IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2018 2064

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)

Section 67 of the Coroners Act 2008

Deceased:	Ricky James Broughton
Delivered on:	8 December 2023
Delivered at:	Coroners Court of Victoria, 65 Kavanagh Street, Southbank
Hearing dates:	Inquest: 12-16, 19-23, 26-30 July and 7 and 8 December 2021 Final Submissions: 7 Oct – 15 Dec 2022 Replies: 25 January 2023
Findings of:	Deputy State Coroner Paresa Antoniadis Spanos
Counsel assisting the Coroner:	Ms R. Ellyard of Counsel, instructed by Samantha Brown from the Court's In-house Legal Service

Representation:	Ms M. Fitzgerald of Counsel, instructed by HWL Ebsworth, on behalf of Barwon Health
	Ms R. Kaye of Counsel, instructed by Lander + Rogers, on behalf of Ballarat Mental Health Services
	Mr P. Lawrie of Counsel, instructed by Russell Kennedy, on behalf of the Chief Commissioner of Police with final written submissions prepared by Mr A. Imrie of Counsel
	Mr M. McLay of Counsel, instructed by Legal Services Branch Department of Families, Fairness and Housing, on behalf of the Department of Families, Fairness and Housing
	Mr P. Hamilton, instructed by Avant Mutual, on behalf of Dr Scott Taylor
	Ms C. Fitzgerald of Counsel, instructed by Australian Government Solicitors, on behalf of the National Disability Insurance Agency with final written submissions prepared by Mr C. McDermott of Counsel
	Ms E. Gardner of Counsel, instructed by K+L Gates, on behalf of Wellways

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INTRODUCTION

1. Ricky James Broughton, whom I shall refer to as 'Ricky' in deference to the wishes of his family, was 47 years old when he died at Buninyong on 3 May 2018.

2. Ricky was the seventh of his mother's eight children and grew up in and around Geelong.[1] After leaving school at about the age of 15 years he was employed intermittently in a range of labouring jobs. Following his mother's death in about 1986 and until he was in his late 20s, Ricky lived with family members, initially at the former family home in Geelong and later in Nathalia, Tatura and again in Geelong.[2]

3. While living in Nathalia, in about 1994-1995,[3] Ricky's half-brothers noticed that Ricky 'seemed ok during the day' but at night was 'always awake' and had developed paranoid thoughts about his eldest half-brother.[4] After being found cowering in a neighbour's backyard by police, Ricky's mental health was assessed, culminating in a diagnosis of schizophrenia and prescription of medication to manage his symptoms.[5]

4. Ricky then lived with his older sister and her family in Tatura for a while. He never engaged in paid employment after being diagnosed with schizophrenia.[6] He received a Disability Support Pension which was administered by State Trustees.

5. Ricky returned to the Geelong area in about 1997 and initially lived with his older half-brother William and his family. However, Ricky's habit of being 'up all night, walking around' and then 'crash[ing] for 18 hours straight' did not fit well with William Broughton's family's routine and so Ricky moved out, though Mr Broughton continued to look out for him.[7]

6. While in Geelong, Ricky became a patient of the Barwon Mental Health Service (**Barwon MHS**) and was 'case managed continuously'[8] for most of the following 20 years. Throughout that period, Barwon MHS provided clinical assessment and care including administration of

[1] Coronial Brief [CB], pages 193-194.
[2] Coronial Brief [CB], pages 193-194.
[3] Barwon Health records suggest that Rick's first contact with the public mental health system occurred when he was 19 years old, that is, in about 1990: CB 1765.
[4] CB, pages 193-194.
[5] CB, page 195.
[6] CB, page 195.
[7] CB, page 195.
[8] CB, page 205.

medications, risk assessment and management and liaison with providers of non-clinical community support services.[9]

7. Depending on his clinical presentation at the time, Ricky's mental health was variously managed via compulsory psychiatric inpatient treatment (at the Swanston Centre), compulsory treatment provided in the community and voluntary community treatment. Although Ricky's mental state remained stable with the administration of a combination of oral and depot medications for extended periods, his mental illness was considered chronic[10] and treatment resistant.[11] Even when well, Ricky was considered vulnerable to the influence of others – a cognitive impairment was suspected if not formally diagnosed[12] – and he experienced side effects of long-term use of antipsychotic medications including akathisia.[13]

8. Ricky was known to become "unwell" due to medication non-compliance and required supervision to ensure compliance in part because he lacked any insight into his illness.[14] When unwell, Ricky presented as grossly thought disordered, experienced hallucinations, and expressed delusional ideas, with poor sleep, self-neglect and increased agitation and verbal aggression associated with a decline of his mental state.[15]

9. While case managed by Barwon MHS, Ricky's limited ability to live independently and his housing insecurity was noted.[16] Following an admission to the Swanston Centre, Ricky lived 'for many years'[17] at a Community Rehabilitation Facility (**CRF**) to help him develop self-care and life skills but Ricky was unable to demonstrate the acquisition of such skills.[18] After discharge from the CRF, Ricky lived in a range of accommodation types with varying levels of support including a 'group home', Supported Residential Service (**SRS**) Queenscliff Lodge and a flat provided through the public housing system. When he was unable to sustain living independently in the flat, Ricky returned to Queenscliff Lodge.[19]

10. Thereafter, between approximately 2007 and 2016, Ricky lived at four SRSs in the Greater Geelong area: Brooklyn House, Belmont Manor, Geelong Lodge and, finally, See Change.

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[99] CB, page 200.
[10] CB, page 1765.
[11] CB, page 205.
[12] CB, page 205.
[13] CB, page 2290. Akathesia is a movement disorder characterised by muscle quivering, restlessness, and an inability to remain still.
[14] CB, page 1765.
[15] CB, page 205 and see generally Ricky's Barwon MHS records.
[16] CB, pages 200 and 1765.
[17] CB, page 1765.
[18] CB, page 200.
[19] CB, page 1765.

According to his Barwon MHS case manager Registered Psychiatric Nurse (**RPN**) Wayne Watts, there was a variety of reasons why Ricky moved from place to place.[20]

11. In March 2014, Ricky made a request to the National Disability Insurance Agency (**NDIA**) pursuant to section 18 of the *National Disability Insurance Scheme Act* 2013 (Cth) (**NDIS Act**) to become a participant in the National Disability Insurance Scheme (**NDIS**). The following month, a delegate of the Chief Executive Officer (**CEO**) of the NDIA determined that Ricky met the criteria to become a NDIS participant[21] with his first NDIS Plan commencing in August 2014.[22]

12. Ricky moved into See Change in late October 2016. See Change is a supported accommodation service[23] which at the relevant time was registered with the NDIA as a service provider. Included in Ricky's NDIS Plan while he lived at See Change was funding for 'assistance in a shared living arrangement for four persons', a type of support which later became known as Supported Independent Living (**SIL**) supports.[24]

13. Less than three months after moving into See Change, on 9 January 2017 while admitted to hospital for a second episode of psychogenic polydipsia,[25] Barwon MHS was informed that Ricky could not return given his 'physical issues, poor compliance with management plans,'[26] leaving the premises at night and his high risk of falls on the stairs.[27] Once medically stable in mid-January 2017, Ricky was transferred to the Swanston Centre while discharge planning occurred, primarily to locate suitable accommodation.[28]

14. On 16 February 2017, Ricky was discharged from the Swanston Centre, and from the Barwon MHS, to live at Kallara Care (**Kallara**), an SRS in Ballarat.[29]

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[20] CB, page 201.
[21] CB, page 474.1
[22] CB, page 474.2.
[23] There was a lack of clarity of understanding as to whether See Change is/was an SRS or a SDA (Supported Disability Accommodation) or some other kind of accommodation provider among the various professionals working with Ricky, no doubt contributed to by the availability of (what later became known as) SIL supports to him while he lived there and the common association of SDA and SIL in NDIS Plans: T, pages 1535-1536.
[24] CB, page 474.2. Ricky's NDIS Plans 3 (17/10/2016-6/12/2016) and 4 (7/12/2016-17/4/2017).
[25] CB, page 2147. Psychogenic polydipsia is characterised by excessive volitional water intake and is often seen in patients with psychiatric disorders and/or neurodevelopmental disorders.
[26] CB, page 2148.
[27] CB, page 2149.
[28] CB, page 2159. There were 'major bed pressures' at the Swanston Centre: CB, page 2158.
[29] CB, page 224.

CIRCUMSTANCES IN WHICH THE DEATH OCCURRED

15. Ricky remained at Kallara until his eviction on 17 July 2017.[30] He then lived at another SRS in Ballarat, Browen Lee Lodge (**Browen Lee**), from 18 July until his eviction on 1 August 2017.[31] Thereafter, Ricky lived at Merindah Lodge (**Merindah**), a boarding house located on the Midland Highway in Buninyong, a township about 15 kilometres south of Ballarat.

16. Ricky's housing, medical and support needs while he lived in Ballarat, how these were managed and by whom was the focus of the coronial investigation and inquest together with the immediate circumstances of his collapse and death and will be discussed in some detail below.

17. Suffice for present purposes to say that by 2 May 2018, Ricky's accommodation at Merindah could no longer be sustained. He underwent psychiatric assessment by clinicians from Ballarat Mental Health Service (**BMHS**) on 2 and 3 May 2018, with the second assessment resulting in Ricky being made subject to an Inpatient Assessment Order requiring his further assessment at a designated mental health service.[32] Victoria Police was called to facilitate Ricky's transfer to hospital on 3 May 2018.

18. Ballarat West 303, comprising of Leading Senior Constable (**LSC**) Eleanor Bergheim and LSC Carley Davis, were tasked to attend Merindah and arrived around 5.15pm on 3 May 2018. When the police members approached Ricky, he ran from them. Following a foot pursuit, Ricky was restrained on the ground and after a struggle, by about 5.27pm,[33] handcuffs had been applied. Ricky continued to resist the police members and so additional police units were requested.[34]

19. Ballarat 302 arrived at the scene at about 5.35pm.[35] Less than two minutes later, LSC Bergheim transmitted via Police Communications (**D24**) that Ricky had become unresponsive and that an ambulance was required.[36] At 5.41pm, replying to a transmission asking for the ambulance to 'hurry,' D24 confirmed that an ambulance was enroute with lights and siren activated.[37]

[30] CB, page 224.
[31] CB, page 271.
[32] Sections 29, 30 and 33 of the *Mental Health Act* 2014.
[33] CB, page 3776.
[34] CB, page 3777.
[35] CB, page 3783.
[36] CB, page 3785.
[37] CB, page 3788.

20. By 5.44pm, police members had commenced cardiopulmonary resuscitation (**CPR**).[38] Within minutes, paramedics were on scene and continued CPR. Unfortunately, Ricky could not be revived and was pronounced deceased by paramedics at the scene at 6.35pm on 3 May 2018.

INVESTIGATION AND SOURCES OF EVIDENCE

21. This finding is based on the totality of the material the product of the coronial investigation and inquest into Ricky's death. That is, the initial brief of evidence compiled by Detective Sergeant Tim Bell of the Homicide Squad of Victoria Police which includes relevant witness statements, the forensic pathologist's report and medical and other records, together with the materials obtained subsequently at my direction[39] and those added to the coronial brief as Additional Materials[40] during the inquest; the evidence of the witnesses required to testify at inquest and any documents tendered through them; and the final submissions of Counsel.

22. All of this material, together with the inquest transcript, will remain on the coronial file.[41] In writing this finding, I do not purport to summarise all the material and evidence but will only refer to it in such detail as is warranted by its forensic significance and the interests of narrative clarity.

PURPOSE OF A CORONIAL INVESTIGATION

23. The purpose of a coronial investigation of a *reportable death*[42] is to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.[43]

24. Ricky's death clearly falls within the definition of a reportable death in section 4 of the Act, satisfying both section 4(2)(a) of the Act which includes (relevantly) a death that appears to be unexpected, and section 4(2)(c) which captures deaths where a person immediately before death

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[38] CB, page 3792.
[39] These materials will be referred to as the "coronial brief" (or CB) in the rest of this finding.
[40] For clarity, references to documents added as 'Additional Materials' will by cited as 'AM' followed by the relevant page number.
[41] From the commencement of the *Coroners Act 2008* (the Act), that is 1 November 2009, access to documents held by the Coroners Court of Victoria is governed by section 115 of the Act. Unless otherwise stipulated, all references to legislation that follow are to provisions of the Act.
[42] The term is exhaustively defined in section 4 of the Act *2008*. 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). Some deaths fall within the definition irrespective of the section 4(2)(a) characterisation of the 'type of death' and turn solely on the status of the deceased immediately before they died – section 4(2)(c) to (f) inclusive.
[43] Section 67(1) of the Act.

was a person placed 'in custody or care.' By virtue of being subject to an Inpatient Assessment Order Ricky was 'in care' and, once apprehended by police to facilitate his transfer to a designated mental health service, he was 'in the custody of a police officer' at the time of his death.[44]

25. The *cause* of death refers to the *medical* cause of death, incorporating where possible the *mode* or *mechanism* of death. For coronial purposes, the *circumstances* in which death occurred refers to the context or background and surrounding circumstances but is confined to those circumstances sufficiently proximate and causally relevant to the death, and not all those circumstances which might form part of a narrative culminating in death.[45]

26. The broader purpose of any coronial investigations 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.[46]

27. 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.[47] These are effectively the vehicles by which the coroner's prevention role can be advanced.[48]

28. 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 any statement that a person is, or may be, guilty of an offence.[49]

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[44] See the definition of a 'person placed in custody care' in section 3 of the *Coroners Act* 2008.
[45] This is the effect of the authorities – see for example *Harmsworth v The State Coroner* [1989] VR 989; *Clancy* v *West* (Unreported 17/08/1994, Supreme Court of Victoria, Harper J.)
[46] 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'.
[47] See sections 72(1), 67(3) and 72(2) regarding reports, comments and recommendations respectively.
[48] See also sections 73(1) and 72(5) which requires publication of coronial findings, comments and recommendations and responses respectively; section 72(3) and (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.
[49] Section 69(1). However, a coroner may include a statement relating to a notification to the Director of Public Prosecutions if they believe an indictable offence may have been committed in connection with the death. See sections 69 (2) and 49(1).

IDENTITY

29. Ricky James Broughton, born 28 January 1971, aged 47 years, was identified on 3 May 2018 by the proprietor of Merindah, Jacinta Peart.[50]

30. Ricky's identity was not in issue and required no further investigation.

CAUSE OF DEATH

31. On 4 May 2018, forensic pathologist Dr Linda Iles from the Victorian Institute of Forensic Medicine (**VIFM**), reviewed the circumstances of Ricky's death as reported by police to the coroner and post-mortem CT scans of the whole body, and performed an autopsy.

32. Dr Iles provided a written report of her findings dated 23 August 2018.[51] Among the key anatomical findings were patchy bruising to the back, knuckles of the left hand and right cheek, patchy abrasions over the shins and bruising and abrasions to the wrists consistent with a history of restraint.[52] Further, although Dr Iles found no evidence of traumatic injury directly contributing to Ricky's death, she observed bilateral anterior rib and transverse sternal fractures, lacerated pericardium and right atrium and a two litre right haemothorax which she considered were consistent with prolonged vigorous resuscitative efforts and not the primary cause for Ricky's collapse.[53]

33. Dr Iles noted some minor scarring within the heart, non-specific inflammation within the pituitary gland, right hippocampal dysplasia and mild diffuse white matter loss within the brain but these were not considered to be significant contributors to death.[54]

34. Routine post-mortem toxicology detected valproic acid, quetiapine, chlorpromazine, risperidone and its metabolite, and 7-aminonitrazepam in blood[55] consistent with the concomitant use of several antipsychotic drugs. Dr Iles opined that the effect of this combination of drugs on the cardiac conduction cycle in the setting of prolonged struggle and acute psychosis was not clear.[56]

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[50] Statement of Identification signed by Jacinta Peart on 3 May 2018.
[51] CB, pages 162-181.
[52] CB, page 164.
[53] CB, page 165.
[54] CB, page 166.
[55] CB pages 182-192. Valproic acid is an anticonvulsant, while quetiapine, chlorpromazine and risperidone are antipsychotics; 7-aminonitrapepam is the metabolite of nitrazepam, a sedative (hypnotic drug) of the benzodiazepine class.
[56] CB, pages 166-167.

35. Following the autopsy, Dr Iles reviewed Ricky's medical records and Ambulance Victoria's patient care records, statements made by LSCs Bergheim and Davis and scene photographs.[57] From these materials, Dr Iles gleaned that Ricky died after a chase and prolonged struggle in the setting of increased agitation and acute psychotic symptoms on a background of chronic schizophrenia.[58]

36. Dr Iles advised that the soft tissue injuries observed at autopsy were consistent with accounts of police members' attempts to restrain Ricky on rough terrain.[59] There was nothing to indicate that Ricky had been restrained in a prone position for a lengthy period and although his restraint on his side appeared to involve some lateral chest compression, in the absence of prone positioning, the contribution of such positioning although difficult to assess appeared to be negligible.[60]

37. Dr Iles opined that there were some features of Ricky's death that raised the possibility of "excited delirium" recognised by forensic pathologists and emergency physicians as a distinct entity but one without universal acceptance.[61] She observed that regardless of the terminology used, deaths involving acute agitation, prolonged struggle, acute psychosis in the setting of restraint, often in response to associated behavioural changes, are well recognised. These circumstances raised the possibility of the contribution of an acidotic and hyperadrenergic state ("post exercise peril") following extreme exertion.[62]

38. During her oral evidence at inquest, Dr Iles explained the physiological mechanism resulting in cardio-respiratory arrest in the following terms: an acutely agitated psychotic state translates to physical agitation which with prolonged struggle, including struggle against restraint, overloads the muscles producing hyperkalaemia and lactic acidosis which, in turn, result in metabolic and electrolyte shifts that impact heart rhythms.[63] The mechanism is not anatomical and so cannot positively be identified at autopsy; rather, it is inferred from the circumstances of the death.[64]

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[57] The medical records reviewed by Dr Iles were those maintained by Ballarat Health Services and Ballarat Group Practice; Dr Iles also reviewed the statement made by Wayne Watts.
[58] CB, page 166.
[59] CB, page 166. In her oral evidence at inquest, Dr Iles confirmed that there was no evidence that Ricky had sustained any significant injury consistent with a fall involving a head strike: Transcript (T), page 40.
[60] CB, page 166. At inquest, Dr Iles gave evidence that there was no evidence of positional asphyxia: T, page 42.
[61] CB, page 166.
[62] CB, page 166.
[63] T, page 41.
[64] T, page 42.

