IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2020 1763

FINDING INTO DEATH FOLLOWING INQUEST

Form 37 Rule 63(1)

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

INQUEST INTO THE DEATH OF MATTHEW DONGELMANS

Findings of:	Coroner David Ryan
Delivered on:	22 February 2022
Delivered at:	Coroners Court of Victoria, 65 Kavanagh Street, Southbank, Victoria, 3006
Inquest Hearing Dates:	16 February 2022
Counsel Assisting:	Lindsay Spence Principal In-House Solicitor Coroners Court of Victoria
Family of Matthew Dongelmans:	Heidi Knust
Chief Commissioner of Police:	Sylvia Cecchin Victorian Government Solicitor's Office

I, Coroner David Ryan, having investigated the death of Matthew Dongelmans, and having held an inquest in relation to this death on 16 February 2022 at Melbourne, find that:

- the identity of the deceased was Matthew Lee Dongelmans born on 27 October 1989;
- the death occurred on 29 March 2020 at Footscray Hospital, 160 Gordon Street, Footscray;
- from 1(a) Complications of Methylamphetamine Toxicity

in the following circumstances:

BACKGROUND:

1. Matthew was the youngest of six children born to his mother, Tracey Dongelmans. Little is known in respect of Matthew's upbringing with statements unable to be obtained from direct family members. The Dongelmans family originally lived in the Dimboola township before moving to a property on Coker Dam Road, Lochiel. Matthew's education was inconsistent, with him intermittently attending either the Dimboola Primary School or Horsham Special School.[1]

2. The property at Lochiel was a rundown weatherboard house and adjacent to the house were several small sheds located on approximately fifty hectares of land. Tracey lived at this location with her youngest daughter and during his adult life, Matthew lived there on an intermittent basis. The only stable male figure in Matthew's adult life was Tracey's partner, Terry Biddle, however he left the area approximately five years prior to Matthew's passing.

3. Leading Senior Constable Neil Zippel, Dimboola Police stated that '*on many occasions I had dealings with Matthew while attending the residences of known drug users. On each of these occasions Matthew was observed to be affected by unknown substances and most times incoherent*'. Tracey Dongelmans passed away in 2020 leaving Matthew as the main beneficiary of the estate; however, when the estate was finally settled and all of the mortgages cleared, there were minimal funds remaining.

4. Matthew had been in a de facto relationship with Heidi Knust for approximately twelve months prior to his death.[2]

[1] Statement of Leading Senior Constable Zippel, Inquest Brief, p122.
[2] Statement of Heidi Knust, Inquest Brief, p32.

5. On 21 February 2020, Heidi reported to police that she had been the victim of a family violence incident at her residence where Matthew grabbed her around the throat and applied pressure, before picking up a cushion and attempting to smother her face with it. Matthew then left the premises taking Heidi's mobile phone with him. Heidi was subsequently hospitalised for treatment. Victoria Police applied for an Interim Family Violence Intervention Order that was issued at Magistrates' Court on 2 March 2020.[3] This Interim Order prevented Matthew from contacting or communicating with Heidi by any means, and approaching or remaining within 5 metres of her, or within 200 metres of her residence.[4] Matthew was arrested on 12 March 2020 at which time the Interim Order was served and he was subsequently bailed to appear in the Magistrates' Court on a later date.[5]

THE PURPOSE OF A CORONIAL INVESTIGATION

6. Matthew's death constitutes a '*reportable death*' under the *Coroners Act 2008* (Vic) (**the Act**), as Matthew resided in Victoria and his death appears to have been unnatural and unexpected.[6] Matthew was also immediately before his death a person placed in custody or care[7] and I was therefore required to conduct an inquest into his death pursuant to section 52 of the Act. In the circumstances, I considered it appropriate to hold a summary inquest which occurred on 16 February 2022.

7. At the hearing, a summary of the evidence was provided to the Court by Principal In-House Lawyer, Lindsay Spence. The individual witnesses who provided statements in the brief were not required to give evidence at the inquest as, after carefully considering all of the material in the brief, I was satisfied that there were no factual disputes or controversies which remained unresolved. The Chief Commissioner of Police and Heidi were also given an opportunity to make submissions in relation to the evidence.

8. The jurisdiction of the Coroners Court of Victoria is inquisitorial.[8] The role of the Coroner is to independently investigate reportable deaths to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.[9]

[3] Statement of Heidi Knust, Inquest Brief, p32.
[4] Family Violence Application Interim Order, Case No. K12031035 issued Horsham Magistrates' Court on 2 March 2020.
[5] LEAP – Family Violence IVO Record Enquiry, Inquest Brief, p188; Custody and Attendance History, Inquest Brief, p177.
[6] *Coroners Act 2008*, s4.
[7] *Coroners Act 2008*, s4(2)(c).
[8] *Coroners Act 2008* s 89(4).
[9] *Coroners Act 2008*, preamble and s 67.

Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death.

9. It is not the role of the Coroner to lay or apportion blame, but to establish the facts.[10] It is not the Coroner's role to determine criminal or civil liability arising from the death under investigation,[11] or to determine disciplinary matters.

10. The expression "*cause of death*" refers to the medical cause of death, incorporating where possible, the mode or mechanism of death.

11. For coronial purposes, the phrase "*circumstances in which death occurred*,"[12] refers to the context or background and surrounding circumstances of the death. Rather than being a consideration of all circumstances which might form part of a narrative culminating in the death, it is confined to those circumstances which are sufficiently proximate and causally relevant to the death.

12. 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 Court's "*prevention*" mandate.

13. Coroners are also empowered:

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

    (b) 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

    (c) 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.

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

[10] *Keown v Khan* (1999) 1 VR 69.
[11] *Coroners Act 2008*, s 69 (1).
[12] *Coroners Act 2008*, s 67(1)(c).

15. Victoria Police assigned Detective Sergeant Tony Euvrard to be the Coroner's Investigator for the investigation into Matthew's death. The Coroner's Investigator conducted inquiries on my behalf and submitted a coronial brief of evidence.

16. This Finding draws on the totality of the material obtained in the coronial investigation of Matthew's death, that is, the Court File, the Coronial Brief prepared by the Coroner's Investigator and further material obtained by the Court, together with a transcript of the Inquest hearing.[13]

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

18. In determining these matters, I am guided by the principles enunciated in *Briginshaw v Briginshaw*.[16] 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.

