A/Prof Rauchberger noted that the reliance on security led to a short delay in staff accessing Daylon. However, A/Prof Rauchberger considered that in balancing the clinical needs of a patient in seclusion with the risk of harm to others, the decision to rely on security guards to enable access to Daylon's seclusion was reasonable.

64. A/Prof Rauchberger concluded that the care provided to Daylon was reasonable:

    [Daylon]Mr Roeton was assessed by emergency department and psychiatric staff prior to being admitted to the inpatient psychiatry unit. He fulfilled the Mental Health Act criteria to be placed under an Assessment Order and subsequently under an Inpatient Temporary Treatment Order. The decision to admit Mr Roeton to the inpatient psychiatry unit was appropriate given his psychiatric presentation and associated risks.

    The prescription of antipsychotic medication, olanzapine as well as benzodiazepine medication, diazepam and lorazepam were reasonable. The use of these medication was consistent with the Rapid Tranquillisation Guidelines of the service.

In my opinion, the decision to seclude Mr Roeton at 17:45 hours [5.45pm] was reasonable. The relevant Mental Health Act forms were adequately completed in documentation around the use of restrictive intervention and subsequent observations. Documentation suggested that there was no prior opportunity to provide Mr Roeton with copies of the paperwork regarding his rights under the MHA due to his level of disturbance. Documentation suggested that this was going to occur at a later stage, which seems reasonable.

In my opinion, it was reasonable for nursing staff to be concerned about the behaviour of Mr Roeton while he was in seclusion and it was appropriate for nursing staff to arrange for extra security guards and to enter seclusion at the time that they did.

65. A/Prof Rauchberger also considered the prescribing and administrating of sedating medicines to Daylon including an antipsychotic medication, olanzapine as well as benzodiazepine medications, diazepam and lorazepam on a pro re nata[19] (**PRN**) basis. A/Prof Rauchberger stated that the decision to prescribe a sedating antipsychotic such as olanzapine as well as benzodiazepines was reasonable. A/Prof Rauchberger also raised the possibility that given the level of arousal, agitation, and level of aggression that Daylon presented with, it may have been reasonable to prescribe regular doses of olanzapine and benzodiazepines rather than prescribing them on a PRN basis.

66. I accept A/Prof Rauchberger's opinion that the decision to prescribe a sedating antipsychotic to Daylon was reasonable. As to whether it would have been reasonable to prescribe regular doses of medication to Daylon, I do not propose to take this matter any further on the basis that I am unable to conclusively say whether this would have averted Daylon from taking the tragic action that he took in the context of the availability of the ready availability of an item that could be used for self-harm in an environment where his visibility was impaired.

DAYLON'S DEATH WAS A CATALYST FOR CHANGE – SWH RESPONSE

67. In correspondence to the Court SWH conceded that there was a lack of line of sight and visibility over Daylon while he was in the seclusion room and accepted that this was a deficiency causally related to Daylon's passing.

[19] Pro re nata means as needed.

68. In relation to Daylon's access to an in item, namely a blanket, which could be modified and used as a ligature to enable Daylon take his own life (and which is in turn connected to the lack of line of sight and visibility over Daylon as discussed above), SWH accepted that staff could not observe Daylon while he was undertaking this action and SWH accepted that this was a deficiency causal to Daylon's passing as well as being connected to the lack of visibility over him.

69. SWH confirmed that following Daylon's tragic passing, SWH undertook a number of measures with the aim of eliminating the risk of similar deaths and in this regard, Daylon's tragic passing was an important catalyst for change. SWH advised:

a) Since Daylon's passing, SWH has undertaken a replacement of the blankets and the door hinges, the introduction of a large convex mirror, the lighting has been changed (from warm to white light), and a larger viewing window in the door to the seclusion room. A line-of-sight assessment was undertaken after the changes were made, and it determined that all locations within seclusion rooms 1 and 2 were visible by looking through the viewing panels in the doors;

b) SWH has installed piano hinges in the two seclusion rooms and in the high-dependency unit and has scheduled mirror cleaning; and

c) SWH has further implemented changes to the Restrictive Interventions Policy to include a room set-up procedure. This policy requires the use of special seclusion blankets, which must be checked prior to every use for holes and tears that could be used as a potential ligature.

FINDINGS AND CONCLUSION

1. Having applied the applicable standard to the available evidence, I make the following findings pursuant to section 67(1) of the Act:

a) the identity of the deceased is Daylon John Roeton born on 3 June 1991;

b) his death occurred on 17 March 2020, at Warrnambool Base Hospital, 25 Ryot Street, Warrnambool, Victoria, 3289, from hanging in the circumstances where Daylon intended to take his own life; and

c) Daylon's death occurred in the circumstances outlined above.[20]

COMMENTS

1. South West Healthcare has taken remedial actions to address the concerns about Daylon's care and has accepted and conceded the deficiencies in relation to Daylon's care.