39. Dr Iles concluded that the medical cause of Ricky's death was *1(a) unascertained* given the absence of distinct anatomical findings to explain it.[65] However, the cause of death could be phrased as *complications of acute agitation in the setting of a prolonged struggle in an acutely psychotic man with a history of chronic schizophrenia*.[66]

40. I accept Dr Iles' opinion as to the cause of Ricky's death. I prefer the narrative, more descriptive formulation which is amply supported by the evidence of the circumstances in which Ricky died which will be set out below, especially from paragraphs 263 and following.

THE FOCUS OF THE CORONIAL INVESTIGATION AND INQUEST

41. In common with many other coronial investigations, the focus of the coronial investigation and inquest into Ricky's death was on the circumstances in which his death occurred.

42. Somewhat unusually, here the proximate and causally relevant circumstances of Ricky's death are not just those of 3 May 2018. Rather, they encompass the whole period Ricky lived in Ballarat, starting with his transition from the Barwon region in February 2017.

43. It is convenient to address the relevant evidence under the following headings:

    a. Ricky's care, housing, medical and support needs at the time he arrived in Ballarat in February 2017;

    b. The arrangements in place to meet those needs between February 2017 and May 2018;

    c. To what extent, and by whom, were Ricky's care, housing, medical and support needs being met, including consideration of the division of responsibility between the people and entities involved and how information was shared between service providers; and

    d. The immediate circumstances of Ricky's collapse and death on 3 May 2018.

44. However, before doing so there is a need to outline the key features of the NDIS, which had been implemented in Ballarat shortly before Ricky arrived, as it provides important context for the provision of services and supports given the complexity of Ricky's needs and the multiplicity of services involved.

[65] CB, page 167.
[66] CB, page 167.

45. Also instructive and necessary to contextualize the discussion that follows, is a brief overview of Ricky's management by Barwon MHS while he resided in the Geelong area, before the move to Ballarat.

The NDIS

46. The NDIS is an insurance scheme representing 'one of the most complex changes' that the Commonwealth and state and territory governments have implemented in a generation.[67] The broad purpose of the NDIS is to support the independence and social and economic participation of people with disability by funding reasonable and necessary supports required by participants of the scheme to pursue their goals.[68]

47. The operation of the NDIS Act is underpinned by principles that promote the independence of people with disability, including that they should be supported to exercise 'choice and control,' including in relation to taking reasonable risks; determining their own best interests; and engaging as equal partners in decisions that affect their lives.[69] These principles are intended to displace paternalism as an assumed systemic value, and with it, the risk of reinforcing stigma and adverse attitudes toward people with disability that are conducive to discrimination and exclusion.

48. Accordingly, in the exercise of functions under the NDIS Act the CEO and delegates of the NDIA are required to assume that participants in the scheme, so far as is reasonable in the circumstances, have capacity to determine their own best interests and make decisions.[70] That said, given the practical level of independence experienced by people with disability is variable, the NDIS Act allows a 'nominee' to be appointed to act on behalf of the participant, either at the request of the participant or on the initiative of the CEO of the NDIA.[71]

49. An important feature of the NDIS is that it does not provide services to participants of the scheme. Rather, it provides participants with funds to spend on supports listed in their plan with the supports delivered by a service provider of their choice.[72] Supports in a plan may be

[67] CB, page 4396.
[68] Section 3 NDIS Act.
[69] Section 4 NDIS Act.
[70] Section 17A NDIS Act.
[71] See generally, sections 78-98 of the NDIS Act.
[72] CB, page 474.3.

described generally or specifically,[73] with those described generally able to be used flexibly; funds for 'stated' supports must be used in the way described in the plan.[74]

50. The supports funded by the NDIS are categorised by support purpose: 'core,' 'capital,' and 'capacity building' supports.[75] Core support funding may be spent flexibly across four sub-categories: assistance with daily life (but not SIL funding), consumables, transport and assistance with social and community participation; use of capital funds is restricted to items identified in a plan (such as for home or vehicular modifications or equipment or for Specialist Disability Accommodation (**SDA**)); and capacity building funds must be used to achieve plan goals related to building the participant's independence and skills (examples include support coordination, improved relationships and daily living skills funding).[76]

51. Relevantly,[77] SIL funding was previously known as 'assistance in a shared living arrangement' and related to the assistance or supervision provided for tasks of daily living and, it seems, was only available to participants living in congregate dwellings.[78] Now, SIL funding is available to eligible participants living in a range of accommodation types.[79] SDA funding is a capital support for "bricks and mortar" with specific eligibility criteria outlined in the *National Disability Insurance Scheme (Specialist Disability Accommodation) Rules* 2016 (**SDA Rules**).[80] That is, to be eligible for SDA funding, the participant must have 'an extreme functional impairment[81] and requires an SDA response' or 'very high support needs[82] most appropriately met by a SDA response.'[83]

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[73] Section 33(3) NDIS Act.
[74] CB, page 474.4.
[75] AM, page 143.
[76] AM, page 143.
[77] That is, at the time Ricky was a NDIS participant.
[78] AM, page 157 and T, pages 1647-1649.
[79] T, page 1648.
[80] AM, pages 361-400.
[81] The participant has an extreme functional impairment if (a) the impairment results in an extremely reduced functional capacity of the participant to undertake one or more of the activities of mobility, self-care or self-management and (b) the participant has a very high need for person to person supports in undertaking the activity even with assistive technology, equipment or home modifications: AM, page 369. The criteria also guide the assessment of when the participant 'requires a SDA response'.
[82] The participant has very high support needs if (a) the participant has previously lived in SDA for extended periods and this has impacted the capacity of the participant to transition to alternative living arrangements and supports; or (b) the participant has a very high need for person to person supports, either immediately available or constant, for a significant part of the day and either: (i) there are limitations on the availability, capacity or capability of the participant's informal support network, or risks to its sustainability; or (ii) the participant is at risk or poses a risk to others, and that risk could be mitigated by provision of SDA, having particular regard to the participant's response to risk and the interaction of the participant with the environment: AM, pages 369-370. The criteria also guide the assessment of when the participant's needs are 'most appropriately met by a SDA response'.
[83] AM, page 369.

52. To become a NDIS participant, a person must meet the age, residence and disability requirements.[84] Relevantly, a person will meet the disability requirement if they have a disability attributable to one or more intellectual, cognitive, neurological, sensory or physical impairments or has one or more impairments to which a psychosocial disability is attributable. The impairment(s) must be likely to be permanent and result in substantially reduced functional capacity to undertake specified activities and capacity for social or economic participation.[85]

53. Eligible participants receive an individualised package of funded supports – a plan – developed by a "planner" with the participant and approved by a delegate of the CEO of the NDIA. A plan is based on the participant's goals and will include funding for supports to enhance their functional needs for daily living and socio-economic participation and to pursue their goals. To be funded in a plan, a support must be reasonable and necessary,[86] and most appropriately funded through the NDIS not through other systems of service delivery[87] such as the (state) government funded health, mental health or public housing systems or other community-based services.[88]

54. The participant may choose to manage their NDIS plan themselves, nominate someone else to manage it, or ask the NDIA to manage all or part of it on their behalf.[89] Although a specific type of capacity building support, support coordination is, in practical terms, a mechanism through which some participants will implement or "manage" their plan.[90]

55. There are three levels of support coordination funding relating to the intensity of the assistance required by the participant. Relevantly, intermediate support coordination – coordination of supports – involves the support coordinator assisting the participant to understand their plan; connect with supports and services; establish supports; build capacity and resilience; and crisis planning, prevention, mitigation and action.[91] Support coordination is time limited and focusses

[84] Section 21 NDIS Act.
[85] Section 24 NDIS Act. Impaired functional capacity to undertake the following activities: communication, social interaction, learning, mobility, self-care and self0management.
[86] Section 34 NDIS Act.
[87] Section 34(1)(f) NDIS Act.
[88] With this latter consideration in mind, Commonwealth, State and territory governments agreed to uphold the Principles to Determine the Responsibilities of the NDIS and Other Service Providers and the associated Applied Principles and Tables of Support (APTOS) which define the funding and delivery responsibilities of the NDIS and other service systems and how these interface. CB, pages 4320 and 4328-4353 (in particular: pages 4330-4332 [health], 4333-4334 [mental health], 4345-4346 [housing] and 4347 [transport]). Regard will also be had to Schedule 1 of the NDIS (Supports for Participants) Rules 2013: CB, page 466.
[89] CB, page 469.
[90] T, page 709.
[91] CB, page 4286.

on addressing barriers and reducing complexity in the support environment[92] and is distinguishable from "case management."[93]

56. NDIS plans are commonly in effect for 12 months[94] and reviewed at designated intervals.[95] However, a participant may request a plan review at any time,[96] usually in the context of a significant change in circumstances that indicates the need for change to the reasonable and necessary supports funded in the plan.

57. The NDIS commenced in several trial sites in Victoria (including the Barwon region) in July 2013,[97] before a progressive roll-out to other areas from July 2016. Transition from existing disability services to the NDIS occurred in the Central Highlands region (including Ballarat) from 1 January 2017.[98]

58. The roll-out of the NDIS involved transitioning large numbers of people with disability from existing disability support services to the NDIS which reportedly led to delays in access to the scheme during the transition.[99] It also required disability service providers to transform their models of service from a state and federal government "block-funded" approach to the "pay by the hour" approach envisioned by the NDIS. The change in funding model led to a reduction of the budgets of many disability service providers and a concern amongst them that they would be unable to maintain quality services – some service providers left the field.[100]

59. In the nomenclature of the NDIS, it is tolerably clear from the available evidence that Ricky's eligibility for the scheme was based solely on psychosocial disability – disability arising from his mental health condition – rather than a combination of schizophrenia and his suspected but unassessed cognitive impairment.

Ricky's engagement with Barwon Mental Health Service

60. Ricky had been a patient of Barwon MHS for many years. His schizophrenia was described as "treatment resistant" which meant that despite maximal therapies – a range of different forms of medical and other treatments having been tried over time – he continued to have functional

[92] NDIS Provider Guide to Suitability, v 1.09 (July 2018), quoted at CB, page 4286.
[93] T, page 1667.
[94] CB, page 467.
[95] CB, page 4285.
[96] Section 48 NDIS Act.
[97] CB, page 4282.
[98] CB, page 4282.
[99] CB, page 4282 and T, pages 1689 and 1705.
[100] CB, page 4283.

deficits that related to his condition, including delusional and disordered thinking.[101] Ricky was also known to exhibit problematic behaviours – including poor sleep, cigarette-seeking, wandering, agitation and (ordinarily verbal) aggression – that contributed to housing instability.

61. Associate Professor (**A/Prof**) Moylan, Clinical Director of Mental Health, Drug and Alcohol Services at Barwon Health, testified that it was 'very challenging' to draw a distinction between symptoms of illness (including "behaviours") and behaviours that are unrelated to mental illness,[102] in part because all behaviour is generally informed by an individual's personality and experience, and the symptoms of mental illness may change the types of experiences an individual has which may, in turn, change their behaviour.[103]

62. Similarly, A/Prof Moylan considered there is 'no clear definition' that describes the difference between a chronic mental health presentation and one that is acute, or to identify a presentation that is 'acute on chronic' in the sense that symptoms have become exacerbated at a point in time.[104] He went on to say that the assessing clinician's perception of the impact of 'extra treatment' on the presentation might inform a determination as to its chronicity or acuity; if additional or different treatment is not considered likely to 'change the ultimate outcome,' the presentation is more likely to be considered chronic.[105] This was particularly the case in an acute medical treatment paradigm[106] such as exists in the public mental health system.

63. A/Prof Moylan agreed that a behaviour that continues long enough without intervention is likely to be considered chronic behaviour and, 'possibly' that behaviours regarded as chronic and untreatable may actually be those for which an effective treatment is yet to be found.[107]

64. Given these complexities, A/Prof Moylan testified that the quality and context of the information available to an assessing clinician is very important. He observed that even optimal documentation cannot completely 'paint the full colour of a person's presentation in real terms;'[108] changes in an individual's presentation may be subtle and clinicians (and others)[109]

[101] T, page 1149.
[102] T, page 1150.
[103] T, pages 1150-1151.
[104] T, page 1152.
[105] T, page 1153.
[106] T, page 1153.
[107] T, page 1154.
[108] T, page 1154.
[109] T, pages 1155-1156.

with longitudinal experience of working with the person are advantaged in understanding their mental state at a point in time.[110]

65. Among the services provided to Ricky by Barwon MHS was case management. Case management involves the 'coordination of [the person's] care' in a holistic way that in addition to mental health assessment and treatment encompasses medical, general health and nursing oversight, and identifying and addressing other factors affecting the person's 'outcomes' such as accommodation and other psychosocial supports.[111] The case manager is the 'central co-ordinating person' within a 'team structure' that might involve service providers (for want of a better phrase) from within and outside Barwon Health.[112] Whether someone with a mental illness is case managed is a clinical decision informed by psychiatric intake assessments and the person's needs.[113]

66. RPN Watts was Ricky's case manager for many years until he moved to Ballarat. He described the case manager's role as one-to-one intervention with the patient to 'help them negotiate the system' to ensure required care is provided.[114] Case management enabled him to assertively follow-up with people who might not self-present for care, particularly if no other carers or advocates were involved.[115] Intervention is 'recovery based,' that is, designed to assist patients to become more independent and gain insight into their illness so that they might manage it for themselves.[116] Frequency of contact related to the patient's clinical stability[117] and the continuation of case management was dependent on the identification of unmet clinical or other needs. If all the patient's needs were being met by other service providers, the episode of case management by Barwon MHS would be closed.[118]

67. RPN Watts described Ricky as a gentle soul[119] who was not assertive[120] nor could he identify his issues and needs or that he had a disability:[121] 'in his mind he ha[d] no problems at all.'[122] Although Ricky needed assistance to negotiate his NDIS Plan,[123] he was able to make decisions

[110] T, page 1155.
[111] T, page 1144.
[112] T, pages 1144-1145.
[113] T, page 61.
[114] T, page 63-64.
[115] T, page 64.
[116] T, page 64.
[117] T, page 64.
[118] T, page 62-63.
[119] T, page 97.
[120] T, page 97.
[121] T, page 112.
[122] T, page 112.
[123] T, page 100.

about what to eat, what to wear,[124] express a preference about where he wanted to live,[125] and sign tenancy agreements.[126] Some of his problematic behaviours were 'just more extreme when Ricky was unwell'[127] and he did not respond well to restrictive environments such as a psychiatric inpatient unit where he could not come and go as he pleased.[128]

68. Indeed, RPN Watts observed that throughout the time he case managed Ricky, his re-presentations to Barwon MHS were not often related to any major change in his mental state but due to housing instability and, latterly, medical issues.[129] Every time he had to move, Ricky became unsettled.[130] Mindful of this, as Ricky's case manager, RPN Watts sought to support Ricky and accommodation providers to maintain tenancies with the key strategies being stabilisation of sleep pattern through medication changes or a short voluntary psychiatric admission,[131] recommending structured activities throughout the day[132] and providing behavioural counselling.[133]

69. However, while 'the care environment'[134] is considered one of the most important factors for the ongoing stability of people like Ricky with a major mental illness, it was considered very difficult for those who present with mental health issues and agitation and aggression to access stable long-term accommodation.[135] The availability of transitional housing programs (as opposed to bed-based mental health services)[136] operated under the auspices of Barwon MHS ebbed and flowed during the period Ricky was engaged with the service. A/Prof Moylan observed that these programs washed away around the time the NDIS was implemented and other changes occurred to mental health policy, though had started to re-emerge from about 2020.[137]

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[124] T, page 122.
[125] T, page 113.
[126] T, page 113.
[127] T, page 108.
[128] T, page 97.
[129] T, page 62.
[130] T, page 96.
[131] T, pages 71 and 95.
[132] T, pages 70 and 75.
[133] T, page 68.
[134] T, page 1160.
[135] T, page 1148. Without appropriate accommodation individuals will find it more difficult to engage with other service providers: T, page 1631.
[136] Which in Victoria include(d) bed-based clinical services such as acute psychiatric inpatient units, Prevention and Recovery Care, Community Care Units, and Secure Extended Care Units.
[137] T, page 1145. Nonetheless, A/Prof Moylan mused that it was difficult to know if Ricky would have been able to access the new iterations of mental health-specific transitional housing available around the time of inquest in the Barwon region as, 'in general the people who are getting the opportunities to engage in such housing … don't have those significant issues:' T, pages 1147-1148.

70. One of RPN Watts' chief collaborators was Paul Aldridge of Genu, Ricky's NDIS support co-ordinator while he lived in Geelong. Together, and with evidence of Ricky's need for assistance with many activities of daily life in the form of an occupational therapy report,[138] they were able to secure NDIS funding that enabled Ricky to live at See Change. Although Mr Aldridge understood that the "See Change funding" was not transferrable to another accommodation provider, and the approval process had been quite involved, precisely which line item of the plan was referrable to it was unclear to him.[139]

71. It emerged at inquest that it was 'assistance in a shared living arrangement for four persons, standard' (the precursor to SIL funding) that paid for the round the clock support staff the NDIS Plan reflected Ricky required.[140] It appears that because See Change was NDIS-accredited – perhaps the only one of its kind at the time in the Barwon region[141] – Ricky's accommodation and daily supports could be provided by a single provider and under one roof.