19. 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.[17] 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.[18]

IDENTITY OF THE DECEASED

20. On 31 March 2020, Matthew's body was identified by visual identification by Heidi Knust.[19]

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

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[13] From the commencement of the Act, that is 1 November 2009, access to documents held by the Coroners Court of Victoria is governed by section 115 of the *Coroners Act 2008*.
[14] *Re State Coroner; ex parte Minister for Health* (2009) 261 ALR 152.
[15] *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.
[16] (1938) 60 CLR 336.
[17] *Anderson v Blashki* [1993] 2 VR 89, following *Briginshaw v Briginshaw* (1938) 60 CLR 336.
[18] *Briginshaw v Briginshaw* (1938) 60 CLR 336 at pp 362-3 per Dixon J.
[19] Statement of Identification, Inquest Brief, p189.

MEDICAL CAUSE OF DEATH

22. On 1 April 2020, Dr Gregory Young, Forensic Pathologist at the Victorian Institute of Forensic Medicine (**VIFM**) performed an autopsy upon Matthew's body. In a report dated 7 January 2021, Dr Young made the following comments following autopsy:[20]

    (a) There was widespread evidence of multi-organ failure and sequelae of decreased vascular perfusion in the body, including global cerebral ischaemic injury in the brain, hepatic centrilobular necrosis, pleural effusions, small bowel ischaemia and large bowel infarction.

    (b) Ante mortem blood samples showed the presence of methylamphetamine (~3.4mg/L), amphetamine (~0.2mg/L) and midazolam (~0.2mg/L). Based on the blood level of methylamphetamine, it is not possible to determine how much had been consumed, or when it had been consumed. Ethanol and novel psychoactive substances were not detected in the blood.

    (c) Hair collected at the time of autopsy showed the presence of methylamphetamine, amphetamine and midazolam, in a length that correlated to an approximate timeframe of 29 November 2019 to 29 March 2020.

    (d) The toxicology results indicated both acute and chronic methylamphetamine consumption.

    (e) Matthew's symptoms of chest pain, twitching eyes and sweating, and signs of tachycardia, hypertension and hyperthermia, are in keeping with acute methylamphetamine toxicity. Acute methylamphetamine use may also be associated with cardiac arrhythmias, coronary artery vasospasm, circulatory collapse, and acute coronary syndromes, leading to decreased vascular perfusion and eventual multi-organ failure. Left ventricular hypertrophy and accelerated coronary artery atherosclerosis may be seen in the setting of chronic methylamphetamine use.

    (f) The external injuries seen to Matthew (bruises and abrasions to multiple planes of the body) have, by definition, been caused by blunt force trauma. While none of the observed injuries have clearly caused death, any of them may have involved Matthew coming in contact with another surface, implement or person. The distribution of

[20] Statement of Forensic Pathologist Dr Young, Inquest Brief, pp100-101.

injuries does not allow one to favour any particular mechanism over another. However, there were no patterned injuries to suggest any specific implement. Similarly, the cause of the bruising to the scrotum, associated with testicular haemorrhage, could not be determined with any certainty, but the location of these injuries is unusual, given the relatively protected nature of this part of the body.

23. Dr Young formulated the cause of death as:

    1(a) Complications of methylamphetamine toxicity.

24. I accept Dr Young's opinion.

CIRCUMSTANCES IN WHICH THE DEATH OCCURRED

25. On Thursday 26 March 2020 Matthew, Heidi and a mutual friend known as 'Roony' were at Heidi's residence in Horsham. In the afternoon, Heidi left to visit her daughter.[21]

26. That afternoon, Leading Senior Constable Parkinson (**LSC Parkinson**) and Constable Hew (**Cst Hew**) were performing general patrol duties in a police divisional van in the Horsham area. At 3.43pm they observed Heidi in Harriett Street and stopped to speak with her as they had received information that Matthew had been staying at Heidi's residence in contravention of both the Intervention Order and bail conditions.[22] The entire interaction with Heidi was captured on the Officers' Body-Worn Cameras (**BWC**)[23] and lasted for approximately three minutes.

27. I have viewed the entirety of the BWC footage which discloses that LSC Parkinson initially enquired as to whether Heidi had seen Matthew to which she replied that it had been approximately three and a half weeks since she had seen him. When questioned whether Matthew was at her house, Heidi replied '*I haven't seen him*'. It is evident that Heidi becomes agitated when LSC Parkinson asks whether it is possible to meet Heidi back at her house '*to have a look through and make sure he's not hiding there*' to which Heidi replies '*I seriously have not seen or heard from him*'.

[21] Statement of Heidi Knust, Inquest Brief, p33.
[22] Statement of Leading Senior Constable Parkinson, Inquest Brief, p35.
[23] Inquest Brief Exhibit #1, BWC footage of LSC Parkinson.

28. LSC Parkinson then indicates to Heidi that under the *Family Violence Protection Act 2008*, they are empowered to enter and search premises in circumstances where they believe an offence is being committed, in these circumstances being breach of a current Intervention Order. Later in the conversation, Heidi indicated to LSC Parkinson that Matthew is not permitted under his bail conditions to be in Horsham. At the conclusion of the conversation LSC Parkinson and Cst Hew departed in their divisional van and drive to Heidi's residence, while enroute LSC Parkinson commented '*she'll be fucking ringing him*'. LSC Parkinson then drove for about fifteen seconds down the street to Heidi's residence and kept his BWC continually activated and recording.

29. On arrival at Heidi's residence, Cst Hew attended at the rear of the premises while LSC Parkinson attended at the front door where he was met by a male, Aaron Grambeau.[24] LSC Parkinson had a brief conversation with Aaron who indicated that he had not seen Matthew and that he was not inside the residence. LSC Parkinson then indicated to Aaron that under the Family Violence Act he had the power to enter and search.

30. LSC Parkinson entered the premises searching for Matthew and repeatedly called out his name as he searched the house. Upon entering and searching the main bedroom that had the door closed, light off and blinds drawn, Matthew was located hiding underneath the bed.[25] LSC Parkinson directed Matthew to get out from underneath the bed '*otherwise I'm going to spray you'.* He then told Matthew, '*I want you to stand up against the wall with your hands behind your back*'.

31. Matthew complied with LSC Parkinson's directions, removing himself from underneath the bed and standing against the far wall with his hands behind his back. At LSC Parkinson's direction, he then walked backwards towards the bedroom door while LSC Parkinson placed him under arrest for '*breach of Intervention Order and breach of bail*'. LSC Parkinson then cautioned Matthew and while he was applying handcuffs Heidi returned to the premises. Heidi appeared to be in a very distressed state and repeatedly verbally abused both LSC Parkinson and Cst Hew during this interaction.