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

3. I find that the actions of Victoria Police were reasonable, proportionate and appropriate in the setting of Daylon's presentation at the time of their interaction with him.

4. Daylon died by suicide while in seclusion (a restrictive intervention under the *Mental Health Act 2014* (Vic)) at the South West Healthcare Warrnambool Hospital Mental Health Acute Inpatient Unit and used a ligature made from the binding of a blanket and attached to the seclusion room door hinge.

5. Prior to his hospitalisation, Ms Tilley, gravely concerned for her son's mental state and safety, and took all steps available to her to protect Daylon and render him the assistance he very much needed but was reluctant to seek of his own accord. Having taken these steps, Ms Tilley was entitled to take some comfort that, as an inpatient and under medical care, her son would be safe from harm.

6. Having reviewed all of the available evidence and having had regard to the submissions made by the parties, I find that Daylon's death was preventable and that there were three areas of deficiency in Daylon's care which were causally connected with his death:

    a) Daylon's access to a blanket which was capable of being readily modified and used as a ligature for the purposes of self-harm;

    b) The availability of hinges within the seclusion room, which were ultimately used by Daylon as a ligature point to self-harm; and

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[20] I have made a number of pertinent findings as to the circumstances of Daylon's death throughout this finding based on the weight of the evidence that shall not be repeated here.

c) Restrictions in the line of sight of Daylon while he was in the seclusion room meant that hospital staff were unable to conduct thorough and meaningful visual observations of Daylon at all times.

7. Following Daylon's passing, SWH implemented a number of remedial actions to address these risks and deficiencies in care. I consider that the remedial and preventative actions of SWH are appropriate, and on that basis, I do not intend to make any recommendations for prevention or further remedial actions arising from the circumstances of Daylon's passing.

8. I will now turn to additional matters arising from the expert opinion and submissions from the parties connected with the circumstances of Daylon's passing.

9. I accept the opinion of A/Prof Rauchberger, and I find that the decision to place Daylon into seclusion was reasonable based on his escalating behaviours. The evidence clearly indicates that Daylon was exhibiting significant aggression and challenging behaviours, which put both himself and hospital staff at serious risk of harm.

10. I accept the opinion of A/Prof Rauchberger and find that the frequency of observations while Daylon was in seclusion was reasonable. However, I consider that irrespective of the reasonableness of the <u>frequency</u> of observations, the <u>quality</u> of those observations was effectively impeded by the deficiencies in line-of-sight visibility of Daylon in the seclusion room.

11. I accept the opinion of A/Prof Rauchberger and find that the decision to call for extra security prior to entering the seclusion room was reasonable, given Daylon's presentation and his previous behaviours that resulted in the use of seclusion. I have had careful regard to Ms Tilley's submissions that once Daylon was unable to be seen by hospital staff, <u>immediate</u> steps should have been taken to enter the seclusion room. However, I consider that one of the challenges for hospital staff at this moment is that they could not visually observe Daylon sufficiently to assess what was occurring in the seclusion room properly. Informed by Daylon's previous presentation and behaviours, I consider that hospital staff had an obligation to seek additional security before entering the room in the interests of ensuring the health and safety of both Daylon and hospital staff. Based on the available evidence, the decision to request additional security resulted in a short delay of between two to three minutes. From Ms Tilley's perspective, I acknowledge that this timeframe would seem

unfathomable in the context of the tragic outcome. However, in that precise moment of decision-making and based on the information before them, I consider that hospital staff adopted a risk-informed approach based on the information available and adopted a course that was necessary, reasonable and appropriate.

I convey my sincere condolences to Jennifer, Jaice and Daylon's loved ones for their loss.

PUBLICATION OF FINDING

Pursuant to section 73(1) of the Act, the findings and comments made following an inquest must be made following an inquest must be published on the Internet, I order that this finding to be published on the Coroners Court of Victoria's website.

DISTRIBUTION OF FINDING

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

Ms Ann Cunningham, Grit Legal, on behalf of Ms Jennifer Tilley

Ms Ingrid Brent, MinterEllison, on behalf of South West Healthcare

Mr Bilal Katar, Moray & Agnew Lawyers, on behalf Chief Commissioner of Police

Associate Professor Ilan Rauchberger

Detective Acting Sergeant Derek Verity

Signature:

Coroner Kate Despot

Date: 15 September 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 inquest. 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.