72. When Ricky's placement at See Change broke down in January 2017, he remained at Barwon MHS' Swanson Centre while RPN Watts planned his discharge. A key part of discharge planning was locating suitable accommodation for Ricky. Unable to find Ricky a suitable place to live in the Geelong area,[142] RPN Watts looked further afield, ultimately securing a place for him at Kallara in Ballarat. These accommodation and relocation arrangements occurred without Mr Aldridge's involvement or prior knowledge[143] and in the context of 'bed pressures' in the psychiatric inpatient unit.[144] Accordingly, what was intended to be an opportunity for Ricky to see his proposed new residence became his move-in day.[145]

RICKY'S NEEDS AT THE TIME HE MOVED TO BALLARAT

73. RPN Watts considered the arrangements in place for Ricky upon his move to Kallara were sufficient to meet his needs without ongoing case management. Ricky was placed in an SRS whose staff could supervise him and administer oral medications, a general practitioner (**GP**) provided in-reach services and so would monitor and manage his medical and mental health,

[138] T, page 76.
[139] T, pages 184-186. It emerged at inquest that See Change was at the relevant time a group home funded by the Victorian Government and which 'would have provided' the day-to-day supports delivered in that location: T, page 1648.
[140] T, pages 1648 (Faulkner) and 1160-1661 (Moylan).
[141] T, page 76.
[142] T, page 104.
[143] T, page 81-82
[144] T, pages 82 (Watts) and 1164 (Moylan).
[145] T, page 81.

and Mr Aldridge would transfer coordination of NDIS Plan supports to a service provider in Ballarat.[146]

74. For these reasons, and because Ricky would be living outside Barwon MHS' catchment, RPN Watts closed Ricky's episode of case management, a decision endorsed by a consultant psychiatrist.[147] Absent a GP providing home visits – assertive care – to Ricky, RPN Watts testified at inquest that he would have made a referral to BMHS,[148] observing that whether the BMHS provided ongoing case management for a voluntary psychiatric patient was a clinical matter for it to determine.[149] Barwon MHS' case closure documents were provided to BMHS to alert the service that Ricky now lived in Ballarat.

75. A/Prof Moylan considered the decision to discharge Ricky from Barwon MHS upon his relocation outside its catchment was appropriate.[150] However, he conceded that 'hard boundaries' between mental health services had the potential to influence treatment decisions.[151] A more cautious approach might have been to refer Ricky to BMHS to oversee his transition, [152] noting that while not 'binding' on a receiving mental health service, such referrals are highly persuasive when the receiving service assesses the need for continuing care.[153]

ARRANGEMENTS IN PLACE TO MEET RICKY'S NEEDS FEBRUARY 2017 – MAY 2018

Kallara

76. Ricky arrived at Kallara on 16 February 2017. Supported by RPN Watts, he signed a residential and services agreement on the same date, and an interim support plan was commenced.[154]

77. Kallara is an SRS that provides supported accommodation for a cohort of clients with a range of disabilities, including those with mental illness.[155] Glenn Smyth, director of Kallara, characterised the facility as a 'low care' facility, which in addition to accommodation, meals and cleaning and laundry services, provides residents assistance with activities of daily life (ranging from prompting to full support), some in-house activities, behavioural guidance and

[146] T, page 87.
[147] T, page 108.
[148] T, page 91.
[149] T, pages 109-110.
[150] T, page 1173.
[151] T, page 1161.
[152] T, page 1161.
[153] T, pages 1157-1158.
[154] CB, pages 2722-2734 and T, page 210.
[155] T, page 208.

emotional support and administration of medication.[156] Kallara is staffed all day and overnight,[157] and GP Dr Scott Taylor of Ballarat Group Practice (**BGP**) regularly attends to provide primary medical care to residents.[158]

78. As an SRS, Kallara is a privately operated business registered and regulated by the Victorian Department of Families, Fairness and Housing (**DFFH**) pursuant to the *Supported Residential Services (Private Proprietors) Act* 2010 (**SRS Act**).[159] SRS proprietors are required to prepare an ongoing support plan for each resident in consultation with health service providers and are responsible for ensuring that relevant health supports are accessed appropriately to manage any health conditions.[160] Failure to monitor a resident's health and support needs is an offence,[161] and when an SRS proprietor identifies a gap in health care or support all reasonable steps must be taken by the proprietor to ensure appropriate care is provided. Compliance with these obligations is monitored by the DFFH, including through site visits by Authorised Officers.[162]

79. Under the SRS Act, when a proprietor cannot, after taking all reasonable steps, secure the appropriate level of health care or personal support required by a resident they must notify the Secretary to the DFFH without delay.[163] If notification occurs, pursuant to section 62 of the SRS Act, the DFFH must make enquiries and assess how a resident's needs may best be met. This may include requesting a report from a medical professional and may also involve sourcing suitable alternative accommodation for the resident. However, given the complexity of a resident's needs there can be delays identifying suitable alternative accommodation such that the resident continues to live at the SRS in the interim.[164]

80. In prescribed circumstances, an SRS may issue a resident with a notice to vacate (**NTV**) within a specified minimum notice period. The DFFH must be notified whenever a NTV is issued. Relevantly, a NTV may be issued (with at least 14 days' notice) if a resident requires more health care or personal support than can be provided by the SRS,[165] however, this type of NTV

[156] T, page 212 and CB, pages 2810 and 5173.
[157] However, the staff to resident ration was not high, according to Mr Smyth: T, page 221.
[158] CB, page 318.
[159] CB, page 5173. The DFFH was previously known as the Department of Health and Human Services or 'DHHS.' SRSs are regulated pursuant to the *Supported Residential Services (Private Proprietors) Act* 2010.
[160] T, page 1521.
[161] Section 60(1) of the SRS Act.
[162] CB, pages 5173-5174 and 253.
[163] Sections 60(3) and 61(3) of the SRS Act.
[164] CB, page 5174.
[165] Sections 115 and 116 of the SRS Act.

may only be issued following a section 62 assessment by the DFFH; a NTV may be issued immediately when a resident endangers the safety of others.[166]

81. Statistics provided by the DFFH for the period 2016-2020 show only six notifications relating to SRS' inability to meet residents' health or care needs but that 10 NTV were issued on these grounds; in contrast, 164 NTV immediately on safety grounds were issued.[167] Notwithstanding that SRS proprietors must balance their obligation to one resident with those owed to ensure the safety of co-residents and that these obligations may conflict at times, the statistics suggest an underuse of the sections 60 and 61 reporting procedures, inconsistent use of NTV issued pursuant to sections 114 and 115, and the relative overuse of immediate NTV under section 110 of the SRS Act.

82. Following Ricky's arrival at Kallara, the SRS was provided with a copy of the Barwon MHS Case Closure Summary[168] which informed development of an Interim Plan dated 1 March 2017. The Interim Plan identified and sought to address Ricky's personal hygiene, nutritional, health, medication requirements and his social, emotional and behavioural support needs and was amended periodically.[169] Kallara was also informed that Ricky was a NDIS participant.[170]

83. On 21 February 2017, Dr Taylor attended Kallara and was alerted that Ricky had recently moved in. As Ricky was asleep and could not be roused, Dr Taylor did not examine him but noted 'nil acute issues' and his current list of medications. The GP later made enquiries about the timing of Ricky's next Risperdal intramuscular depot injection (**depot**) and upon learning of his chronic hyponatremia made a referral to a pathology service to continue twice weekly blood tests so that sodium levels could be monitored.[171]

84. On 3 March 2017, Kallara staff notified Dr Taylor that Ricky was displaying delusional symptoms and sought additional medication to manage them as needed (**PRN**). The GP prescribed Risperdal tablets. The same day, Dr Taylor received Ricky's blood tests results indicating low sodium levels[172] and called Kallara to advise staff to restrict Ricky's fluid intake as best they could. At the time of the call, Ricky was conscious and walking around but irritable.

[166] Section 110 of the SRS Act.
[167] CB, page 5176. I note Ms Bruinhout's evidence that NTV procedures are used infrequently when considering the cohort of "pension-level" SRS number about 2000: T, page 1524.
[168] CB, page 5166.
[169] CB, page 2714-2716.
[170] CB, page 2719.
[171] CB, page 3360.
[172] CB, page 3360 and T, page 443.

Dr Taylor advised that Ricky should be taken to hospital if there was any deterioration in his conscious state, or increased agitation.[173]

85. Between 3 and 6 March 2017, Ricky was admitted to Ballarat Hospital to manage low sodium levels.[174]

86. On 7 March 2017, RPN Watts emailed Mr Smyth to ascertain how Ricky was settling in at Kallara. Mr Smyth reported that Ricky was 'going ok' but that his first week's residence had been a 'steep learning curve.'[175]

87. On 10 March 2017, Kallara staff reported Ricky missing but he returned to the facility independently the following day.[176]

88. On or about 14 March 2017, Mr Smyth contacted both the NDIA and DFFH to highlight concerns about Kallara's capacity to meet Ricky's needs (in relation to wandering and excessive water consumption). He told DFFH that Kallara needed assistance to meet Ricky's 'high needs' or would be 'forced to evict him.'[177]

89. The same day, Mr Smyth sought the assistance of DFFH Authorised Officer Timothy Lubke, who was conducting a routine inspection of Kallara, to achieve transfer of Ricky's NDIS package from Geelong to Ballarat. Mr Smyth reported making numerous calls to the NDIA and the Local Area Coordinator, Latrobe Community Health Service (**LCHS**),[178] without success.[179] Mr Lubke volunteered to make enquiries and contacted LCHS directly that day and again on 4 April 2017 upon learning that Ricky still did not have access to his NDIS supports.[180]

90. Independently, on 15 March 2017 Mr Aldridge emailed a Request for Plan Review and a Progress Report to the NDIA on Ricky's behalf, highlighting its urgency and that he had liaised with Wellways in Ballarat which had capacity to take on the role of support coordinator.[181]

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[173] CB, page 3360.
[174] CB, page 225.
[175] CB, pages 2810-2811.
[176] CB, page 228.
[177] CB, pages 226 and 248.
[178] Latrobe Community Health Service is a contracted Local Area Coordination partner of the NDIA delivering the NDIS to participants in six local government areas in the Central Highlands region of Victoria. LCHS was not involved in any of Ricky's plans because of his 'streaming status' within the NDIS, that is, he was streamed as 'Super Intensive' and 'Intensive;' LCHS is only funded to support participants with streamed factors 'General' and 'Supported:' CB, pages 4316-4317.
[179] CB, page 233.
[180] CB, pages 233 and 237-241.
[181] CB, page 2636.

91. On 21 March 2017, Dr Taylor performed an annual health check of Ricky at Kallara.[182] The GP was never able to obtain any significant medical history directly from Ricky and attended fortnightly to administer his depot, with which Ricky was generally compliant.[183]

92. On or about 18 April 2017, Ricky's NDIS package was transferred from Geelong to Ballarat.[184] The goals of Ricky's first NDIS Plan in Ballarat (**NDIS Plan 1**) were to participate in social and community activities, stay healthy and access all medical appointments, with the longer-term goals of learning to use public transport and to remain living at Kallara. The NDIS Plan funded support coordination, transport, improved daily living and core supports and was anticipated to be in place for the following 12 months.[185]

93. On 20 April 2017, Wellways received a request for service from the NDIA accompanied by Ricky's NDIS Plan 1.[186] Wellways' first contact with Ricky occurred by phone on 3 May 2017, with a face-to-face meeting two days later between Ricky, Wellways' Corey Manton (Ricky's first support coordinator in Ballarat) and Russell Belshaw of Centacrare.[187] Ricky signed the first of several service agreements with Wellways.

BMHS Referral 1, 19 May 2017: Setting Ricky's "baseline"

94. On 19 May 2017, Mr Smyth contacted BMHS Triage (**Triage**) requesting psychiatric intervention in the context of Ricky's refusal to take oral medications, verbal abuse of staff and the possible emergence of paranoid ideas.[188] He also indicated his view that Ricky may require a higher level of care than Kallara could provide.[189] As Mr Smyth was unable to provide much information about Ricky's psychiatric history, the clinician said she would liaise with Barwon MHS and revert, and in the meantime, he should negotiate medication compliance in exchange for cigarettes.[190] The referral was triaged according to the state-wide triage scale guidelines as a 'Category D' referral.[191]

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[182] CB, page 3359.
[183] T, pages 417-418.
[184] CB, page 233.
[185] CB, pages 2993-2997.
[186] CB, pages 2993-2997: NDIS Plan dated 18 April 2017-18 April 2018.
[187] CB, page 4288.
[188] CB, pages 3501-3503.
[189] CB, page 3499.
[190] CB pages 3501-3503.
[191] CB, page 3502. The triage scale guidelines classifies the outcome of the triage assessment according to the patient's eligibility and priority for mental health services and the response required ranging from categories 'A' (emergency services response) to 'G' (advice or information only/more information is needed). Category D requires a semi-urgent mental health response: CB, page 4303. Triage categories 'A' to 'E' will ordinarily result in an intake assessment of some kind, with the timeframe within which assessment should occur shortening depending on classification: T, pages 1181-1183.

95. Mr Smyth had assumed that Ricky would have been transferred from Barwon MHS to BMHS as an 'open case' and that BMHS would be managing Ricky's mental health and treatment in Ballarat.[192]

96. A BMHS clinician called Kallara the next day and was told that Ricky had settled overnight and had been calm and compliant with medications that morning and there were no current psychotic symptoms.[193] PRN medication resolved agitation the previous afternoon, however, a 'usual pattern' of agitation in the afternoon was noted by the Kallara staff member.[194] The clinician concluded there was no indication for urgent intake assessment but would call again in a few days to determine the need for further BMHS involvement, encouraging Kallara to contact Triage if concerns arose.[195]

97. On 22 May 2017, Mr Smyth called Triage again 'very concerned with Ricky's current mental state and behaviour' including increased agitation (making staff feel unsafe), fluctuating compliance with medications, wandering, and talking to walls and barking at trees.[196] As Mr Smyth had understood his previous call would result in Ricky's assessment by BMHS, the Triage clinician advised that the plan had been to call that day to arrange a non-urgent assessment given the absence of 'acute concerns' over the weekend.[197]

98. At a BMHS Multidisciplinary Team Meeting (**MDTM**) the same day, and given Mr Smyth's 'further contact,' an intake assessment was considered warranted to review Ricky's symptoms.[198]

99. Having obtained information about Ricky's psychiatric history from Barwon MHS,[199] two BMHS clinicians attended Kallara on 23 May 2017 to assess Ricky. He was clean, tidy and appropriately dressed, maintained good eye contact and was friendly, but with underlying irritability. Ricky engaged well, though with minimal conversation which clinicians found hard to understand at times due to slurred speech attributed to a cognitive impairment.[200] No formal thought disorder was evident, and he provided logical responses to basic questions;[201] auditory

[192] T, pages 215-216.
[193] CB, page 3500.
[194] CB, page 3500.
[195] CB, page 3500.
[196] CB, page 3499.
[197] CB, page 3499.
[198] CB, page 3498.
[199] CB, page 3496.
[200] CB, page 3491.
[201] CB, page 3491.

hallucinations were reported but were not perceived by Ricky as problematic and where characterised as chronic by the clinicians.[202]

100. The overall clinical impression was that Ricky's mental state[203] and risk profile[204] were 'consistent with his chronic presentation as described' in Barwon MHS case closure documents but that he may be experiencing increased stress due to poor sleep, which had been addressed with medication.[205] The 'management issues' reported by Kallara were likely associated with poor sleep, medication non-compliance, financial difficulties, frustration at not having needs met and cognitive impairment.[206]

101. The clinicians provided education to Ricky and Kallara staff about sleep hygiene, medication compliance and behaviour modification and feedback to Ricky's GP and Kallara about the outcome of the assessment, namely, that BMHS had no acute concerns.[207]

102. The intake assessment, including a recommendation for no further action by BMHS, was endorsed by the MDTM on or about 26 May 2017.[208] The MDTM minutes noted that Dr Taylor had added medication to assist with Ricky's sleep, aggressive behaviour and irritability and was agreeable to continue prescription, and that Ricky was:

> referred by SRS staff in context of aggressive behaviour. Client presented with chronic delusions and auditory hallucinations, as per his longstanding Sx [symptom] profile. Nil acute Sx or risks present at time of intake Ax [assessment].[209]

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[202] CB, page 3490.

[203] CB, pages 3491-3493: Mental State Examination: appearance/behaviour – ALDs attended to; good eye contact; appropriate engagement; nil agitation or abnormal motor activity; mood/affect – mood not rated; affect reactive, euthymic, fatuous smile at times; underlying irritability evident when discussion medications/behaviours; speech – normal tone and volume; slurred speech sometimes difficult to understand; thought – nil formal thought disorder; logical answers to basic questions; minimal conversation possibly related to cognitive impairment; goal directed with prompting; perception – auditory hallucinations; Ricky ignores them and walks for distraction; voices neither derogatory nor command; cognition – oriented to place but not day/month/year; appears cognitively impaired with poor memory; judgement and insight – partial due to cognitive impairment but understands he has a mental illness; appears to understand consequences of actions/importance of maintaining good sleeping habits and medication compliance but reports that he does not follow through..

[204] CB, pages 3491-3493: Risk Assessment: accidental self-harm – moderate (cognitive impairment, poor memory, poor sleep and decline in ADLs when unwell; deliberate self-harm – low (nil depressive cognitions or threats of self-harm voiced or observed; harm to others – moderate (underlying irritability; history of becoming verbally abusive to staff and physically aggressive to co-residents when unwell; vulnerability – moderate (cognitive impairment – including vulnerable to influence of others; failed residential placements; nil family involvement; treatment compliance – low (compliant with medications under supervision; engaging with GP and NDIS); protective factors – low (stable accommodation and meals provided; GP and NDIS involvement; compliant with medication; finances managed).