[24] Statement of Leading Senior Constable Parkinson, Inquest Brief, p35; On 1 April 2020 Detectives from the Horsham CIU attended at Grambeau's address where they were informed that he was unwilling to assist with any police enquiries, Inquest Brief, p134.
[25] Statement of Leading Senior Constable Parkinson, Inquest Brief, p36.

32. While LSC Parkinson was leading Matthew to the divisional van, Heidi attempted to impede their passage and hugged Matthew before she was removed by Cst Hew. At the rear of the divisional van Matthew was searched and his pockets were emptied by LSC Parkinson with a number of items being removed and handed to Heidi including cigarettes, a paper item and a mobile phone. Heidi continued to address the Officers throughout the search saying, '*arrest me, arrest me, arrest me, go, go, least I'll be with my man hey*'. Matthew was clearly upset at being arrested and said as he entered the divisional van '*I'm not going to get out*'. While LSC Parkinson conversed with Heidi, Matthew could be heard yelling out from the rear of the divisional van although it is not possible to determine what he was saying.

33. Matthew's transport in the custody area of the divisional van from Heidi's address to Horsham Police Station[26] was captured on the vehicle's closed-circuit television (**CCTV**) system[27] and lasts for approximately four minutes (3.53pm 31sec – 3.57pm 30sec). The divisional van CCTV was activated manually by one of the Officers, although LSC Parkinson in a supplementary statement was unable to recall who had activated the CCTV.[28]

34. I have viewed the entirety of the CCTV from the Horsham divisional van and it is unremarkable. It shows Matthew for the entire journey sitting calmly within the custody vehicle pod, hands handcuffed behind his back. There is no evidence of any erratic or provocative driving from LSC Parkinson. Upon arrival at Horsham Police Station, Matthew exits the divisional van with minimal assistance and there is nothing in Matthew's behaviour or demeanour within that footage that is concerning, or which suggests that Matthew was suffering any form of medical condition.

35. Matthew's arrival and a significant amount of his time within Horsham Police Station was captured on various CCTV cameras located within the premises.

36. I have viewed the entirety of the CCTV Files 'Export_Sallyport Rear' and 'Export_Sallyport Front' (both duration 4min 01sec) and it shows the Horsham Divisional Van drive into the custody garage and a short time later Matthew exiting with minimal assistance and being led, handcuffed into the custody corridor. Again there is nothing within Matthew's behaviour or demeanour within that footage that is concerning, or which suggests that Matthew was suffering any form of medical condition.

[26] Statement of Leading Senior Constable Parkinson, Inquest Brief, p36.
[27] Inquest Brief Exhibit #2, Horsham Divisional Van Footage.
[28] Statement of Leading Senior Constable Parkinson, Inquest Brief, p388.

37. Upon arrival at the Horsham Police Station, Police Custody Officer (**PCO**) Lia Landrigan asked Matthew the initial attendance questions and entered the responses into the computer system. In PCO Landrigan's opinion:

> '*Matthew presented at the custody counter exhibiting typical behavioural traits which I had observed on many previous dealings with him in custody. These behaviours included slurred speech, becoming emotional, excessive anxiety and acting in a vague manner. Matthew was upset and crying but I was able to understand what he was saying*'.[29]

38. The relevant Attendance Summary[30] noted in response to the question '*Was the attendee affected by alcohol/drugs at the time of the offence?'* with the response recorded '*No'*.

39. I have viewed the entirety of the CCTV File 'Export_Custody Coridoor 2_Thursday March 26 2020212240 7ecc288' (duration 7min 00sec) that shows Matthew being led from the custody garage into the custody corridor where Matthew's handcuffs are removed and he is entered into custody. Matthew is seen to have a conversation with PCO Landrigan through an open sliding window, at one point being handed a pair of black gloves that he puts on, at another point signing some paperwork. At the conclusion of the custody entry process Matthew then follows Cst Hew through a doorway on the far right-hand side of the corridor into the police interview room. While Matthew appeared to be visibly upset and agitated a number of times during the seven-minute period, there is nothing within Matthew's behaviour or demeanour that that suggests he was experiencing a medical episode.

40. At approximately 4.08pm, Acting Sergeant David Gaw attended the custody area and conducted an Initial Supervisor Check with Matthew. In A/Sergeant Gaw's opinion '*Matthew appeared quiet but was able to answer questions. He then became visibly upset due to being arrested*'.[31]

[29] Statement of PCO Landrigan, Inquest Brief, p58.
[30] VPR0005a – Attendance Summary, Matthew Dongelmans, Horsham Police Station, 26/03/2020, Inquest Brief, p142.
[31] Statement of A/Sergeant Gaw, Inquest Brief, p55.

41. At approximately 4.10pm, Matthew was taken to the interview room escorted by Cst Hew and PCO Landrigan provided Matthew with a coffee.[32] Cst Hew stated:

> '*Dongelmans was taken to the interview room by me after he provided his details to the Police Custody Officer Landrigan. I sat with Dongelmans in the interview room whilst LSC Parkinson had prepared materials for the interview. PCO Landrigan came into the interview room a short time later to pass Dongelmans a drink. I had sat across the table with Dongelmans whilst he was in the interview room. Aside from the drink PCO Landrigan gave Dongelmans, he did not eat anything or drink anything during my whole interaction with Dongelmans'*.[33]

42. At approximately 4.13pm, LSC Parkinson contacted Christopher Harrison, the Aboriginal Community Justice Panel (**ACJP**) Wimmera Chair in respect of Matthew's arrest.[34] LSC Parkinson informed Christopher that this was the first time in his dealings with Matthew that he had identified as an Aboriginal/Torres Strait Islander.[35] Mr Harrison then had a conversation with Matthew between approximately 4.20pm-4.35pm[36] at the custody counter regarding the circumstances of how Matthew had come to be arrested. Mr Harrison asked Matthew whether there were any family that he could contact, with Matthew stating, '*he had no family around and had not been in contact with them for years as of stuff that was done when he was younger*'.[37]

43. Mr Harrison then asked Matthew if he had any medical conditions with Matthew informing him that he had '*high blood pressure, the runs and a running nose. Matthew stated he had mental health but is trying to get linked with a service*'.[38] At the conclusion of the call, Mr Harrison spoke with LSC Parkinson and requested that he be informed of the outcome of the bail justice hearing. Further, Mr Harrison outlined Matthew's symptoms as disclosed over the phone to LSC Parkinson.[39] After Matthew's passing, there were further discussions between Mr Harrison and the Koori Liaison Unit of this Court after which it was concluded that he was not Indigenous.