[205] CB, page 3493.

[206] CB, page 3493.

[207] CB, page 3493.

[208] CB, page 3488.

[209] CB, page 3488.

103. Consultant psychiatrist Dr Anoop Lalitha, Clinical Director of BMHS, testified that together the Barwon MHS case closure documents and BMHS assessment set Ricky's 'baseline.'[210] All future contacts between Ricky and BMHS would be determined with reference to that baseline.[211] Dr Lalitha observed that a constellation of psychiatric symptoms and behaviours that were chronic, or persisted over time[212] may fluctuate[213] and that active psychotic symptoms may not rise to indicate acute unwellness at given point in time.[214] Whether a presentation is consistent with Ricky's baseline or demonstrated a need for acute intervention is a clinical judgement.[215]

104. Indeed, the dominant criterion for intervention by tertiary mental health service – including intervention by way of case management – is acuity of presentation. Dr Lalitha observed that Ricky 'fits within [the] missing middle category'[216] of mental health patient highlighted by the Royal Commission into Victoria's Mental Health System in its Final Report. The "missing middle" are a 'large and growing group of people that have needs that are too 'complex,' too 'severe' and/or too 'enduring' to be supported by primary care alone, but not 'severe' enough to meet the strict criteria for entry to specialist mental health services. As a result, [they] receive inadequate treatment, care and support, or none at all.'[217]

105. It is unclear whether, or to what extent, the fact that Barwon MHS had closed Ricky's episode of case management was a factor in decisions by BMHS about the manner of its intervention at this point, or later when the "assertive care" relied upon by RPN Watts had fallen away.

106. On 1 June 2017, Mr Manton saw Ricky at Kallara and introduced him to Wellways support worker, Steve, who would start to assist him to access the community twice each week commencing the following week.[218]

[210] T, page 1214. Or his 'new baseline' for the purposes of BMHS decision-making: T, page 1197.
[211] T, page 1214.
[212] T, page 1198.
[213] T, page 1227.
[214] T, page 1211.
[215] T, page 1238.
[216] T, page 1217.
[217] AM, page 235.
[218] CB, page 3118. I note that Mr Manton had made enquiries on Ricky's behalf about social and community activities from May 2017 but encountered availability problems and, on 18 May 2017, had refused to sign a service agreement: CB, page 3119.

107. On 26 June 2017, Kallara staff became aware that Ricky's right index finger was infected and contacted Dr Taylor, who attended the following day.[219] On review, Ricky refused to let the GP examine his finger, but Dr Taylor glimpsed the wound and antibiotics were prescribed.[220]

108. On 30 June 2017, Dr Taylor returned to Kallara and this time Ricky allowed him to examine his finger which was swollen and infected. The GP referred him to hospital. At Ballarat Hospital, Ricky was initially non-compliant with nurses making vital observations and resisted cannulation. He wandered around the ward seeking cigarettes but settled, allowing observations to be taken and intravenous antibiotics commenced.[221]

109. However, at about 9.30pm, Ricky did not return to the ward after having a cigarette outside. When he could not be located within an hour, hospital staff reported Ricky missing. Police located Ricky walking down the middle of a highway about an hour later with an intravenous line still attached. After being returned to the hospital to have the cannula removed, Ricky was taken home to Kallara by police.[222]

110. On 1 July 2017, Ricky was admitted to Warrnambool Hospital for partial amputation of his infected finger. It appears that Mr Broughton made medical decisions on Ricky's behalf in relation to this episode of care.[223]

111. On 3 July 2017, Kallara notified DFFH of a Prescribed Reportable Incident relating to the partial amputation of Ricky's finger.[224]

112. In June or July 2017, Ricky became a client of Russell Belshaw though he had seen Ricky informally during visits to Kallara.[225] Mr Belshaw's role was as Key Support Worker under Centacare's Supporting Connections program which involved working with residents of SRSs to identify their needs, make referrals and facilitate access to appropriate supports.[226]

113. On 5 July 2017, Mr Belshaw called the NDIA seeking an 'urgent review' of Ricky's plan and, in particular, a 'housing options package SIL funding' so that he 'could be considered for SDA accommodation.'[227] Mr Belshaw informed Mr Smyth, Wellways, and Mr Lubke of his actions;

[219] CB, pages 2821 and 3358.
[220] CB, pages 3358 and 242.
[221] CB, page 3572.
[222] CB, page 3576.
[223] CB, page 3527.
[224] CB, pages 242-243 and 2823.
[225] CB, page 259.
[226] CB, page 258.
[227] CB, page 2849.

Mr Lubke reportedly disclosed an awareness of concerns relayed to him by Kallara about the facility's capacity to meet Ricky's needs.[228]

114. Based on Ricky's Wellways file, it appears that Ricky's support coordination was re-allocated to Athanasia Avraam on about 6 July 2017.[229] At the time Ms Avraam commenced, Mr Manton advised her of the circumstances of Ricky's admission to Warrnambool Hospital, that Mr Broughton was pursuing Medical Guardianship so that he could make decisions about Ricky's medical care and that a NDIS 'Emergency Plan Review ha[d] been enacted,' Ms Avraam noting that she needed to 'find out who started this process and follow up.'[230]

115. Ricky was discharged from Warrnambool Hospital on 6 July 2017 and returned to Kallara.

116. Ms Avraam contacted Mr Smyth who reported that Ricky was in good spirits and showing off his bandaged hand to staff and co-residents. She asked if he knew who had initiated an urgent review of Ricky's NDIS Plan 1 but he did not know. Mr Smyth was aware of concerns (of those outside the facility) about Kallara's ability to manage Ricky but expressed optimism that it could continue to do so provided Mr Broughton was appointed Medical Guardian, which he considered would assist staff to administer medications to mitigate Ricky's unpredictable behaviour. Mr Smyth expressed concerns about the goals in Ricky's NDIS plan, particularly that he learn to use public transport; he considered that Ricky going out unsupervised posed a 'very real hazard.'[231]

117. On 7 July 2017, Ms Avraam and Mr Belshaw discussed Ricky's situation. Mr Belshaw confirmed contacting the NDIA two days earlier and being told someone from the Ballarat office would contact him with no timeframe given. They canvassed identifying alternative supported accommodation options or, if Ricky wished to stay at Kallara, increasing the frequency of support worker attendance from the current frequency of two two-hour shifts per week.[232]

118. The same day, Ms Avraam called the NDIA to follow-up on the "Emergency Plan Review" and was informed that 'there were no notes' suggesting a review had been requested.[233] Mr Belshaw testified that because of his contact with the NDIA,[234] he received what he believed was a

[228] CB, page 2848.
[229] CB, page 3117.
[230] CB, page 3117.
[231] CB, pages 3116-3117.
[232] CB, page 3115.
[233] CB, page 3116.
[234] T, page 285 and CB, page 4082-4083.

Request for Plan Review later the same month. He recalled hand-delivering hard copy documents to the Wellways office,[235] but it appears that the (plan review) documentation from NDIA was provided to him electronically.[236] For her part, Ms Avraam recalls receiving a hard copy document from Mr Belshaw for a plan review for a continence assessment and submitting it to the NDIS.[237] She did not specifically recall any other document, nor could she explain why she would perform work on one document but not another if she had received them both.[238]

119. Ricky was due to attend BPG on 7 July 2017 for post-operative review but refused to attend.[239]

BMHS Referral 2, 7 July 2017

120. On 7 July 2017, Mr Smyth called Triage reporting that though Ricky's 'mental state was unchanged' he had refused to attend his GP for review and re-dressing of his surgical wound following finger amputation.[240] The Triage clinician provided advice to Mr Smyth about requesting a home visit by the GP or arranging for the District Nursing Service (**DNS**) to commence sooner than planned. The MDTM determined that no further assistance from BMHS was required.[241]

121. Between 7 and 10 July 2017, Mr Smyth and Mr Belshaw discussed Ricky's ongoing refusal of post-operative wound care and concerns that this may lead to medical complications. Mr Belshaw's notes reflect a discussion he had with an (unnamed) Authorised Officer who reportedly suggested that Mr Smyth draft a NTV on the grounds Kallara could not meet Ricky's care needs to 'add weight to … an urgent review of [Ricky's] NDIS plan for … accommodation.'[242] The plan was then for a 'worker' to contact the NDIA about the review highlighting the NTV and the reason it was issued.[243]

122. Dr Taylor arranged for the DNS to attend Kallara to provide post-operative wound care. When a nurse attended on 10 July 2017 to re-dress the wound, Ricky was cooperative, removing the dressing himself, and allowing the wound to be re-dressed without issue.[244]

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[235] T, 343.
[236] T, page 327.
[237] T, page 731.
[238] T, page 731.
[239] CB, page 3357.
[240] CB, page 3484-3486. The triage referral was classified as Category G: CB, page 3485.
[241] CB, page 3482.
[242] CB, page 2848.
[243] CB, page 2848.
[244] CB, pages 3704-3705.

123. On 10 July 2017 Mr Smyth issued a NTV within 28 days citing section 115 of the SRS Act and indicating that Ricky's healthcare needs were greater than Kallara could provide. The NTV also stated that Kallara was an inappropriate place for Ricky to live because it could not provide the 'constant supervision or intensive one to one care' he required.[245] The copy of the notice that appears in Ricky's Kallara file is annotated indicating a copy was given to Ricky on the date of issue.[246] It does not appear that DFFH or Wellways were informed that this NTV was issued.[247]

BMHS Referral 3, 13 July 2017

124. Mr Smyth called Triage again on 13 July 2017.[248] He reported 'significant deterioration' in Ricky's 'behaviour' which appeared to coincide with the two days before and after depot was administered: he characterised Ricky's behaviour that day as 'extreme' and 'unlike' him.[249] Ricky had run around Kallara in a 'chaotic manner,' speaking to others in aggressive and derogatory ways – even a staff member with whom he ordinarily had a good rapport found it difficult to have any meaningful interaction with him.[250] Ricky was also reported to be 'speaking vaguely about a boy that has been hurt and needs help.'[251] The clinician recommended use of PRN medication and proposed a face-to-face assessment that day.[252]

125. When the clinician attended Kallara, a staff member reported that Ricky had become more settled. On review, Ricky declined to speak to the clinician at length but 'politely' answered the questions asked.[253] He reported feeling 'stressed' that morning but could not explain the reason[254] and was feeling better at the time of the assessment.

126. The clinician identified no acute risks to Ricky or others and characterised his mental state as consistent with his chronic symptoms of schizophrenia.[255] She reported the outcome of the assessment to Mr Smyth and asked Kallara staff to monitor Ricky's mental state and risks and contact Triage again if needed.[256]

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[245] CB, page 2755.
[246] CB, page 2755.
[247] CB, pages 232-250 (Lubke, DFFH), 253 (Pender, DFFH) 3113-3115 (Wellways file); see also, Ms Bruinhout's evidence that a section 60/61 notice should have occurred to the DFFH prior to the issue of this NTV: T, page 1563.
[248] CB, page 3477.
[249] CB, page 3477.
[250] CB, page 3478.
[251] CB, page 3478.
[252] CB, page 3479. The triage referral was classified as Category F (not requiring a face-to-face response).
[253] CB, page 3479.
[254] CB, page 3479.
[255] CB, page 3479.
[256] CB, page 3479.

127. When Mr Smyth's third Triage referral was considered by the MDTM, it recommended a follow-up phone call to Kallara.[257]

128. On 14 July 2017, when a BMHS clinician contacted Kallara, the staff member reported that Ricky's presentation was similar to his usual presentation, and that PRN medication had been used.[258] The clinician reported that as there were no current concerns, BMHS would close this episode of care.[259]

129. On 17 July 2017, the MDTM endorsed the plan for no further action by BMHS.[260]

130. The same day, Kallara served Ricky with a NTV immediately pursuant to section 110 of the SRS Act.[261] The NTV referred to Ricky's repeated aggressive behaviour towards staff and residents and an incident that morning during which he 'displayed psychotic and delusional behaviour threatening physical harm to [others] … and punched [a] fellow resident.'[262]

131. A Kallara staff member contacted Triage to advise that Ricky had been evicted for allegedly assaulting another resident; his behaviour was 'unmanageable' notwithstanding medication compliance.[263] When it was put to him during his oral evidence at inquest that the purpose of this call to Triage was to 'get [Ricky] evicted,' Mr Smyth disagreed, stating that the purpose was to discuss concerns about Ricky's behaviour with psychiatric services: 'it wouldn't be purely to get anyone evicted, it doesn't really work like that.'[264] The Triage clinician, having discussed the matter with her manager, recommended that the police be called as Ricky had been discharged from BMHS.[265]

132. The police were called to attend Kallara in relation to 'a dispute' between two residents.[266] On arrival, Senior Constable (**SC**) Brenton Walker was informed of Ricky's increasingly aggressive behaviour over the previous week and that staff 'wanted him evicted.'[267] There being no alternative accommodation arrangements in place, SC Walker contacted members of

[257] CB, page 3475.
[258] CB, page 3474.
[259] CB, page 3474.
[260] CB, page 3473.
[261] CB, page 247.
[262] CB, page 247.
[263] CB, page 3472.
[264] T, page 241.
[265] CB, page 3472.
[266] CB, page 256. I note that Mr Smyth informed Mr Lubke on 21 July 2017 that following an (I assume internal) investigation the co-resident alleging she was assaulted by Ricky later 'changed her story'. Obviously, Ricky was long gone from Kallara by then and, according to Mr Smyth, the co-resident's recantation did 'not change the specifics of' the NTV because 'other incidents of intimidating other residents were witnessed:' CB, page 2826.
[267] CB, page 256.

Ricky's family to ascertain if they could assist with accommodation. When they could not assist, he contacted Triage relaying the information he had been provided by Kallara staff.[268] SC Walker was told that BMHS was 'aware' of Ricky but were 'unable to provide any immediate assistance.'[269] The Triage clinician's note of this communication was that SC Walker had reported that Ricky was presenting with no acute mental health issues.[270]

133. A Kallara staff member made enquiries of Merindah, which had a vacancy. Upon being told that Merindah provided the 'same service' as Kallara and was 'suitable' for Ricky, SC Walker transported Ricky to Merindah.[271]

134. Mr Smyth emailed Mr Lubke to notify him of Ricky's eviction. Among the matters mentioned in that correspondence, to which the NTV was attached, were that BMHS 'would not attend' and Mr Smyth's view that Ricky's care needs were greater that could be provided at Kallara: 'we feel he should be in a secured environment so that he does not present a danger to himself or others.'[272] Although DFFH was notified of the NTV,[273] Wellways was not.[274]

135. Ricky spent the night of 17 July 2017 at Merindah. The following morning, Ms Peart its proprietor, called Mr Belshaw to ascertain what he knew of Ricky. Mr Belshaw was unaware of Ricky's eviction and told Ms Peart Merindah was unsuitable for Ricky because he required a level of supervision that could not be provided at a boarding house.[275] Mr Belshaw advised Ms Avraam of Ricky's eviction. [276]

136. It was not Mr Belshaw's role to find Ricky another place to live but as he did not appreciate the role a support coordinator might play in arranging crisis accommodation[277] he made enquiries of SRSs in the region, locating a vacancy at Browen Lee.[278] Mr Belshaw collected Ricky from Merindah and took him to Browen Lee.[279]

[268] CB, page 256.
[269] CB, page 256.
[270] CB, page 3471.
[271] CB, page 256.
[272] CB, page 246. Lorraine Smyth's statement clarifies her view (as co-manager of Kallara) that Ricky required a 'proper psychiatric facility placement': CB, page 216.
[273] CB, page 253.
[274] CB, pages 3112-3114.
[275] CB, page 261.
[276] CB, page 3113. Ms Avraam spoke to Ms Peart and Mr Smyth on 18/7/17 to understand what had occurred; Ms Peart told her that Ricky could not stay long at Merindah because his needs could not be met there: CB, pages 3113-3112.
[277] T, page 333.
[278] CB, page 261.
[279] CB, page 261.

Browen Lee

137. According to Emma Broughton of Browen Lee (no relation), Ricky was agitated upon arrival and so did not sign a residential services agreement on 18 July 2017 (or later).[280]

138. Ms Broughton called Mr Smyth to obtain information about Ricky's needs soon after his arrival.[281] She prepared Ricky's Browen Lee file,[282] which included a Resident's Ongoing Support Plan[283] drawing on information provided by Kallara,[284] including the Barwon MHS case closure documents.[285] Ricky's GP's details were also recorded, along with a list of his medications and dosing instructions.[286] Dr Taylor did not provide home visits to Browen Lee[287] and Browen Lee did not provide support for its residents to attend appointments.[288] However, as an SRS, Browen Lee could administer Ricky's oral medications.[289]

139. Dr Taylor arranged for the DNS to attend Browen Lee to continue management of Ricky's surgical wound and start to administer his fortnightly depot injection.[290]

140. On 20 July 2017, Mr Belshaw and Ms Avraam visited Ricky.[291] Ms Broughton told Ms Avraam that Ricky was coughing and experiencing rib pain and so Ms Avraam arranged an appointment with Dr Taylor,[292] which Ricky attended with a support worker on 24 July 2017.[293] That appointment was the only time Ricky saw a GP while at Browen Lee.

141. Ms Broughton gave evidence at inquest that Ricky was settled during his first week at Browen Lee but during his second week there, he was agitated, pacing, entering other residents' rooms and was verbally aggressive toward staff three or four times.[294] Following a verbal warning about his conduct, Ricky's behaviour improved for a few days but then deteriorated, prompting delivery of a written warning.[295] No copy of the written warning appears in Ricky's Browen

[280] T, page 359.
[281] T, page 360.
[282] T, page 358.
[283] CB, pages 3225-3229.
[284] T, page 358.
[285] T, page 361.
[286] CB, page 3222.
[287] T, page 362.
[288] T, page 363. If Ricky needed to see a doctor, he would have to do so in the ordinary way, perhaps with the assistance of a support worker.
[289] T, page 358.
[290] CB, pages 3704-3705 and T, page 420.
[291] CB, page 3111.
[292] It was unclear from Ricky's account if rib soreness was the result of an assault on him by someone at Merindah, or had been hit on the back to help him cough: CB, page 3111.
[293] CB, pages 3356-3357.
[294] T, page 355.
[295] T, page 355.