[32] Statement of PCO Landrigan, Inquest Brief, p58.
[33] Statement of Constable Hew, Inquest Brief, p390.
[34] Statement of Christopher Harrison, Inquest Brief, p45.
[35] Statement of Christopher Harrison, Inquest Brief, p46.
[36] Statement of PCO Landrigan, Inquest Brief, p59.
[37] Statement of Christopher Harrison, Inquest Brief, p47.
[38] Statement of Christopher Harrison, Inquest Brief, p47.
[39] Statement of Christopher Harrison, Inquest Brief, p48.

44. Between 4.41pm and 5.05pm, Matthew was interviewed by LSC Parkinson with Cst Hew corroborating, the entire interview being video recorded.[40] At 4.44pm while the interview preliminaries were being conducted, Matthew stated, '*um, I feel that crook, I really do*' although in the ensuing interview he repeatedly stated that he had been feeling unwell since at least his arrival in Horsham the previous day. Towards the end of the interview at 5.04pm Matthew stated '*I just want to go down to the hospital and get some help, like that's what I came down here [to Horsham] for … … I just feel that crook, I just want to go see the doctor, I just want to go see the hospital … … I just want to go see the doctor mate*'.

45. I have viewed the entirety of the record of interview which shows Matthew participating in the interview, being able to rationally answer and respond to questions and being compliant. Apart from Matthew indicating that he felt unwell there is nothing within Matthew's behaviour, demeanour or appearance that would suggest that he was suffering any form of medical condition.

46. Matthew again stated that he did not feel well and when questioned further indicated that the discomfort he was experiencing was that his heart was racing.[41] At approximately 5.22pm, A/Sergeant Gaw attended the interview room and had a conversation with Matthew who stated '*I'm not feeling too well … … I have some chest pain. Just not feeling well*'.[42] A/Sergeant Gaw observed that '*Matthew's eyes had become glazed over and they were darting left and right rapidly*'.[43] Minutes later PCO Landrigan spoke with Matthew and noticed that '*his eyes were twitching from side to side uncontrollably and he was becoming quite agitated*'.[44] PCO Landrigan asked Matthew whether he had taken any drugs and Matthew replied that he had not.[45]

47. Matthew was then placed in a police cell[46] with arrangements made for paramedics from Ambulance Victoria to attend and assess him.

48. I have viewed the CCTV File 'Export_Female Exercise Yard Int 1' (relevant time period 00:50-01:10) that shows Matthew being led by Cst Hew, A/Sergeant Gaw and PCO Landrigan down a corridor and directly into a cell.

[40] Statement of Leading Senior Constable Parkinson, Inquest Brief, p36; Inquest Brief Exhibit #7, Victoria Police Record of Interview.
[41] Statement of First Constable Hew, Inquest Brief, p41.
[42] Statement of A/Sergeant Gaw, Inquest Brief, p55.
[43] Statement of A/Sergeant Gaw, Inquest Brief, p55.
[44] Statement of PCO Landrigan, Inquest Brief, p59.
[45] Statement of PCO Landrigan, Inquest Brief, p59.
[46] Statement of Leading Senior Constable Parkinson, Inquest Brief, p36.

49. I have viewed the entirety of the CCTV File 'Export_Female Cell' (duration 1hr 5mins 1sec) that shows Matthew entering the cell at timestamp 1min 06sec with Cst Hew and A/Sergeant Gaw. Matthew is then requested to remove all items of clothing and over an approximate three-minute period up to timestamp 4min 00sec, Matthew is seen to remove his shirt, socks, trackpants and underwear with all items being searched by the two Officers. Matthew then re-dresses himself with all of his clothing excluding socks. During the re-dressing process and once Matthew is wearing his underwear and trackpants, PCO Landrigan enters the cell and asks Matthew a number of questions, making notations on a notepad. A/Sergeant Gaw stated that '*at this point Matthew became unsteady on his feet at times. His right leg and foot became uncontrollably twitchy and his speech became harder to understand*'.[47]

50. PCO Landrigan noted that while conducting the Detainee Risk Assessment that:

> '*Matthew was still unsteady on his feet so he was asked to sit. His left leg was twitching uncontrollably, he was starting to sweat, and his speech was becoming harder to understand. He indicated that he had chest pain. Against he was asked whether he had taken any drugs and again, he stated that he hadn't*'.[48]

The Detainee Risk Assessment notes that Matthew denied either recent drug use or being in possession of any prohibited articles, including illicit drugs.[49]

51. At timestamp 10min 25sec on the CCTV footage, Matthew upon request removes the pair of black gloves that he was provided in the custody corridor and the police members then depart the cell at timestamp 10min 48sec leaving the cell door open and with a mattress in the cell.

52. After the police members departed the cell leaving Matthew alone, he walked over and had a drink and then used the urinal. At various stages as seen in the ensuing footage, Matthew paces around the cell for a period of time, lies down or sits upon the mattress, rests on the cell wall or stretches. At timestamp 16min 57sec, Matthew's legs are seen to shake uncontrollably for a short period of time however that appears to resolve when he uncrosses his legs and then grabs hold of his left leg. At various stages Matthew exits and then re-enters the cell,[50] and is seen to wet his hands and then run them over his face, head, neck and the top of his shoulders.

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[47] Statement of A/Sergeant Gaw, Inquest Brief, p56.
[48] Statement of PCO Landrigan, Inquest Brief, p59.
[49] Detainee Risk Assessment, Matthew Dongelmans, Horsham Police Station, 26/03/2020, Inquest Brief, p143.
[50] At timestamp 22min 25sec Matthew walks out of the cell, reappears briefly at 26min 25sec, re-enters the cell at 26min 40sec, takes his shirt off at 27min 00sec, exits the cell at 30min 15sec, re-enters at 30min 43sec, exits at 31min 08sec, re-enters at 33min 56sec, exits at 34min 34sec, reappears briefly at 36min 33sec, re-enters at 36min 54sec, exits at 38min 30sec, re-enters at 39min 34sec.

53. Upon exiting the cells, PCO Landrigan contacted the Custodial Health Advice Line (**CHAL**) due to her concerns in respect of Matthew's condition[51] and spoke with Custodial Nurse Taylor Davies at 5.46pm.[52] Custodial Nurse Davies stated that:

> '*Matthew was known to Custodial Health Services due to being a recidivist offender. Previously when he has come into police custody, he was usually either ice-affected or disclosed that he used ice*'.[53]

54. Custodial Nurse Davies opined that:

> '*on this occasion, most of these symptoms [pacing, erratic, heart racing, eyes unfocused and darting] could be attributed to being acutely ice-affected but the Person In Custody was denying any recent illicit substance use. However it seemed that Matthew had deteriorated quickly since police interviewed him that afternoon*'.[54]

55. As a result of that conversation, PCO Landrigan telephoned for an ambulance at approximately 5.51pm.[55]

56. Paramedic Emma Clark and Graduate Paramedic Sophie Antonello from Ambulance Victoria arrived at Horsham Police Station at 5.57pm and were escorted to the police cells where Matthew was observed to be profusely sweating, agitated and fidgety.[56] On examination Matthew was found to be confused, with a high heart rate, high blood pressure, high respiratory rate and slurred speech.[57] Matthew denied any drug use to the paramedics,[58] however police informed them that Matthew had a significant drug history.[59]

[51] Statement of PCO Landrigan, Inquest Brief, p59.
[52] Statement of Custodial Nurse Taylor Davies, Inquest Brief, p61.
[53] Statement of Custodial Nurse Taylor Davies, Inquest Brief, p61.
[54] Statement of Custodial Nurse Taylor Davies, Inquest Brief, p61.
[55] VACIS electronic Patient Care Record, Inquest Brief, p154.
[56] Statement of Paramedic Clark, Inquest Brief, p64.
[57] Statement of Paramedic Clark, Inquest Brief, p64.
[58] Statement of Paramedic Clark, Inquest Brief, p64; Statement of Paramedic Antonello, Inquest Brief, p66.
[59] Statement of Paramedic Clark, Inquest Brief, p64.

57. A/Sergeant Gaw and PCO Landrigan during this time observed that Matthew began to sweat profusely and the twitching in his leg became a lot worse.[60] At 6.28pm, Matthew was administered 10mg intramuscular midazolam for agitation and at 6.34pm Matthew was conveyed by ambulance to the Wimmera Base Hospital.[61] Matthew was accompanied by Cst Hew in the rear of the ambulance as he remained under police custody, while LSC Parkinson followed in the divisional van and attended the Wimmera Base Hospital.[62]

58. Ambulance Victoria arrived at Wimmera Base Hospital at 6.37pm, and Matthew was triaged at 6.40pm and handed over to hospital staff at 7.01pm.[63] Paramedic Clark provided a verbal handover to Manjusha Nair, Associate Nurse Unit Manager (**ANUM**) at the Emergency Department (**ED**) who made the following notations:

> '*complaining of palpitations and chest pain. Agitated. Shakey. Sweaty. At a friends' place today, had a ?spike coffee. Confused. GCS 13. Pupils dilated. Weird movements of arms. Chewing a lot. Hx of drug use. Vital signs: HR148. RR24. SpO2 93% on room air. BPO 153/73. Temp 35.8. BSL 7.7 GCS13'*.[64]

Matthew was assessed as a triage category 2 and remained on the ambulance trolley until one of the eight ED beds became available.

59. At the same time as Matthew's admission, ED staff were treating a patient suffering from diabetic ketoacidosis for admission to the Intensive care Unit (**ICU**) who due to presenting symptoms was being treated as a possible COVID-19 case (noting March 2020 was the onset of the COVID-19 pandemic within Australia). That patient required assistance with breathing firstly using a BiPAP machine and subsequently via intubation. This resulted in the After-Hours Coordinator, Nerida Patterson, contacting infection control to obtain assistance and advice in respect of all staff who had been within the resuscitation bay treating this patient and their possible exposure to a suspected COVID-19 case.[65] This complication in intubating a suspected COVID-19 case, and the associated issues surrounding decontamination and infection control, unexpectedly consumed significant staff within the ED for a substantial period of time.

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[60] Statement of A/Sergeant Gaw, Inquest Brief, p56; [60] Statement of PCO Landrigan, Inquest Brief, p60.
[61] Statement of Paramedic Clark, Inquest Brief, p64(a).
[62] Statement of First Constable Hew, Inquest Brief, p41; Statement of Leading Senior Constable Parkinson, Inquest Brief, p36.
[63] Statement of Paramedic Clark, Inquest Brief, p64(a).
[64] Statement of Manjusha Nair, Inquest Brief, p79.
[65] Statement of Nerida Patterson, Inquest Brief, pp81-82.

60. At 7.35pm, RN Vicki Yann-Mintern cannulated Matthew in the right cubital fossa and collected a blood sample for pathology.[66]

61. Approximately an hour later, Paramedic Clark returned to Wimmera Base Hospital transporting a patient from an unrelated matter and while there was approached by either LSC Parkinson or Cst Hew who expressed concerns in respect of Matthew stating he had not improved. Paramedic Clark went and observed Matthew who was:

> *'…seen to be pulling against his hand restraints, extremely diaphoretic, significantly agitated, had his legs up the wall, no monitoring on patient and no nurse in attendance. I looked at the patient's paperwork, he had had only one set of observations documented at ~1905hrs which was just after we had handed the patient over (approximately one hour ago) … … I went and spoke to Nurse – Nerida and asked if the patient could be reviewed by the doctor as I had concerns … … at ~2015hr a male doctor approached me and asked what my concerns were … … I explained that the patient had been tachycardic, hypertensive, tachypnoeic and GCS of 14 confused then to 13 with eyes closed following our midazolam whilst in the care of AV. I communicated that I was concerned that he may also become hypoglycaemic and hyperthermic.*
>
> *I stated that the patient's agitation had escalated since he was off stretcher with AV. We discussed that I was unsure of the cause of the patient's presentation as he was confused and unable to give us more detail into the events leading up to AV being called however, all I knew from the police was that he had a significant drug history of methamphetamines … … the same male doctor approached me ~10 minutes later with another female doctor again wanting to discuss the patient. I had a similar conversation as written above highlighting my concerns for the patient and his need for assessment and management*'.[67]

62. Ms Patterson then attended to review Matthew followed by both intern Dr Wong and medical registrar Dr Lee. It was not possible to gain a full set of observations or perform an electrocardiogram (**ECG**) on Matthew due to his level of agitation. A further dosage of midazolam was ordered; however, before it could be given, Matthew had to have his

[66] Statement of Vicki Yann-Mintern, Inquest Brief, p85.
[67] Statement of Paramedic Clark, Inquest Brief, p64.

intravenous cannula reinserted as he had dislodged one inserted earlier. Two ED nurses re-cannulated Matthew and the midazolam was administered at about 8.45pm.[68]

63. At approximately 9.10pm, it was observed that Matthew's condition had deteriorated further with his GCS[69] 3 and oxygen saturation 90% on room air. RN Vicky Yann-Mintern applied a Hudson mask and then attempted to insert an oropharyngeal airway, however was unable to do so due to Matthew clenching his jaw. Matthew's blood pressure had dropped to 80/50, temperature was 42ºC and his heart rate was in the 130s.[70] Senior Medical Officer Dr Thet then reviewed Matthew and it was determined that his ECG showed wide complex tachycardia with his heart rate increased to 160bpm resulting in defibrillations being performed. Matthew was subsequently sedated and intubated.[71]

64. At approximately 12.30am the following morning, Paramedics Clark and Antonello transferred Matthew from Wimmera Base Hospital to the Horsham Airfield for transfer to Footscray Hospital via Adult Retrieval Victoria (Ambulance Victoria).