Lee file, nor are there any indications in either the Centacare or Wellways case notes that Browen Lee communicated its concerns about Ricky's behaviour – or that his tenancy might be at risk – in this period.[296]

142. However, following an incident overnight on 31 July 2017 when it is alleged Ricky entered the backyard of a property neighbouring Browen Lee, the proprietor issued an immediate NTV on 1 August 2017.[297] There is no copy of the notice to vacate in Ricky's Brown Lee's file. Centacare was informed of the eviction by Browen Lee staff,[298] and in turn, notified Wellways[299] and Mr Lubke.[300] Although Ms Broughton conveyed to Centacare that Ricky required a higher level of care than could be provided at Browen Lee[301] it appears that the primary reason for his eviction was the effect of his behaviour on other residents who reported feeling unsafe.[302] Notwithstanding that Centacare notified Mr Lubke of Ricky's eviction from Browen Lee, the DFFH appears to have no record of Ricky ever living there.[303]

143. On 1 August 2017, neither Mr Belshaw nor Ms Avraam were working. Jill Spicer, one of Mr Belshaw's colleagues at Centacare contacted Mr Manton, Ricky's first Wellways support coordinator. They were both concerned that Ricky's needs could not be met by an SRS,[304] and discussed the process 'to get [Ricky] into Sovereign House,'[305] which required 'referral from psychiatric services.'[306] Ms Spicer informed Mr Manton that Wellways was the 'lead agency' with responsibility for securing Ricky alternative accommodation[307] but suggested he contact the Uniting Care Open Doors Program, other SRSs and respite care providers.

144. Mr Manton contacted the Opening Doors Program for crisis accommodation but was informed that because Ricky's finances were administered by State Trustees he could not be accommodated.[308] He also noted having 'spoken to DHHS and was told they had no

[296] CB, pages 2847-2848 (Centacare) and 3110-3111 (Wellways).
[297] T, page 355.
[298] Browen Lee informed the DNS that Ricky was 'no longer welcome' there due to 'behaviour issues' and that it was unclear whether he would remain at Merindah until his wound care review on 4/8/17 or next depot injection on 8/8/17: CB, page 3703.
[299] Upon learning from Centacare that Ricky was to be evicted that day, Mr Manton contacted Browen Lee directly: CB, pages 3109-3110.
[300] CB, page 2847. Mr Lubke's statement records no contact concerning Ricky after 17 July 2017: CB, page 234.
[301] T, page 355.
[302] T, pages 364 and 368.
[303] CB, page 235. This is perhaps because Ricky never signed a service/tenancy agreement.
[304] CB, pages 2847 (Centacare) and 3110 (Wellways).
[305] Sovereign House is a secure extended care unit for involuntary psychiatric patients with acute psychotic illnesses who required extended inpatient case: CB, page 3445.
[306] CB, page 3110.
[307] CB, page 2874. According to Ms Spicer's note, Mr Manton was 'persistent' for Centacare to find Ricky accommodation. This is not reflected in Mr Manton's notes.
[308] CB, page 3109.

accommodation,'[309] followed up with BMHS concerning Sovereign House and sought the assistance of Ballarat Health Services for management of Ricky's medication.[310]

145. Mr Manton learned there was a vacancy at Merindah 'for a couple of days' while Wellways identified a suitable alternative.[311] He requested and received Centacare's assistance to transfer Ricky from Browen Lee to Merindah.[312]

Merindah

146. At the time Ricky was living there, Merindah operated as a boarding house having previously been a motel.[313] Its approximately 19 residents tended to be individuals with mental illness or other disabilities.[314] In addition to a furnished room with ensuite bathroom, residents are provided three meals each day, a laundry service and access to the communal kitchen, lounge and dining areas. There was one full time staff member, Kayleen Stephens, and three other staff including an overnight caretaker; no staff are onsite, except at mealtimes, on weekends.[315] Although according to Ms Peart staff try to help with 'whatever the residents needs'[316] there are practical and legal limits to staff assistance: staff levels were relatively low, and staff were not authorised to administer medication.[317]

147. On 2 August 2017, Mr Manton received a call from Mr Belshaw who suggested he discuss 'SDA options' with one of his Centacare colleagues given Mr Belshaw's concerns about Ricky's needs and housing insecurity.[318] Mr Manton handed over this lead to Ms Avraam who pursued it. She was told that 'all SDAs in Ballarat were at full capacity' but she could seek housing alternatives for Ricky through McCallum Disability Services, the Tipping Foundation and DFFH but was warned the latter option was 'more difficult' when no NDIS funding was available and was generally a longer process.[319] Mr Avraam observed at inquest that a key barrier to resolving Ricky's accommodation issues was a lack of availability.[320]

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[309] CB, page 2847.
[310] CB, page 3109.
[311] CB, page 2847.
[312] CB, page 2847.
[313] T, page 882.
[314] T, page 883.
[315] CB, pages 286, 293 and 4063 and T, pages 888 and 907.
[316] T, page 882.
[317] CB, page 286.
[318] CB, page 3109.
[319] CB, page 3108.
[320] T, pages 736-737. In addition to Ms Avraam's evidence about difficulty finding SRS and similar accommodation scarce in the areas she made enquiries (Ballarat and Melbourne), Ms Bruinhout gave evidence that at the time of inquest, 50,000 households were waiting for social housing, about half of which was considered priority cohort: T, page 1513; Mr MacIsaac testified to the ongoing shortage of SDA: T, page 1536.

148. On 3 August 2017, Ms Avraam called Merindah to check on Ricky. She spoke to Ms Stephens who said that Ricky's Wellways support worker, Steve, was there and while Ricky 'ha[d] not been threatening anyone yet' she was concerned about what might occur at the weekend and wanted 'Ricky gone ASAP.'[321] Ms Avraam then spoke to Steve who reported that Ricky 'appears to have deteriorated since [his] last visit, seems highly agitated.'[322]

BMHS Referral 4, 3 August 2017

149. On the same day, Ms Avraam contacted Triage and spoke to Benjamin Gillett. She relayed the concerns raised by Centacare and Merindah staff about Ricky's increased agitation, refusal of medication and wandering.[323] She recounted Ricky's recent stays at Kallara and Browen Lee following a move from Geelong, and that the Merindah placement was a 'short term solution' because it was 'not appropriate' to Ricky's high care needs and there was concern he might wander onto the highway.[324]

150. Mr Gillett then spoke to Ms Stephens at Merindah who confirmed Ricky required a 'higher level of supervision.'[325] She reported that Ricky was not attending to self-care, wandered 'constantly' and that he was drinking excessive fluids.[326] Mr Gillett then spoke briefly to Ricky who was 'very difficult to understand' but able to communicate that he would soon be having dinner and agreed to take his evening medication.[327]

151. Mr Gillett's clinical impression was that while the referral disclosed 'nil acute risks,' Ricky was highly vulnerable and 'given the possible evidence of EWS [early warning signs of mental state deterioration], behavioural issues and at-risk accommodation, a face-to-face review is warranted' to ascertain if Ricky was in the early stages of relapse.[328] The triage referral was classified as Category D.[329]

152. On the morning of 4 August 2017, two BMHS clinicians reviewed Ricky at Merindah after a discussion with Ms Stephens who reported compliance with oral medications, and the use of

[321] CB, page 3108.
[322] CB, page 3108.
[323] CB, page 3467.
[324] CB, page 3467.
[325] CB, page 3468.
[326] CB, page 3468.
[327] CB, page 3468.
[328] CB, page 3469.
[329] CB, page 3469.

one of his two PRN medications.[330] It is clear from the notes that the clinicians believed Merindah to be an SRS.[331]

153. Ricky was pleasant and cooperative with clinicians, reporting poor sleep the previous night and so he had taken a walk, and that he had showered the day before (though Ms Stephen reported while the shower was turned on following prompting, Ricky had not bathed).[332] Ricky appeared cognitively impaired, did not respond to auditory hallucinations during review but expressed grandiose with no persecutory or paranoid themes in conversation. The clinical impression was that Ricky's presentation related to frequent moves upsetting his usual routine and difficulty adjusting to new environments and people, with associated behavioural attempts to meet his perceived need for cigarettes.[333] There were no acute symptoms or risks requiring further BMHS intervention.[334]

154. The clinicians reviewed Ricky's Webster pack, noting that the medications were consistent with the regime in place at the time of BMHS' May 2017 intake assessment. Ms Stephens was encouraged to prompt use of both PRN medications and Ricky 'was agreeable' to taking them at the time of review.[335]

155. Mr Manton and Ms Avraam were informed of the outcome of the BMHS review. When Mr Manton asked for accommodation ideas to meet Ricky's care needs, the clinicians suggested an Aged Care Assessment Service (**ACAS**) assessment but noted that Ricky's young age may be a barrier.[336] Accessing one-on-one assistance for care needs through the NDIS was also suggested.[337]

156. Later the same day and after speaking to Ms Peart, Ms Avraam called BMHS again to relay fresh concerns raised by Ms Peart about Ricky's risk to others and of accidental harm if he were to wander onto the highway.[338] When Ms Avraam asked if an inpatient admission could be used to manage Ricky's risks, she was informed that in the absence of acute psychiatric symptoms

[330] CB, page 3463.
[331] CB, pages 3464-3465.
[332] CB, page 3463.
[333] CB, page 3464.
[334] CB, page 3464.
[335] CB, page 3464.
[336] Dr Taylor confirmed that Ricky was too young for an ACAS assessment: T, page 410.
[337] CB, page 3465.
[338] CB, page 3107. Based on Ms Avraam's note, Ms Peart was keen for Ricky to move on as Merindah had 'fulfilled its obligation' to provide two days' accommodation: CB, page 3106.

an admission was not indicated.[339] The advice provided earlier about use of PRN medications was reiterated and that police should be called to manage safety concerns.[340]

157. Ms Avraam also called Scope and McCallum for alternative accommodation for Ricky but their facilities either did not meet his requirements or had no vacancy.[341]

158. The MDTM endorsed the clinical impression that Ricky's presentation was chronic and that the 'slight changes to mental state' were attributable to recent relocations.[342]

159. BMHS reported the outcome of its recent assessment of Ricky, and the recommendations made to Wellways and Dr Taylor on 8 August 2017.[343] The GP was also asked to investigate Ricky's diabetes status given the reports from Merindah about his excessive fluid intake.[344]

160. By 7 August 2017, Ricky had settled at Merindah. When Ms Avraam called to check on his progress, Ms Peart said she was happy for Ricky to stay as he had been 'an absolute delight all weekend.'[345] She reported that Steve had assisted Ricky to shower that day and canvassed the idea of rostering additional shifts for support workers to keep him occupied and to engage a personal care attendant to help Ricky with self-care activities.[346] Ms Peart was optimistic that Ricky could be managed at Merindah with those types of supports and that staff had worked out a good system to ration Ricky's cigarettes.[347]

161. On 8 August 2017, the DNS attended Merindah to review his surgical wound, which had healed, and administer his fortnightly depot injection.[348]

162. Ms Avraam arranged for a second Wellways support worker, Savvas, to spend time with Ricky on weekends.[349] They met with Ricky on 18 August 2017.[350]

163. Upon receipt of Ms Stephens' advice that Ricky was increasingly agitated, particularly in the afternoon and disruptive overnight, abusive to co-residents and threatening to Ms Peart, with

[339] CB, page 3462.
[340] CB, page 3462. Ms Avraam relayed the suggestion to call police if safety concerns arise but Ms Peart was noted to be reluctant to do so: CB, page 3107.
[341] CB, page 3106.
[342] CB, page 3458.
[343] CB, page 3516.
[344] CB, page 3516.
[345] CB, page 3105.
[346] Ms Avraam informed Ms Peart that she would arrange a personal care assistant if Ricky was agreeable: CB, page 3105.
[347] CB, page 3105.
[348] CB, page 3703.
[349] CB, pages 3103-3104.
[350] CB, page 3103.

PRN medications having little effect, Ms Avraam contacted Triage on 23 August 2017.[351] The triage clinician classified the referral as Category G.[352]

164. When considered by the MDTM the following day, Ricky's reported presentation was characterised as consistent with previous referrals, with no acute symptoms or risks requiring BMHS involvement. The plan was to recommend referral to a private psychiatrist with the potential for 'brief' follow-up by BMHS until one was engaged.[353]

165. A BMHS clinician spoke to Ms Stephens, the DNS and Dr Taylor's receptionist to confirm information provided by Ms Avraam, ascertain Ricky's medication compliance and recommend referral to a private psychiatrist.[354] The advice concerning referral to a private psychiatrist was relayed to Ms Avraam.[355]

166. At inquest, Dr Lalitha testified that the decision to recommend review by a private psychiatrist rather than a BMHS psychiatrist related to the determination that Ricky did not require ongoing case management by BMHS.[356] Moreover, the referral suggested the need for no more than a medication review.[357] If Ricky's presentation in August 2017 had demonstrated a change from his baseline (as established by BMHS in May 2017), he might have been a candidate for case management but because his 'behavioural and mental status challenges' accorded with those documented earlier, BMHS intervention was not warranted.[358] Implicitly, Dr Lalitha acknowledged that the conclusion that Ricky did not meet the criteria for case management or intervention in May 2017 meant that successive referrals, where similar behaviours were described, were less likely to result in intervention and the chronicity of his presentation was reinforced.[359]

167. Ms Avraam arranged for Ricky to see one of Dr Taylor's colleagues at BGP about a medication review and referral to a private psychiatrist. When Savvas attended Merindah to take Ricky to the appointment on 25 August 2017, Ricky was agitated and unwilling to accompany him. Ms

[351] CB, pages 3103 and 3455.
[352] CB, page 3457.
[353] CB, page 3453. I note that the erroneous assumption that Merindah is an SRS is perpetuated in the clinical notes.
[354] CB, page 3452.
[355] CB, page 3451.
[356] T, page 1207.
[357] T, page 1210.
[358] T, page 1212.
[359] T, pages 1212-1214.

Avraam warned Savvas to 'tread carefully' because Ricky had a 'tendency to abscond' if unwilling to do something and offered to reschedule the appointment.[360]

168. Ultimately, Ricky attended – with both Savvas and Ms Avraam – and was seen by Dr Elizabeth Ellis.[361] While Dr Ellis was unwilling to make any immediate changes to Ricky's medication regime,[362] she did make a referral to Dr Robert Proctor of Mind @ Home Psychiatry.[363] Her letter referred to Ricky's agitation, recent review by BMHS and that his PRN medications were having less effect on agitation. She asked Dr Proctor to assess and manage Ricky.[364]

169. On 31 August 2017, in the context of continuing reports from Merindah and Ricky's Wellways support workers about his increasing agitation and restlessness, Ms Avraam contacted BMHS to discuss these behaviours.[365] She also reported obtaining a referral for Ricky to see Dr Proctor, and that the associated GP appointment had been 'traumatic' for him.[366] The BMHS clinician suggested the GP perform a home visit and prescribe a sedative.[367] When she followed up with BGP, Ms Avraam was advised that Dr Taylor did not perform home visits.[368]

170. Ms Avraam emailed Mind @ Home Psychiatry to ascertain when Ricky could be seen by Dr Proctor.[369] An appointment was scheduled for 7 September 2017.[370]

171. On 4 September 2017, BMHS contacted Dr Taylor and Merindah to alert them to Ricky's diagnosis of polydipsia. While the GP was already aware and monitoring Ricky's sodium levels, Ms Stephens was advised to manage Ricky's water intake. Merindah removed all available water to a cupboard with a child-proof lock but was unable to restrict Ricky's access to water in his room, or when he was off site.[371]

172. At a MDTM on 6 September 2017, BMHS determined that no further action was required and Ms Avraam's referral was closed.[372]

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[360] CB, page 3101.
[361] CB, pages 3101 and 3356.
[362] CB, page 3356.
[363] CB, page 3340.
[364] CB, page 3340.
[365] CB, page 3100. Although the corresponding BMHS note reflects these matters, it focuses on another comment Ms Avraam apparently made about Ricky's excessive consumption of water, concluding that the contact was 'not psychiatric in nature': CB, page 3449.
[366] CB, page 3100.
[367] CB, page 3100.
[368] CB, page 3098.
[369] CB, page 3341.
[370] CB, page 3098.
[371] CB, page 3447.
[372] CB, page 3445.

173. In September 2017, the Medical Guardianship application made by Mr Broughton with significant liaison effort by Ms Avraam, was refused.[373]

Mind @ Home Psychiatry

174. On 7 September 2017, Ricky attended the first of two appointments with Dr Proctor accompanied by a Wellways support worker who reportedly 'advocated for him,' outlining some of 'the concerns' and 'minimising' the impact of Ricky's behaviours.[374] Dr Proctor diagnosed a personality disorder, that Ricky was 'intellectually limited,' and had 'issues with anger in the past.'[375] He recommended medication changes and appears to have asked Merindah staff to maintain a behavioural logbook.[376] RPN Lorraine Lee, who was present during the consultation,[377] testified that Mind @ Home Psychiatry understood the purpose of Dr Ellis' referral was for assessment rather than Ricky's ongoing psychiatric management.[378]

175. Following the consultation, Dr Proctor sent a letter to BGP stating that he had 'been asked to review [Ricky's] medications' and made a number of changes, including 'quite a serious dose' of Seroquel.[379] He reported having other patients at Merindah and so he would 'keep an eye on him out there … and monitor his progress' on the changed medication regime.[380]

176. Ms Stephens reported to Ms Avraam that Ricky had been unsettled and verbally abusive and had only recently begun to settle on 12 September 2017 following his appointment with Dr Proctor.[381]

177. On 20 September 2017, Ms Avraam contacted Mind @ Home Psychiatry to ascertain the date of Ricky's next appointment. She was advised that the notes indicated a plan to monitor Ricky when a Mind @ Home Psychiatry clinician visited Merindah to consult other patients.[382] Ms Avraam relayed Ms Peart's concern that Ricky was experiencing auditory hallucinations 'more and more' and was verbally abusive when responding to them.[383] She asked if Dr Proctor could

[373] CB, page 3241.
[374] CB, page 316.
[375] CB, page 3345.
[376] The logbook of Ricky's behaviour (21/9/17 - 6/10/17) appears in the Mind @ Home Psychiatry records: CB, 3348-3353.
[377] T, page 372.
[378] T, page 380.
[379] CB, page 3345.
[380] CB, page 3345.
[381] CB, page 3098.
[382] CB, page 3096.
[383] CB, page 3095.

'check in on Ricky' and recommend a psychologist or counsellor who might also be able to assist and was referred to RPN Lee for advice.[384]

178. When she spoke to RPN Lee the same day, Ms Avraam relayed Ms Peart's concerns and a further appointment between Ricky and Dr Proctor was scheduled.[385]

179. Ricky's second appointment with Dr Proctor on 5 October 2017 did not go well. Dr Proctor described him as 'quite psychotic and agitated,'[386] while RPN Lee characterised him as 'belligerent, loud and threatening.'[387] Ricky 'stormed out'[388] and created a 'ruckus'[389] outside the consulting rooms. Although she had no specific recollection, RPN Lee considered it unlikely in the circumstances of Ricky's departure that he would have left with a date for a subsequent appointment; 'but the worker would have been advised.'[390] Ricky's Wellways file does not reflect the relay of any information about the need for a future appointment.[391] The Mind @ Home Psychiatry booking system did not include a reminder function that would have alerted the practice that Ricky had not returned (in the absence of a missed appointment); the practice relied on voluntary patients such as Ricky, or his support workers, to make follow up appointments.[392]

180. Following the consultation, Dr Proctor made a further adjustment to Ricky's medication regime and reported this, and that Mind @ Home Psychiatry 'would review him regularly,' to BGP.[393] Dr Taylor's understanding of this reporting letter was that Dr Proctor would continue to manage Ricky's mental health.[394] There is no evidence that Ricky was seen by Mind @ Home Psychiatry after 5 October 2017. Dr Taylor observed that had he been aware that Dr Proctor did not propose to see Ricky again, he would probably have tried to see him more regularly.[395]

181. Throughout September and October 2017, Ms Avraam made numerous enquiries on Ricky's behalf about recreational day activities having ascertained from him those that might be of interest.[396] She also took Ricky to meet program coordinators in her effort to identify activities

[384] CB, page 3096.
[385] CB, page 3095.
[386] CB, page 3354.
[387] CB, page 316.
[388] CB, page 316.
[389] T, page 384.
[390] T, page 384.
[391] Ms Avraam did contact Mind @ Home Psychiatry subsequently to track down Ricky's behavioural logbook: CB, page 3089.
[392] T, pages 385-387.
[393] CB, page 3354.
[394] CB, page 427.
[395] T, page 427.
[396] T, page 721 and CB, pages 3097 and 3093-3087.

to supplement the one-to-one time Ricky spent with Wellways support workers (shifts had been increased the previous month) and occupy him during the day.[397] Some providers of day activities indicated their programs were tailored to groups with which Ricky might not 'fit in' while others reported no availability.[398] Ms Avraam's plan for Ricky to use the local pool involved, among other things, liaison with State Trustees to increase his fortnightly allowance to enable him to pay the entry fee (for which NDIS funds apparently could not be used).

182. By early October 2017, Ricky had joined Wellways' Day Program. While his first attendance appeared to both engage Ricky and improve his behaviour when at Merindah, he was agitated and pacing the second time he attended and by November declined to go.[399] No explanation for Ricky's refusal to attend was identified – it appeared to come 'out of the blue' because he often expressed a desire to go before his support worker arrived to collect him.[400]

Request for a Plan Review – October 2017

183. Throughout the same period (September-October 2017), Ms Avraam once again sought to identify alternative accommodation options for Ricky. On the basis of Mssrs Smyth and Belshaw's assessment that Ricky's needs could not be met by an SRS, and Mssrs Belshaw and Broughton's belief that Ricky had lived in SDA in Geelong (See Change), Ms Avraam sought to clarify the application and funding processes for SDA through discussions with representatives of the DFFH (as the primary provider of SDA)[401] and the NDIA. She understood SDA to be 'a step up from an SRS'[402] in that it was a place to live[403] offering a higher level of support such that on-site clinical staff could monitor and manage Ricky's medical and mental health,[404] and his problematic behaviours (agitation, aggression, poor sleep and wandering), which she believed were related to his mental health.[405]

184. DFFH representatives advised Ms Avraam that in order for the DFFH to consider an application for SDA, SDA funding must first be 'clearly stated in the NDIS plan.'[406] She was also informed

[397] CB, page 3093.
[398] CB, page 3093.
[399] CB, pages 3087-3084.
[400] CB, page 3084.
[401] T, page 806. Ms Avraam was not aware of any other providers of SDA. Indeed, Mr MacIsaac confirmed that at the time of inquest, DFFH was still the primary provider of SDA in Victoria, with a 70% market share: T, page 1530.
[402] T, page 775.
[403] T, pages 734 and 786.
[404] T, pages 734 and 775.
[405] T, page 774.
[406] CB, pages 3094 and 3096. See also Mr MacIsaac's evidence concerning the practical two-step process foreseen by the SDA Rules whereby the NDIA would determine a participant's SDA eligibility first and then, when a SDA became available the NDIA would allocate SDA funding to the plan: T, pages 1533-1534.

by DFFH that the 'referral process' was lengthy and required 'medical referrals/reports.'[407] Elaborating on the latter point during her evidence at inquest, Ms Avraam's understanding was that DFFH required supporting evidence of Ricky's need for SDA.[408] The DFFH also referred to there being a waiting list for SDA and that agencies such as Wellways would only be contacted once a vacancy was available.[409] Ms Avraam asked for Ricky to be placed on the waiting list[410] but was unsure whether this occurred.[411]

185. Ms Avraam's contact with the NDIA concerning SDA centered on the 'best review process option' to "reinstate" SDA in Ricky's plan.[412] It appears that she submitted and then withdrew a Change of Circumstances form.[413]

186. Ms Avraam met with Ricky at Merindah on 27 October 2017 to discuss a Request for Plan Review with a view to obtaining SDA funding so they could find him more appropriate supportive housing.[414] Although Ricky said he liked living at Merindah, he 'wouldn't mind finding another place to live with better facilities.'[415] Ricky signed a Request for a Plan Review which was submitted to the NDIA on 27 October 2017 and marked as urgent.[416]

187. The request for a plan review outlined Ricky's history in Ballarat, the NDIS funded supports in place and the clinical services to which he was linked. Merindah's unsuitability to meet his needs was highlighted.[417] It explained why Ricky's existing funded supports needed to change in the following terms:

> Previous to Ricky's current plan, Ricky's brother William Broughton confirmed he was residing at an SDA in the Barwon region, however this provision was removed …We request that SDA funding be added to Ricky's plan as DHHS, who advertise all SDA vacancies, have advised that a NDIS plan must have this provision clearly stated before they can consider offering [him] accommodation …Without residing in a suitable facility where [he can] … receive a higher level of care, Ricky is at risk of isolation [and being unable] to build … capacity and work towards his plan goals[418]

[407] CB, page 3094.
[408] T, page 785.
[409] CB, page 3092.
[410] CB, page 3092.
[411] T, page 784.
[412] CB, page 3088.
[413] CB, page 3086.
[414] CB, page 3085.
[415] CB, page 3085. Ms Avraam testified that whenever she'd ask Ricky about accommodation, he'd always give 'the same roundabout answer … that he was happy where he was:' T, page 765.
[416] CB, pages 4062-4064.
[417] CB, pages 4062-4063.
[418] CB, page 4063-4064.

188. In so far as Ms Avraam (and others) misunderstood the nature of SDA funding under the NDIS and erroneously believed that Ricky had previously had such funding in his plan, Ms Avraam conceded those misunderstandings at inquest.[419] She testified that no-one at the NDIA disabused her the notion Ricky had been funded for SDA, nor was she told that her understanding of SDA funding was incorrect, though she could not recall if she had specifically asked.[420] If she had known, her approach to the Request for Plan Review would have been different.[421]

189. Glenn Foard, a social worker by training with more than 20 years' experience in the disability sector, was engaged by Wellways to provide an expert opinion and gave evidence at inquest. In addition to giving evidence that Wellways' support coordination was consistent with industry practice at the time and was reasonable and appropriate in the circumstances,[422] he opined that Ricky was eligible for SDA and complimentary SIL funding based on his very high support needs arising from psychosocial and cognitive disabilities.[423]

190. Christine Faulkner, who gave evidence on behalf of the NDIA and had practical experience as a delegate of the CEO,[424] opined that Ricky was not eligible for SDA funding.[425] Her view, informed by the NDIA Act, SDA Rules and the 'documentation,'[426] was premised on the lack of evidence (by way of formal assessments) of Ricky's "very high support needs" and a supposition that he could continue to live in a 'normal residence' if he had appropriate (behavioural) support plans in place – that is, his needs would not be "most appropriately met by a SDA response."[427]

191. It is not clear to what extent, if any, Ms Faulkner's opinion considered the occupational therapy report relied on to secure the "See Change funding" and she was not explicitly asked during her evidence at inquest. While the report was not part of the Wellways file, it must have been available to the NDIA.

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[419] T, pages 786-787 and 781. Mr Belshaw made the same concessions: T, pages 319-320.
[420] T, pages 814-815.
[421] T, page 781.
[422] AM, page 14. Mr Foard considered both adherence to relevant quality standards and achievement of goals to reach this conclusion: AM, pages 11-13.
[423] AM, pages 1-15 and T, pages 1433-1437. Mr Foard was instructed to provide his opinion on the basis that Ricky 'suffered from schizophrenia and cognitive impairment:' AM, page 16.
[424] AM, page 439.
[425] Ms Faulkner observed that is rare for an individual with a psychosocial disability, in the absence of a comorbid condition, to require SDA – a specialist building is not required): T, pages 1649-1650.
[426] It's not clear what the 'documentation' consisted of – whether it was confined to the information contained in the Request for Plan Review or other materials such as some or all of those in the coronial brief.
[427] T, pages1649-1650. I note that Wellways provided an example of a participant whose circumstances were similar to Ricky's who had received NDIS funding for SDA: AM, pages 567-579.

192. Ms Faulkner testified that paragraphs 3.7 and 3.8 of the SDA Rules broadly required a careful analysis of the participant's person-to-person care needs, the extent to which the existing care network was meeting those needs and was sustainable, the participant's risk to self or others and whether the needs were appropriately met by SDA or could be provided in another setting.[428] She agreed that there was some evidence relevant to these aspects of Ricky's circumstances – if not in formal assessments.[429]

193. Rather than SDA funding, it was Ms Faulkner's opinion that Ricky required 'more supports'[430] She articulated a distinction between 'drop in' activities of daily living support funding[431] (potentially a core support) and SIL funding involving a 24-hour daily 'roster of care.'[432] Ms Faulkner testified that Ricky might have been funded for SIL if those support needs were evidenced[433] but that it was unlikely that they could have been provided to him at Merindah.[434]

194. In any case, both SDA and SIL funding required a 'two step' process.[435] That is, a request for a plan review,[436] with the objective of obtaining NDIS funding so that relevant assessments could be undertaken,[437] and then, upon receipt of reports establishing the need for specific supports, a further request for a plan review to obtain funding for those supports.[438] Where support coordination is funded, as in Ricky's case, the support coordinator is central to the two (review) steps and the interim tasks to facilitate assessments.[439]

195. Ms Faulkner testified that although the support coordinator is intended to work on the instructions of or in consultation with the participant,[440] the NDIA expects support coordinators to monitor the usage of the funds in the plan and the participant's access to supports, and assess whether the NDIS plan goals are being met.[441] If the plan is not meeting the participant's needs/goals, it is expected that the support coordinator notify the NDIA by the submission of a

[428] T, pages 1556-1657.
[429] T, pages 1654-1656.
[430] T, page 1660.
[431] 'Daily living activities' were explicitly funded in Ricky's (Ballarat) NDIS Plan 2, though it seems that this type of service might have been purchased through core support funding used flexibly in NDIS Plan 1.
[432] T, pages 1660-1661.
[433] T, page 1662. This answer responded to a question about whether the NDIS could fund a support worker to essentially come in and manage Ricky's overnight behaviour periodically to help maintain his accommodation.
[434] T, pages1820 and 1824. Only (NDIA) registered SIL providers can deliver SIL supports: T, page 1711. See also the evidence of Mr MacIsaac at T, pages 1528-1529.
[435] T, page 1663.
[436] T, page 1657. A request for a plan review is itself in practice a two-step process: a decision about whether to conduct a plan review and then the plan review itself: T, page 1704.
[437] T, pages 1657-1659.
[438] T, pages 1663 and 1659.
[439] T, page 1659.
[440] T, page 1671-1673.
[441] T, pages 1671-1672, 1678 and 1680.

progress report[442] or by requesting a plan review – but not the latter without the participant's authorisation.[443] When the incongruity of these support coordinator responsibilities with the underlying principles of participant "choice and control" and the rejection of a "paternalistic" case management model of care was highlighted, Ms Faulkner accepted the 'challenge' presented by the situation.[444]

196. Indeed, there is little evidence that Ricky exercised much "control" over any aspect of his NDIS plans (nor significant aspects of his life in Ballarat) in any practical sense, even if he did express preferences – exercising "choice" – if options were presented to him by his support coordinators (or others). While I do not suggest that Ricky's support coordinators acted contrary to his wishes or where relevant, without his authorisation, and they did not raise concerns about his legal capacity to make decisions,[445] the NDIS' only allowance for "grey areas relating to capacity" is the appointment of a nominee.[446] Ricky did not have a nominee. Further, the NDIA makes no independent assessment of a participant's capacity but relies on assessments provided to it. In Ricky's case, 'the assumption' would be that his clinical treating team would determine the need for a nominee to make (or help make) decisions.[447]

197. Ms Faulkner commented that it was possible for the NDIA to initiate a review if it was alerted to a 'significant change of circumstances,' which occurred more frequently at the time of inquest that it would have in 2018.[448] However, if the information was merely that the participant was not benefiting from the NDIS plan (for instance by declining to use funded supports) as opposed to disclosing a risk of harm to self or others,[449] beyond making an enquiry of the participant,[450] the NDIA 'has to be satisfied [by the terms of the NDIS Act] that [the participant] is able to make some level of decision of [their] own accord.'[451] In short, there's 'always the presumption of dignity of risk' in choices made by a participant.[452]

[442] T, page 1681.
[443] T, pages 1671-1672 and 1685.
[444] T, page 1673.
[445] T, page 768.
[446] T, pages 1641-1642.
[447] T, page 1643.
[448] T, pages 1683-1684.
[449] Where the response expected would be for the support coordinator to 'lift [the participant] into the mental health sector:' T, page 1687.
[450] T, pages 1687 and 1689
[451] T, pages 1684-1689.
[452] T, page 1642.