65. At approximately 11.45am on Friday 27 March 2020, Acting Sergeant Adam Rabone and Sergeant Leanne Rivette attended Heidi's premises to notify her in respect of the deterioration in Matthew's condition and to ascertain any relevant medical information that may be of assistance to medical staff. The entire interaction between Heidi and Sergeants Rabone and Rivette was captured on BWC[72] and I have reviewed the entirety of that footage (duration 56min 12sec).

66. During that conversation Heidi repeatedly stated that, to her knowledge, Matthew had not consumed any drugs at her premises. Heidi indicated that in terms of Matthew suffering from any medical conditions, the only thing she was able to identify was that he was complaining of being '*really tired, really stressed and his breathing has been playing up a bit, don't' know if it's asthma or from the stress*' however he was not on any medication.

[68] Statement of Nerida Patterson, Inquest Brief, pp82-83.
[69] The Glasgow Coma Scale (**GCS**) is a neurological scoring system used to assess conscious level. The GCS is comprised of three categories; best eye response, best vocal response and best motor response. The GCS is scored out of 15, with a score of 15 indicating a normal level of consciousness.
[70] Statement of Vicki Yann-Mintern, Inquest Brief, p86.
[71] Statement of Vicki Yann-Mintern, Inquest Brief, p87.
[72] Inquest Brief Exhibit #14, BWC Footage of Sergeant Rivette.

67. Further, Heidi alleged that:

> '*when the police were here [yesterday afternoon] they full on threw him into the cupboard and the bedroom door and then threw him in the back of the police car … … the way they treated him yesterday was wrong, I'm actually waiting on a call back from the Police Ombudsman and a few other people about it*'[73].

68. Heidi was provided with the contact details of Dr Malcolm Moss at Footscray Hospital to urgently contact to discuss Matthew's condition and Heidi made this telephone call in the presence of Sergeants Rabone and Rivette. In that telephone call, Heidi provided no additional probative information that had not already been disclosed to Officers in respect of identifying the cause of Matthew's deterioration.

69. Following the departure of Sergeants Rabone and Rivette, Heidi made arrangements to travel to Melbourne. Sometime later she left her premises and attended the bus stop at Roberts Avenue, Horsham to catch the V-Line bus to Ballarat. While Heidi was waiting for the bus, 'Roony' walked by and in the conversation that followed, 'Roony' told Heidi that after she had left her premises the previous day, Matthew had told him that he had an eight-ball of 'ice' (methylamphetamine) in his pocket.[74] Heidi subsequently telephoned Horsham Police Station approximately 2.30pm and conveyed this information to First Constable Hoffman who was performing watchhouse duties.[75] This information in respect of Matthew's suspected drug possession was later provided to the treating ICU Specialists at Footscray Hospital.[76]

70. Matthew was admitted to the ICU of Footscray Hospital at 4.22am on 27 March 2020 presenting with a suspected drug overdose complicated by severe multi-organ failure and likely severe hypoxic brain injury. Matthew's clinical presentation was suggestive of multi-organ failure from overdose of sympathomimetic agents (for example methamphetamine). A computed tomography (**CT**) brain scan confirmed signs of global hypoxic brain injury and Matthew received mechanical ventilation, dialysis and cardiovascular support and intravenous fluids. His condition was complicated by multi-organ failure including acute kidney injury, ischemic hepatitis, rhabdomyolysis and severe shock.

[73] Inquest Brief Exhibit #14, Body Worn Camera Footage of Sergeant Rivette, Timestamp 11:40+.
[74] Statement of Heidi Knust, Inquest Brief, p33.
[75] Statement of First Constable Hoffman, Inquest Brief, p69.
[76] Statement of Dr Sathyajith Koottayi, Inquest Brief, p89.

71. Late on 28 March 2020 and early the following morning, Matthew's neurological state deteriorated further and, despite multiple supports, his organ function continued to deteriorate and he passed away at 8.55pm on 29 March 2020.[77]

Assault allegations against Victoria Police

72. I refer to the allegations made by Heidi in which she alleges that members of Victoria Police assaulted Matthew at the time of his arrest (see paragraph 67 above). Ms Knust also repeated her allegations at the inquest.

73. I have reviewed the entirety of the BWC footage of LSC Parkinson and the allegations made by Heidi are not supported by what is seen in this footage. Matthew is at all times compliant with the requests made by LSC Parkinson, and there is no evidence that Police Officers engaged in the conduct alleged by Heidi. The circumstances of the arrest were clearly distressing for both Heidi and Matthew but I am satisfied that LSC Parkinson and Cst Hew behaved with professionalism and restraint in a dynamic and heightened situation.

74. I also note that the Custody Attendance Summary in respect of Matthew's arrest and arrival at Horsham Police Station notes that at 4.00pm an arrival check was undertaken with the following notation '*Injuries – Nil Stated – Nil Apparent*', while at 4.30pm an initial supervisor check was undertaken noting '*no visible signs of injury, no complaints*'.[78] There are also no signs of injury that can be seen in the CCTV footage obtained from the Horsham Police Station.

Alleged failure by Victoria Police to perform a search at the time of arrest

75. On 31 March 2020, Heidi sent email correspondence to Coronial Admission Enquiries (**CA&E**) at VIFM in which she stated '*they [the police] also never searched him … … I strongly believe that if the police and the hospital had of done their jobs properly that Matthew would still be here today*'.