198. At about the same time Ms Avraam left Wellways' employ, on or about 8 November 2017, the NDIA sent her an email advising that the request for a plan review had been granted, and that it would schedule a date for the review in due course.[453]

199. Ricky's third support co-ordinator in Ballarat, Matthew Bolton, learned of the NDIA's decision when he followed up by email and phone on 14-15 November 2017 when he started working with Ricky.[454] Mr Bolton made a further enquiry to ascertain the timing of Ricky's plan review on 21 November 2017 and was advised that due to 'a large volume of requests' no timeframe could be provided but the NDIA would endeavour to complete the review in the 'near future.'[455]

200. On the same day, Mr Bolton visited Ricky at Merindah to discuss his current support needs and a proposed change to his service agreement to 'save money' in his plan by suspending his day activities programs (given his non-attendance) and allocate funds to support him to complete activities of daily living (to bathe and clean his room following a discussion with Ms Stephens).[456] Mr Bolton noted that it was 'unclear how much [Ricky] understood' but that he agreed to suspension of his day programs.[457] Although he appeared unwashed, Ricky claimed to have showered that morning and said he always cleaned his room; Mr Bolton counselled Ricky on the importance of hygiene for good health.[458]

201. In December 2017, attendances by Wellways support workers were concluded early at Ricky's request.[459]

202. On 12 December 2017, in one of only two notes of Ricky's behaviour during fortnightly visits by the DNS to Merindah since August, a Merindah staff member's report that Ricky had been 'up late' and engaging in some 'night w[a]ndering.' was recorded.[460] However, Ricky was otherwise 'in bright spirits' and compliant with administration of depot.[461]

203. On 18 December 2017, Mr Bolton met with Ricky again, this time to discuss a further Request for Plan Review to increase support coordination funding.[462] He explained the rationale for the

[453] CB, page 3083.
[454] CB, page 3083.
[455] CB, page 3081.
[456] CB, page 3082.
[457] CB, page 3082.
[458] CB, page 3082.
[459] CB, page 3080.
[460] CB, page 3702. It was noted on 28/8/2017 that Ricky 'did not want injection at first' but that he permitted administration of depot after reassurance was provided.
[461] CB, page 3702.
[462] Ricky's Wellways file reflects a concern that there remained only one funded hour for support coordination: CB, page 3081.

proposed request as relating to Ricky's 'general deterioration in mental health and functioning' and experience of acute symptoms of schizophrenia. Ricky 'vehemently' disputed that description, saying 'I haven't heard voices in ages; there's nothing wrong with me."[463] Although Mr Bolton reassured Ricky that there was nothing "wrong" with him, only that he may require additional supports to achieve his goals, Ricky refused to sign the Request for Plan Review form.[464]

Plan Review Meeting – January 2018

204. On 9 January 2018, Mr Bolton received a call from a representative of the NDIA to discuss Ricky's plan review during which he foreshadowed Ricky's need for funding in the areas of therapy, support coordination and SDA.[465] While the NDIA representative said that the former could be considered at the review, SDA funding 'could not be allocated unless a SDA place was sourced first.'[466]

205. Ricky's plan review meeting occurred at Merindah on 11 January 2018. Ricky was asleep when Mr Bolton and the NDIA planner arrived around 2pm and could not be roused.[467] Mr Bolton apprised the planner of Ricky's circumstances, particularly that Merindah was 'not meeting his needs,' and suggested that he would benefit from funding for occupational and psychological therapy to improve his capacity for personal care and address problematic behaviours, and 'double' his current support coordination funding.[468] The delegate agreed.[469]

206. By about this time, Ricky had woken up and joined the planning meeting, but his involvement was monosyllabic, according to Mr Bolton.[470] The support coordinator suggested that core support funding be provided to enable a support worker to assist with personal care activities every second day and for attendance at day programs twice each week. When the issue of accommodation was reached, Ricky said he wanted to stay at Merindah for the time being, but

[463] CB, page 3080.
[464] CB, page 3080.
[465] AM, page 497.
[466] AM, page 497 and CB, page 3080. Ms Faulkner confirmed that in the period 2017-2018 the NDIA provided incorrect advice that a NDIS participant would not be granted SDA funding unless they could identify the SDA at which they would live: T, page 1664-1665. This advice was incongruent with that provided by DFFH about the need for SDA funding before SDA could be accessed, and likely created a perception of a "chicken and egg problem" in the perception of some working in the disability sector at the time. Ms Faulkner testified that this issue had since been corrected: T, page 1664.
[467] CB, page 3080.
[468] CB, page 3080.
[469] CB, page 3080.
[470] CB, page 3080.

the planner and Mr Bolton agreed that provision be made in this plan to look for suitable alternative accommodation.[471]

207. Ricky's NDIS Plan 2 commenced on 12 January 2018 and was anticipated to be in place until 13 July 2018.[472] Ricky's goals were to participate in social and community activities; stay healthy and attend all medical appointments; with his longer-term goals articulated as to complete all personal care tasks as independently as possible and to continue to live at Merindah until more appropriate accommodation is found.[473] To support achievement of these goals, the NDIS Plan 2 included funding for support coordination (including to assist Ricky to find appropriate accommodation), transport, core supports including funding to be used flexibly to assist with activities of daily living, attend appointments and to engage in social activities.[474] Improved daily living and improved relationships funding was allocated for therapeutic and allied health services to develop and implement a behaviour support plan.[475] Ricky's total budget under NDIS Plan 2 was a little over $51,000.

208. At around the same time the NDIS Plan 2 came into effect, Mr Bolton ceased as Ricky's support coordinator. Between mid-January and mid-March 2018, Ricky's Wellways file reflects several staff members' attempts to link Ricky into the Inspire program and his intermittent attendance there and some one-to-one engagement with support workers, particularly Steve, who helped him with personal care.[476] The Wellways file does not reflect what, if any, attempts were made to link Ricky into the new therapeutic supports in the NDIS Plan 2.[477]

209. On 14 March 2018, Ricky was hesitant to meet Sean Sentance, his fourth Wellways support coordinator.[478] Eventually, he did sit down for a chat. Mr Sentance also spoke to Ms Peart while at Merindah who asked if an appointment could be made for Ricky to see his GP because he

[471] CB, page 3080.
[472] CB, page 2941.
[473] CB, page 2943.
[474] CB, pages 2945-2946.
[475] CB, page 2994.
[476] CB, pages 3078-3079. Mr Sentance gave evidence that Steve was going out to Merindah quite a few times per week during his period as support coordinator: T, page 856.
[477] Mr Sentance testified that he did not recall (certainly by the time of the inquest) anything about the therapeutic supports in Ricky's plan. He agreed that he would have read the notes made by his predecessor(s) but did not himself make any arrangements for therapeutic supports: T, pages 853 and 855.
[478] CB, page 3078. Ms Higgins provided evidence that in the early years of the NDIS staff turnover was not uncommon (not only at Wellways). She attributed this phenomenon to the NDIS being a new model of care/employment, that did not always meet employees'' expectations and the newness of the system made it difficult to navigate with high administrative requirements: T, page 1273. See also T, pages 828 and 848 (Sentance).

was staying up all night and disturbing other residents, which might put his accommodation at risk.[479]

210. On 20 March 2018, Ricky attended the second of three appointments at BGP while living at Merindah.[480] Ms Peart had emailed Dr Taylor her concerns about Ricky's poor sleep pattern, disruption to other residents and that when he slept 48 hours straight to catch up, he missed taking his oral medications.[481] After performing a second annual health check, Dr Taylor prescribed Melatonin for sleep,[482] but replaced it with Largactil the following day.[483] Dr Taylor explained that Largactil[484] is an antipsychotic which, if taken at night as prescribed, would improve Ricky's sleep cycle and reduce agitation and aggression.[485]

211. On 28 March 2018, Ms Peart reported to Mr Sentance that although Ricky had been disruptive during the day since his medication change, he was sleeping most nights.[486]

212. On 11 April 2018, Mr Sentance, who did not have access to the NDIS Portal,[487] called the NDIA to check Ricky's NDIS Plan 2 funding balance. He was informed that the total remaining was $10,634.00, most relating to support coordination funding but less than $2000 for activities of daily living, a little over $4000 for social and community participation and less than $6 to pay for transport.[488] In consequence, Mr Sentance sought to reduce Ricky's use of social and community participation at day programs to reduce costs, which would require him to sign a fresh service agreement (but Ricky refused).[489]

213. In fact, only $7,062 of Ricky's $51,256 NDIS Plan 2 budget had been used by 11 April 2018.[490]

214. On 12 April 2018, Ms Peart emailed Mr Sentance to report that for the previous two weeks Ricky had been extremely aggressive and verbally abusive, disturbing residents and the caretaker overnight and damaging property.[491] He also refused to bathe or attend the Inspire program.[492] She concluded by saying that Ricky needed to move to a more appropriate

[479] CB, page 3078.
[480] CB, page 3356. By way of comparison, Ricky saw a GP, usually Dr Taylor, 13 times in the five months he lived at Kallara.
[481] CB, page 3361.
[482] CB, page 3356.
[483] CB, page 3356.
[484] Chlorpromazine.
[485] T, pages 411-412.
[486] CB, page 3078.
[487] T, page 857.
[488] CB, page 3078 and T, page 857.
[489] CB, pages 3078 and 3077.
[490] CB, page 472.
[491] CB, page 3067.
[492] CB, page 3067.

facility.[493] Mr Sentance replied on 18 April 2018 indicating that he would make enquiries about alternative accommodation but warning that it might 'take some time.'[494]

215. On 19 April 2018, Ricky saw Dr Taylor in relation to an upper respiratory tract infection and ongoing concerns about his sleep pattern.[495] The GP increased his prescribed dose of nitrazepam, a sedative.[496]

216. On 27 April 2018, Ms Peart emailed Mr Sentance again to report no improvement to Ricky's presentation and that she had contacted RPN Watts and Mr Belshaw for advice.[497]

217. On 1 May 2018, Ricky's depot was administered and 'nil new concerns' noted by the DNS.[498]

2 May 2018

218. Between 9am and 10am on 2 May 2018 Ms Peart called Mr Belshaw several times. When they eventually spoke, around 10am, Ms Peart reported that Ricky's behaviour was 'becoming more and more delusional and unpredictable'[499] and he was a nuisance to other residents overnight. She asked him to find Ricky alternative accommodation.[500] Although Mr Belshaw had not seen Ricky since early August 2017 when he moved out of Browen Lee and had no formal responsibility to assist, he agreed to do so.[501]

219. Mr Belshaw spoke to Dr Taylor to ask if medication could be used to decrease Ricky's agitation and help him to sleep through the night.[502] Mr Belshaw was, in part, motivated to make this enquiry so that he could provide some assurance to another accommodation provider that Ricky's wakefulness overnight would resolve.[503] Dr Taylor increased Ricky's nightly dose of Largactil.[504]

220. Mr Belshaw also contacted the proprietor of Golden Gate Lodge (**Golden Gate**), an SRS in Ararat to ascertain whether Ricky could be accommodated there. He was 'upfront and honest' about Ricky's situation and the challenges likely to be faced by the SRS if it offered Ricky

[493] CB, page 3067.
[494] CB, page 3069.
[495] T, page 430.
[496] CB, page 3358.
[497] CB, page 3072.
[498] CB, page 3701.
[499] CB, pages 280-281.
[500] CB, pages 280-281.
[501] CB, page 2847 and T page 302.
[502] T, pages 302 (Belshaw) and 430 (Taylor).
[503] T, page 302.
[504] T, pages 430-431.

accommodation.[505] Ultimately, Ricky was offered a place at Golden Gate 'on a trial basis.'[506] According to Mr Belshaw, it was unlikely that anyone without his 'good rapport and trust' with the SRS would have been able to arrange Ricky's accommodation at Golden Gate in the manner he did that day.[507]

221. Mr Belshaw updated Ms Peart, asking her to have Ricky's belongings packed, and he would attend Merindah to take Ricky to Golden Gate.[508]

222. At about 11.30am, Ms Peart emailed Mr Sentance to inform him that Ricky would be evicted from Merindah that day and that she had contacted Mr Belshaw to assist.[509] Ms Peart clarified in her oral evidence at inquest that she only felt able to evict Ricky because she knew he had somewhere to go.[510] Mr Sentance submitted a Plan Review Request to the NDIA on Ricky's behalf noting that he was 'in urgent need of specialised accommodation.'[511]

223. When Mr Belshaw and a colleague arrived at Merindah around 2.00pm[512] to transport Ricky to Golden Gate, he noted Ricky's 'presentation was very changed.'[513] He was 'heightened and verbally aggressive'[514] which Mr Belshaw, at least in part, attributed to Ricky knowing that he was to be evicted.[515] Ricky was delusional – which was not unusual for Ricky in Mr Belshaw's experience[516] – but appeared 'more delusional' and when his delusions were challenged, uncharacteristically, Ricky became 'very angry.'[517] Ricky was insistent that his mother owned Merindah, and he was not going anywhere because he had done nothing wrong.[518]

224. Mr Belshaw tried to calm Ricky by going outside with him for a chat and a cigarette, circling back to discuss Ricky's eviction and the SRS in Ararat intermittently.[519] This tactic, which had been effective in the past, was not successful. It was clear to Mr Belshaw that Ricky would not accompany him to Golden Gate, and he was concerned about Ricky's mental health which was

[505] T, page 304.
[506] T, page 304 and CB, pages 2931 and 2847.
[507] T, page 304.
[508] CB, page 281.
[509] CB, page 3073.
[510] T, page 893.
[511] CB, pages 3064-3066. See also a Centacare note at CB page 2831 documenting this course.
[512] CB, page 281.
[513] T, page 306. Mr Belshaw told Ms Peart that he was 'shocked' by what he perceived to be deterioration of Ricky's mental health in the months since he had last seen him: CB, page 281.
[514] CB, page 263.
[515] T, page 304.
[516] T, page 287.
[517] T, page 305.
[518] CB, page 263.
[519] CB, page 263; T, pages 304-305.

'now more important than his accommodation.'[520] Ms Peart agreed they needed 'backup' from BMHS.[521]

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225. At about 3.00pm, Mr Belshaw called Triage and spoke to RPN David Clifton. The two men have somewhat different recollections about the tone and content of their phone call.

226. Mr Belshaw testified that he called BMHS to assist with Ricky's mental health.[522] He told RPN Clifton about Ricky's 'very changed' presentation and his aggression when his delusions were challenged, something he had not seen before; he also relayed that Ricky was being evicted from Merindah.[523] According to Mr Belshaw, RPN Clifton said words to the effect that BMHS had had 'lots of complaints' about Ricky and that he was 'not coming out there to get a smack in the head.'[524] RPN Clifton advised Mr Belshaw to call the police and 'have police bring [Ricky] in to the emergency department and [BMHS] would assess him there but there were no beds so they would probably put him in Reid's' Guest House (**Reid's**).[525] There was no discussion about police powers under the *Mental Health Act* 2014 (**MHA**)[526] and Mr Belshaw had no knowledge of them[527] or their limits[528] at the time. He thought police may have had the power to move Ricky off the property.[529]

227. For his part, RPN Clifton testified that, at the time of the inquest, he had little recollection of the specifics of his conversation with Mr Belshaw on 2 May 218 and relied on his notes.[530] On the basis of those notes, RPN Clifton considered that the purpose of Mr Belshaw's call was to obtain his assistance to evict Ricky, not to arrange for him to be psychiatrically assessed.[531] This evidence is somewhat at odds with the psychiatric nurse's assertion, later in his evidence,

[520] T, page 305.
[521] T, page 893.
[522] T, pages 305 and 334.
[523] T, page 306.
[524] T, page 306.
[525] T, pages 307 and 334. Mr Belshaw conceded in cross examination by counsel for BMHS that he may be mistaken in his recollection that during his call with RN Clifton reference was made about there being no beds available: T, page 336. However, it seems likely that a comment of that kind may have been relayed by Ms Peart some time later given the ongoing contact between Ms Peart and Mr Belshaw later on 2 May 2018 and the following day.
[526] T, page 308.
[527] T, page 316.
[528] T, page 317.
[529] T, page 308.
[530] T, page 549-550. When shown RPN Clifton's note of the conversation, Mr Belshaw stated that it did not 'exactly' match his recollection of the conversation, but it did 'sort of outline' what was said: T, page 308.
[531] T, pages 551 and 606.

that he 'wasn't refusing to assess Ricky … I just wasn't going to do it immediately'[532] nor his concession that it was possible Mr Belshaw had requested an assessment during their call.[533]

228. RPN Clifton agreed that Mr Belshaw may have mentioned Ricky's unusual aggression even though he made no note of it.[534] He confirmed that at the time of the call he had ready access to Ricky's CMI[535] and BossNET[536] records and that the information they recorded about previous contacts with the public mental health system, including the outcomes of previous contacts with BMHS, was relevant to his triage assessment,[537] along with information provided by Mr Belshaw about Ricky's changed presentation.[538]

229. RPN Clifton stated that 'at triage' the source of the referral – whether a family member, support worker or clinician – would not affect the weight attached to the information provided by the Triage clinician: no-one would be dismissed.[539] In contrast, Mr Belshaw reported being 'frustrated' by his perception that his requests for assistance from BMHS appeared to carry 'very little or no weight,' including on 2 May 2018,[540] despite being well placed to notice mental health changes among his clients.[541]

230. The psychiatric nurse conceded he possibly said something like the "smack in the head" comment attributed to him by Mr Belshaw in the context of it not being his role to go to Merindah to evict Ricky.[542] He agreed that he might have encouraged Mr Belshaw to consider emergency accommodation options such as Reid's.[543] He denied telling Mr Belshaw there were no beds available at the BMHS inpatient unit.[544]

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[532] T, page 562.
[533] T, page 551.
[534] T, page 550.
[535] CMI is the acronym for 'Client Management Interface', which is a state-wide database reflecting a person's contacts with the public mental health system.
[536] BossNET is the name of Ballarat Health Service's electronic medical records system, inclusive of records maintained by BMHS.
[537] T, pages 546-547. RPN Clifton accessed both Ricky's CMI and BossNET records on 2 May 2018 though it is not clear when access occurred: CB, pages 483-484. The availability of these records might have informed the comments attributed to RPN Clifton by Mr Belshaw concerning an awareness of 'complaints about Ricky' though RPN Clifton had no specific recollection of making them: T, page 549.
[538] T, page 550.
[539] T, page 548.
[540] T, page 314.
[541] Notwithstanding that observation, Mr Belshaw reported productive collaborations with BMHS clinicians at other times: T, page 315.
[542] T, page 552.
[543] T, page 554.
[544] T, page 554.