76. Neither LSC Parkinson nor Cst Hew within their statements explicitly reference the search undertaken of Matthew during the arrest process. LSC Parkinson stated: '*I arrested and handcuffed him … … Dongelmans was placed in the rear of the divisional van and transported back to the Horsham Police Station*'[79] while Cst Hew stated '*Dongelmans was compliant with*

[77] Statement of Dr Sathyajith Koottayi, Inquest Brief, pp88-92.
[78] VPR0005a – Attendance Summary, Matthew Dongelmans, Horsham Police Station, 26 March 2020, Inquest Brief, p142.
[79] Statement of LSC Parkinson, Inquest Brief, p36.

Senior Constable Parkinson's commands and was cuffed and arrested for the breach of the interim IVO and contravention of bail condition. We then transported Dongelmans to Horsham Police Station to be interviewed'.

77. The BWC of LSC Parkinson however records that a pat-down search was undertaken on Matthew. The footage shows that a pat-down search was conducted with Matthew's left and right tracksuit pant pockets being searched, a number of items being removed including a packet of tobacco, packet of gum, paper and a mobile phone with all items subsequently handed to Heidi. The footage refutes the assertion by Heidi that they '*clearly never searched him*'.

When did Matthew consume the methylamphetamine?

78. The first indication that Matthew may have consumed methylamphetamine did not arise until the day after the arrest, when Heidi had a conversation with 'Roony' in which he advised that after she had left her premises the previous day, Matthew had told him that he had an eight-ball of 'ice' in his pocket.[80]

79. No illicit substances were located on Matthew when he was arrested and taken into custody. Further, he repeatedly denied consuming any illicit substances to PCO Landrigan[81] on the Detainee Risk Assessment[82] or to AV Paramedics.[83]

80. A significant proportion of Matthew's time in custody was captured on either BWC or CCTV, including his arrest, transport within the divisional van and while in custody at Horsham Police Station. Nowhere within any of the BWC footage, Divisional Van CCTV or Horsham Police Station CCTV is Matthew seen to be consuming any substance. Matthew can be seen chewing for a lengthy period of time in the Divisional Van CCTV footage, noting that when he was searched it would appear that one of the items removed from his pocket was a packet of gum.

[80] Statement of Heidi Knust, Inquest Brief, p33.
[81] Statement of PCO Landrigan, Inquest Brief, p59.
[82] Detainee Risk Assessment, Matthew Dongelmans, Horsham Police Station, 26/03/2020, Inquest Brief, p143.
[83] Statement of Paramedic Clark, Inquest Brief, p64; Statement of Paramedic Antonello, Inquest Brief, p66.

81. There were a number of periods of time during his custody when Matthew was *not* captured on BWC or CCTV:

(a) The time between the door closing on the divisional van custody pod and the manual activation of the divisional van CCTV. I am of the view that it is unlikely that Matthew consumed methylamphetamine in this short period of time on the basis his pockets had been searched *and* both his hands were handcuffed behind his back. LSC Parkinson in a supplementary statement was unable to recall who had activated the CCTV.[84] I note that the distance from the Harriett Street residence to Horsham Police Station is approximately one kilometre suggesting that the majority if not all of Matthew's time within the custody area of the divisional van was captured on CCTV.

(b) The time within the Horsham Police Station Interview Room. However, in a supplementary statement Cst Hew stated:

'*Dongelmans was taken to the interview room by me after he provided his details to the Police Custody Officer Landrigan. I sat with Dongelmans in the interview room whilst LSC Parkinson had prepared materials for the interview. PCO Landrigan came into the interview room a short time later to pass Dongelmans a drink. I had sat across the table with Dongelmans whilst he was in the interview room. Aside from the drink PCO Landrigan gave Dongelmans, he did not eat anything or drink anything during my whole interaction with Dongelmans'*.[85]

82. On the basis of the entirety of the evidence available, including the BWC footage of arresting officers, CCTV footage from the divisional van and Horsham Police Station, and the statements of LSC Parkinson and Cst Hew, I find that it is likely that Matthew consumed the methylamphetamine prior to his arrest. I note Dr Young's opinion that '*based on the blood level of methylamphetamine, it is not possible to determine how much had been consumed, or when it had been consumed*'. It is possible, although I am unable to conclude with any certainty, that upon being alerted to the impending arrival of Victoria Police at the Harriett Street residence, Matthew panicked and consumed the entire quantity of methylamphetamine to prevent detection.

[84] Statement of Leading Senior Constable Parkinson, Inquest Brief, p388.
[85] Statement of Constable Hew, Inquest Brief, p390.

83. In any event, there is no evidence to support a finding that Matthew consumed the methylamphetamine at any time after his arrest, either in the divisional van or while in custody at Horsham Police Station.

Assessment of the medical care provided by Victoria Police

84. Victoria Police policies and procedures are published in the Victoria police Manual (**VPM**).

85. The *VPM Persons in police care or custody* requires:

    (a) At 1.1 that '*persons must be continually monitored and assessed, particularly in respect of their medical condition … … when medical or safety risks are identified, they must be responded to promptly and the appropriate assistance or advice must be obtained*'.[86]

    (b) At 3.2 that '*members and PCOs who take a person into care or custody must assess the person against the Medical Checklist and obtain medical assistance if required*'.[87]

86. The *VPMG Safe management of persons in police care or custody* also defines requirements in respect of medical and welfare assessments and medical support and advice.

87. The earliest indication that Matthew provided to Officers that he was feeling unwell was during his record of interview at 4.44pm. While the interview preliminaries were being conducted, Matthew stated that '*um, I feel that crook, I really do*' although in the ensuing interview he repeatedly indicates he had been feeling unwell since at least his arrival in Horsham the previous day. Towards the end of the interview at 5.04pm, Matthew stated '*I just want to go down to the hospital and get some help, like that's what I came down here [to Horsham] for … … I just feel that crook, I just want to go see the doctor, I just want to go see the hospital … … I just want to go see the doctor mate*'.

88. The Officers made independent observations of a deterioration in Matthew's medical condition. At approximately 5.22pm, A/Sergeant Gaw attended the interview room and had a conversation with Matthew who stated '*I'm not feeling too well … … I have some chest pain. Just not feeling well*'.[88] A/Sergeant Gaw observed that '*Matthew's eyes had become glazed over and they were darting left and right rapidly*'.[89] Minutes later PCO Landrigan spoke with

[86] VPM Persons in police care or custody, Inquest Brief, p312.
[87] VPM Persons in police care or custody, Inquest Brief, p315.
[88] Statement of A/Sergeant Gaw, Inquest Brief, p55.
[89] Statement of A/Sergeant Gaw, Inquest Brief, p55.

Matthew and noticed that '*his eyes were twitching from side to side uncontrollably and he was becoming quite agitated*'.[90] PCO Landrigan asked Matthew whether he had taken any drugs and Matthew replied that he had not.[91]

89. Within half an hour of those observations, the CHAL had been contacted for advice and Ambulance Victoria had been requested. Just over an hour after those observations Matthew was being transported by Ambulance Victoria under escort to Wimmera Base Hospital.

90. On all of the available evidence, I am satisfied that Officers at Horsham Police Station provided a timely and adequate response in respect of the decline in Matthew's medical condition. Once Officers became aware of Matthew's deterioration, they sought prompt and appropriate assistance through the CHAL and subsequently Ambulance Victoria.

91. In his Autopsy Report, Dr Young observed a number of blunt force injuries including bruising on Matthew's chest, back arms and legs. I am satisfied that these injuries were not sustained during Matthew's arrest or during his custody at the Horsham Police Station. I note that there is no bruising visible on the CCTV during Matthew's record of interview or when he was being strip searched in the cell at the Horsham Police Station. In my view, these injuries are likely to have occurred during his time at the Wimmera Base Hospital when he was clearly in an agitated state while restrained on a trolley and thrashing his legs.

<u>Assessment of the medical care provided by Wimmera Base Hospital</u>

92. The Inquest Brief contains a number of statements from hospital staff that explain the delay in treating Matthew at the Wimmera Base Hospital, including Ms Patterson who was the After-Hours Hospital Coordinator that evening. She stated that the ED was treating a diabetic ketoacidosis patient who had presented with fever and shortness of breath and was being treated as a possible COVID-19 case.

[90] Statement of PCO Landrigan, Inquest Brief, p59.
[91] Statement of PCO Landrigan, Inquest Brief, p59.

93. Due to the unfamiliarity surrounding infection control requirements in respect of COVID-19 at this time, there was an unexpected delay in being able to release staff who had treated this patient, to treat other patients including Matthew, while infection control protocols were confirmed. At the same time, a second unrelated patient had to undergo preoperative procedures within the ED prior to going directly to theatre for an appendectomy.

94. A statement was provided by Dr Andre Nel, the Chief Medical Officer at the Wimmera Base Hospital.[92] He stated that an in-depth clinical review was conducted by the Clinical Risk Management Team of Wimmera Health Care Group which resulted in a number of recommendations. The review conceded that there was delay in the provision of treatment to Matthew, that the ED was beyond capacity and capability, and there was no escalation to obtain assistance. The review found that these circumstances contributed to:

    (a) an initial failure to identify a clinically deteriorating patient;

    (b) inadequate monitoring, observation and documentation of a physically restrained and chemically sedated patient in the first 2 hours of care; and

    (c) a lack of oversight of the ED as both the Associate Nurse Unit Manager and the After-Hours Coordinator were both involved in direct patient care.

95. I referred this matter to the Health & Medical Investigation Team of the Coroners Prevention Unit (**CPU**) to review Matthew's medical care, with a particular focus on the delay in providing treatment. Following a detailed review of Matthew's treatment at Wimmera Base Hospital, the CPU concluded, and I accept, the following:

    (a) Wimmera Base Hospital ED was extremely busy, over capacity, and staff were busy attending to a sick diabetic patient, complicated by possible COVID infection who required intubation. This resulted in significant delays in senior medical staff being available due to infection control protocols, causing a significant delay of approximately 90 minutes in Matthew's assessment.

    (b) Matthew's management once staff were available to treat him was appropriate but unfortunately, he had started to develop the complications of methamphetamine toxicity and developed multi-organ failure that failed to respond to maximal medical therapy.

[92] Statement of Dr Andre Nel, undated

(c) The impact of COVID and the difficulties this brings to patient care are significant. Wimmera Base Hospital is a small hospital in rural Victoria, some four hours from tertiary centres which makes a surge response even more challenging.

(d) A detailed statement was provided by Dr Nel outlining an in-depth clinical review facilitated by the Clinical Risk Management team, which resulted in the following recommendations for improvements made and actioned (at the time of the report):

(i) COVID specific procedures and practices have been developed. (Fully implemented)

(ii) Develop and implement a procedure for escalation and support when ED is over capacity. This is in progress and the draft ED Escalation procedure was attached for review.

(iii) Increase reporting of near misses and major events in the ED. (Partially implemented)

(iv) All cardiorespiratory arrests and major events (for example, trauma) are now reported as an incident and undergo a STOP debrief after the event. The STOP debrief format is a structured tool (Summary, Things that went well, Opportunities for improvement, Plan). Planned electronic reporting system upgrade.

(v) Blood sugar levels monitored according to procedure following the use of glucose/ insulin therapy. (Fully implemented)

(vi) Organisational process of identification and escalation to the Leadership Team when a coroner's request is received. (Fully implemented.)

(vii) Education on the signs and symptoms of methamphetamine overdose and correct management. (Fully implemented.)

(viii) Develop a protocol for the emergency management of the acutely agitated patient. (Fully implemented.)

96. Finally, CPU have advised, and I accept, that it *cannot* be concluded that the absence of delay in treatment at Wimmera Base Hospital in the context of Matthew's presentation would have prevented his death. While an earlier sedation may have reduced the effects of the symptoms he was experiencing, the treating clinicians had no history of Matthew ingesting a significant quantity of methylamphetamine, and there was therefore no basis at that stage to consider flushing the contents of his stomach.

97. I am satisfied that a detailed and considered response has been provided by the Wimmera Health Care Group which makes appropriate concessions in relation to Matthew's treatment, in particular the delay in providing treatment, and addresses the prevention opportunities that have identified. Most importantly, an escalation plan for support when the ED is over capacity has been developed.

FINDINGS AND CONCLUSION:

98. Having held an inquest into the death of Matthew Dongelmans, I make the following findings, pursuant to section 67(1) of the Act:

    (a) the identity of the deceased was Matthew Lee Dongelmans, born on 27 October 1989;

    (b) the death occurred on 29 March 2020 at Footscray Hospital, 160 Gordon Street, Footscray, from complications of methylamphetamine toxicity; and

    (c) that the death occurred in the circumstances set out above.

99. I convey my sincerest sympathy to Matthew's family and Ms Knust.

100. 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.

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

Senior Next of Kin, Ms Heidi Knust.

Chief Commissioner of Police, Mr Shane Patton APM.

CEO Wimmera Health Care Group, Ms Catherine Morley.

Detective Sergeant Tony Euvrard, Coroner's Investigator.

Signature:

Coroner David Ryan

Date: 22 February 2022

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.