231. Although he had no specific recollection of asking to speak to Ricky, RPN Clifton confirmed such a request accorded with his usual practice.[545] According to Mr Belshaw, Ricky refused to speak to RPN Clifton when he relayed the clinician's request to talk to him.[546]

232. It is evident from RPN Clifton's notes that by the end of his call with Mr Belshaw, the clinician had formed the view that Ricky's delusional ideas were voiced 'in response to being evicted' and that his 'other behaviours' – those that resulted in him 'being asked to move on' – were chronic in nature.[547] The notes indicate RPN Clifton's belief that Ricky was receiving treatment from Dr Proctor and that his compliance with medication was reasonably good.[548] His plan was for Mr Belshaw to encourage Ricky to leave Merindah, with police to be used if this proved unsuccessful and 'if police have concerns … they can bring him to ED for further review.'[549] Unlike Mr Belshaw, RPN Clifton understood the police's MHA powers.[550]

233. Although Mr Belshaw's call to Triage did not result in an immediate face-to-face assessment of Ricky, it was processed as a referral that would be considered by the BMHS' MDTM the following day.[551] The referral was not classified according to the triage referral scale.[552]

234. At 3.09pm Ms Peart called Triple Zero and requested police attendance. She explained that Ricky had been evicted and needed to go to the emergency department for psychiatric assessment.[553] Ballarat North 303, SC Richard Parkinson and First Constable Catherine Prentice, was dispatched[554] and arrived at Merindah at about 3.55pm.[555] SC Parkinson spoke to Ms Peart to ascertain the situation: both police members understood they had been called to remove Ricky from the property because he had been evicted.[556] Both were prepared to do so

[545] T, page 551.
[546] CB, page 263.
[547] CB, page 3442.
[548] CB, page 3442.
[549] CB, page 3442.
[550] T, pages 553 and 594.
[551] T, pages 563-565 and 607.
[552] CB, page 3442.
[553] Multimedia Exhibit (Triple Zero call 2/5/2018) and CB, page 3719. The Operator confirmed that Ricky had been evicted and stated, 'what, he's refusing to leave?' to which Ms Peart responded, 'Yeah, he's not very well. He needs to go to the ED to be assessed by psych services.'
[554] The job was dispatched as 'people causing trouble:' AM, page 215-1.
[555] CB, page 325.
[556] T, pages 457 (Parkinson) and 482 (Prentice).

provided it was 'safe' and, ideally, if there was somewhere else for Ricky to go.[557] The members had some awareness of a bed available in Ararat.[558]

235. The police members then spoke to Ricky. He was dishevelled and appeared unwashed.[559] When Ricky was told the police were there to evict him, he said he was 'not going anywhere,'[560] before walking off.[561] When police tried to speak with him again, Ricky again walked off.[562] Although Ricky appeared have 'obvious psych issues' given the content of his speech,[563] neither police member considered they had grounds to apprehend him for a mental health assessment pursuant to section 351 of the MHA.[564] It was clear to SC Parkinson that Ricky needed 'a bit more help than just being taken off the property.'[565]

236. SC Parkinson called Triage and spoke to RPN Clifton. In his evidence at inquest, SC Parkinson explained the reason for the call was to ascertain if BMHS had 'a bit of background'[566] about Ricky or might otherwise be able to assist in resolving the situation.[567] He had no independent recollection of the content of his phone conversation with RPN Clifton but confirmed that it was likely to be in similar terms to those noted by the clinician;[568] this appears to be confirmed by the notes SC Parkinson made contemporaneously.[569] RPN Clifton made the following note of his call with SC Parkinson: Ricky was 'presenting as odd and voicing strange ideas. Requesting review by BMHS prior to eviction.'[570]

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[557] T, page 458 (Parkinson) and 483 (Prentice).
[558] CB, pages 325 (Parkinson) and 322 (Prentice). First Constable Prentice believed the "bed in Ararat" was in a psychiatric inpatient unit or arranged by psychiatric services [T, pages 483 and 485] but conceded that she made have been mistaken about the nature of the accommodation and how it had been arranged [T, page 489]. Even if Ricky had been willing to accompany police to the bed in Ararat, police would not transport a person in the course of their duties to another location unless they were under arrest nor to a location outside their service area [T, pages 461-462], nor should they be expected to do so.
[559] CB, page 323.
[560] CB, page 325.
[561] CB, page 323.
[562] CB, pages 323 (Prentice) and 325-326 (Parkinson).
[563] CB, page 325.
[564] T, pages 459 (Parkinson) and 497 (Prentice). Section 351 of the *Mental Health Act* 2014 empowered police members to apprehend a person who appears to have a mental illness if satisfied that the person needs to be apprehended because of their apparent mental illness to prevent serious and imminent harm to themselves or to another person.
[565] T, page 458.
[566] T, page 462.
[567] T, page 463.
[568] T, page 463.
[569] AM, pages 215-3 and 215-4. It is not clear whether SC Parkinson explicitly requested a psychiatric assessment or whether RPN Clifton volunteered to attend for this purpose. SC Parkinson's notes include the following: 'Peart … stated resident …is acting erratic and needs psych evaluation;' 'obvious MH [mental health] issues;' 'liaised with Dave Clifton from Psych Services same to come out and assess.'
[570] CB, page 3440.

237. SC Parkinson recalled that RPN Clifton did not have to be persuaded[571] to come out to Merindah, he just said, 'I'll come out.'[572] For his part, RPN Clifton gave evidence that as a duty worker he had the ability to go out and perform a face-to-face assessment of Ricky and chose to do so.[573] Volunteering to attend aligns with the account RPN Clifton provided in the statement he made days later, if not with his clinical notes.[574] The clinician did not apprehend that police were considering use of their MHA powers.[575]

238. When asked why the call from police appeared to receive a different response to the call made earlier in the day by Mr Belshaw, RPN Clifton testified that if the second call to BMHS Triage had come from Mr Belshaw (rather than police) he would 'like to think' he would have attended.[576] He said that the referral to the BMHS MDTM would have occurred even without a second call,[577] and Mr Belshaw's referral 'just grew leaves' after the police called.[578]

239. I am invited in submissions filed on behalf of BMHS to conclude that it was the fact of a second call on the same afternoon about Ricky, rather than the identity of the subsequent caller, that prompted RPN Clifton's attendance at Merindah.[579] RPN Clifton testified that his decision to attend occurred in the context of (part of) the plan discussed with Mr Belshaw failing[580] and people were 'reporting that [Ricky] was unwell, the police especially.'[581] Given the content of the clinician's note of his conversation with SC Parkinson, it is improbable that any observation relayed about Ricky's presentation was of greater clinical import than those provided by Mr Belshaw. Indeed, it is only RPN Clifton's clinical note that even suggests a police request for psychiatric assessment (or attendance), and this does not accord with the balance of RPN Clifton's evidence, particularly his second statement in which he states that he believed the duty worker was 'required to attend when called by police, if possible.'[582] It is tolerably clear that

[571] T, page 463.
[572] T, page 464.
[573] T, page 562.
[574] CB, page 329.
[575] T, page 561.
[576] T, page 562.
[577] T, page 564.
[578] T, page 563.
[579] Submissions filed on behalf of Ballarat Mental Health Service dated 28 November 2022.
[580] CB, page 3442. That is, part of RPN Clifton's plan was that Mr Belshaw try to convince Ricky to leave with him, otherwise call police to evict Ricky.
[581] T, page 561. The second part of RPN Clifton's plan was for police to use their MHA powers to transport Ricky to the emergency department if *members* had concerns. The clinician knew SC Parkinson did not harbour the kind of concerns relevant to section 351 of the MHA: CB, page 3442.
[582] CB, page 4299. RPN Clifton also refers to his experience on the Crisis and Assessment Team during his oral evidence: T, page 561.

the *identity* of the caller figured to some extent in RPN Clifton's decision to attend when police called BMHS Triage about Ricky on 2 May 2018.[583]

RPN Clifton's Assessment

240. RPN Clifton arrived at Merindah at about 5.15pm, having reviewed Ricky's CMI records.[584] After speaking with Merindah staff – who provided a 'running commentary'[585] – and the attending police members, RPN Clifton 'attempted to assess' Ricky.[586] 'Multiple attempts' were made to engage with Ricky but he was unwilling, which was attributed to Ricky not wanting to leave Merindah.[587] Ricky was not aggressive, rather, he remained some distance from the psychiatric nurse and increased the distance between them when RPN Clifton approached.[588] According to RPN Clifton, Ricky presented 'very much as a chronic schizophrenic' referring to Ricky's untidy appearance, restlessness, and the delusional content of his speech.[589]

241. The clinical notes made later suggest little direct engagement between RPN Clifton and Ricky, at least while police remained at the scene; much of what is recorded is collateral information provided by Ms Peart.[590] That said, the psychiatric nurse noted that Ricky was 'unable to give coherent answers' and displayed 'gross thought disorder'[591] which was considered to be his chronic presentation, Ricky's baseline.[592]

242. In RPN Clifton's opinion, informed by 40 years' clinical practice, Ricky presented with no acute symptoms and did not meet the MHA criteria[593] for an Assessment Order.[594] Rather,

[583] Dr Lalitha also testified that priority is given in practice to requests made by police for assessments: T, page 1204.
[584] CB, page 326 and T, page 566.
[585] CB page 329.
[586] CB, page 3438.
[587] CB, page 330.
[588] T, page 567.
[589] T, page 566.
[590] CB, pages 3438-3439. The reports of Ricky banging on other residents' doors overnight were characterised by RPN Clifton as 'behaviourally based, not part of [his] mental illness' but later qualified that comment by saying that the behaviours 'might be a little bit entwined with his chronic illness': T, page 609.
[591] CB, page 3438.
[592] T, page 568; see also RPN Clifton's evidence concerning acute versus chronic presentations: T, page 611.
[593] The criteria for an Assessment Order (that is, compulsory psychiatric assessment at a designated mental health service) appear in section 29 of the MHA as follows: (a) the person appears to have a mental illness; and (b) because the person appears to have mental illness, the person appears to need immediate treatment to prevent (i) serious deterioration in the person's mental or physical health or (ii) serious harm to the person or to another person; and (c) if the person is made subject to an Assessment Order, the person can be assessed; and (d) there is no less restrictive means reasonably available to enable the person to be assessed.
[594] CB, page 3438 and T, pages 568 and 569.

Ricky's heightened behaviour was situational, relating to his impending eviction and the police presence.[595]

243. RPN Clifton called the BMHS' on-call consultant psychiatrist to discuss Ricky's presentation in accordance with usual practice.[596] According to RPN Clifton, all options (including psychiatric admission) were 'probably discussed'[597] and the appropriate option determined.[598] The psychiatrist recommended that Ricky's medications be reviewed and authorised administration of an increased dose of Largactil that night.[599] Otherwise, the Triage referral would be considered the following day at the MDTM.

244. While RPN Clifton was on the phone, at about 5.30pm, Patrol Duty Supervisor Acting Sergeant (**A/Sgt**) Pieter Haans arrived at Merindah to check on the Ballarat North 303 members who had been occupied there for some time.[600] As SC Parkinson was briefing A/Sgt Haans, RPN Clifton concluded his call and advised that he had a resolution: there were no beds available at BMHS inpatient unit but additional medication would be administered to Ricky, who would stay another night at Merindah, with BMHS to reassess/follow up the next day.[601]

245. RPN Clifton denied saying that there was no bed available for Ricky,[602] and if he had said anything about beds, it had been 'taken out of context' or misunderstood.[603] Ms Peart,[604] Ms Stephens,[605] SC Parkinson,[606] and A/Sgt Haans[607] were adamant that RPN Clifton had commented that no psychiatric inpatient bed was available; First Constable Prentice accepted the possibility of a miscommunication about bed availability or the need for an inpatient bed.[608] The weight of the evidence suggests that RPN Clifton's recollection is mistaken.

[595] CB, page 4299.
[596] T, page 569.
[597] T, pages 569-570.
[598] T, page 570.
[599] T, page 570 and CB, page 3438.
[600] CB, page 333.
[601] CB pages 333, 326, 323, 281, and 288.
[602] CB, page 4299 and T, pages 571, 572 and 574.
[603] T, page 572.
[604] CB, page 281; though at the time of inquest, Ms Peart could not recall what RPN Clifton had said about bed availability: T page 896.
[605] T, page 953.
[606] T, pages 465 and 467.
[607] T, pages 507 and 509-510.
[608] T, pages 489-490.

246. There was, in fact, no bed available at the BMHS inpatient unit on the afternoon of 2 May 2018.[609] While RPN Clifton's evidence at inquest cast doubt over his awareness of this fact at the time,[610] it is improbable that he would have made the comment attributed to him without it.

247. That said, bed unavailability was not a barrier to making an Assessment Order[611] because if a psychiatric bed was required, the patient could remain in the emergency department until one became available either at BMHS or at another designated mental health service.[612] Indeed, it appears more likely that RPN Clifton's conclusion that Ricky did not require involuntary psychiatric admission turned on the absence of anything in his "attempted assessment" of Ricky to displace the view he had formed by the end of his call with Mr Belshaw rather than whether an inpatient bed was available.

248. Although not 'thrilled' by RPN Clifton's resolution,[613] Ms Peart agreed to let Ricky remain at Merindah another night – rather than be taken to Reid's – fortified by her understanding that BMHS would revert the next day with a plan.[614]

249. Police left Merindah at around 5.45pm.[615] RPN Clifton observed that Ricky's demeanour changed 'dramatically'[616] after police left: he relaxed.[617] The psychiatric nurse was able to engage Ricky in a discussion about his overnight behaviour[618] and supervised him taking his nightly medications and the additional dose of Largactil authorised by the consultant psychiatrist.[619]

250. RPN Clifton left anticipating that the MDTM might result in further contact between BMHS and Ricky. In his view, there were 'lots of things', such as Ricky's 'hotch-potch'[620] of medications and ongoing behavioural issues,[621] to indicate BMHS intervention was warranted and might involve short-term case management.[622]

[609] CB, page 4304.
[610] T, page 573.
[611] CB, page 4305.
[612] T, pages 574 and 608.
[613] CB 326.
[614] T, pages 896 and 926.
[615] CB, page 326.
[616] T, page 587.
[617] CB, page 330.
[618] CB, page 3438.
[619] T, page 596.
[620] CB, page 330.
[621] T, page 569.
[622] T, page 593.

THE EXTENT TO WHICH RICKY'S NEEDS WERE BEING MET, AND BY WHOM

251. Due to his psychosocial (and suspected cognitive) disability Ricky required support to identify and meet his needs: at all times, supporting Ricky was a shared responsibility.

252. Upon his arrival in Ballarat in mid-February 2017, Kallara had a significant and formal role in meeting Ricky's need for supported accommodation, including responsibility to ensure that his health and support needs were being met, and administer his oral medications. Through the SRS, Ricky's health was managed and monitored fortnightly by Dr Taylor who also administered his depot.

253. Ricky did not have the benefit of NDIS supports for the first three months he lived in Ballarat.

254. In May 2017, Wellways commenced support coordination pursuant to Ricky's NDIS Plan 1, with one-to-one support worker shifts commencing in June 2017 to assist Ricky to access the community. With most of Ricky's day-to-day and medical needs being met by or through Kallara, Wellways' roles (as support coordinator and provider of support services) were relatively confined.

255. Kallara staff referred Ricky to BMHS three times between May and July 2017 when concerned about his mental health. Although assessments occurred, and advice was provided, these contacts did not result in ongoing tertiary mental health management.

256. Despite having concerns about Kallara's capacity to meet Ricky's needs as early as April 2017, no formal notification was made to DFFH by the proprietor and so Ricky was deprived of the protections provided in section 62 of the SRS Act. Wellways was not notified when Ricky's tenancy at Kallara was at risk and so had no opportunity to intervene.

257. Mr Belshaw's formal role with Ricky coincided with his finger amputation and could only continue so long as Ricky lived in an SRS. He escalated his concerns that Ricky's needs were not being met to DFFH, NDIA and Wellways but either due to a communication or administrative breakdown, the NDIS plan review he sought to trigger in July 2017 was not actioned.

258. No-one with a formal role to support Ricky was informed of his eviction from Kallara before it occurred. Before Wellways knew of Ricky's eviction, Mr Belshaw had arranged his placement at Browen Lee.

259. Most of Ricky's day-to-day needs were met by Browen Lee for the short time he lived there, and staff alerted Wellways to Ricky's medical needs so that his support coordinator could arrange for him to see a doctor.

260. Centacare alerted Wellways to Ricky's immediate eviction from Browen Lee and though his support coordinator arranged accommodation at Merindah, Centacare helped Ricky to move there.

261. Upon Ricky's move away from Kallara, the "assertive care" provided by Dr Taylor that was essential to RPN Watts' discharge plan, fell away. However, Dr Taylor arranged for the DNS to administer depot and continued to prescribe Ricky's medications. The GP was never informed that medication administration could not be provided by Merindah staff.

262. Following Ricky's move to Merindah, the role for his support coordinator increased, particularly to facilitate mental health and medical care and arrange personal care and social activities to maintain that placement while pursuing alternative accommodation options.

263. As a boarding house, Merindah staff had no formal role to support Ricky's needs beyond provision of his accommodation, meals and laundry services. Despite this, Ms Peart and Ms Stephens played a significant informal role in identifying and responding to his day-to-day needs and by alerting Wellways to their concerns as they arose. This enabled Ricky's support coordinators, particularly Ms Avraam, to link him to medical and mental health services and increase personal care and community access supports and so sustain his tenancy for longer than might have been expected.

264. Although Ms Avraam's referral to BMHS prompted a further psychiatric assessment by the specialist mental health service, it did not result in any ongoing involvement. Ms Avraam arranged Ricky's referral to a private psychiatrist, and though medication changes were made by Dr Proctor there was lack of communication between Mind @ Home Psychiatry and the other parts of the support network which undermined any possibility of continuity of mental health care. Beyond regular administration of depot by the DNS and Ricky's (fluctuating) willingness to take his oral medications as prescribed, his mental health needs were inadequately managed between October 2017 and May 2018.

265. Although everyone in Ricky's support team who understood Merindah was not an SRS thought it unsuitable to his "high needs," there was confusion about the nature of supports he had received through NDIS plans in the past, what the NDIS could offer, and to a degree, how to

ask for what was required. Much of that is explicable by the newness of the scheme. Nonetheless, when the planning meeting eventually occurred in January 2018, the October 2017 Request for Plan Review resulted in an effective doubling of Ricky's core and support coordination funding, in addition to the funding of new targeted supports designed to develop positive behaviours.

266. As at April 2018, Ricky had plenty of funding in NDIS Plan 2 that might have been used to support him with personal care and other activities (assuming he was willing). However, an apparent administration error at NDIA together with lack of access to accurate data at Wellways led his support coordinator to restrict expenditure in the mistaken belief that Ricky's funding was nearly exhausted.

267. Ms Peart's communications with Wellways and directly with Dr Taylor in the weeks leading to 2 May 2018 reveal the extent to which Ricky's behaviours had escalated. Despite abundant goodwill, by this stage, Merindah staff could no longer manage Ricky in a boarding house context. Ms Peart only felt able to evict Ricky because Mr Belshaw was able (once again) to obtain at short notice through his connections with SRS providers what his Wellways support coordinators could not.

THE CIRCUMSTANCES OF RICKY'S COLLAPSE AND DEATH ON 3 MAY 2018

268. At around 1.00pm on 3 May 2018, Ms Peart called Triage to follow up on the "plan" foreshadowed by RPN Clifton the previous evening.[623] She spoke to Mr Gillett who reviewed RPN Clifton's notes during the conversation and relayed to Ms Peart some of their content concerning a need for the NDIS provider to be 'reminded of their responsibility.'[624] Ms Peart's 'frustration' at a perceived lack of assistance and intervention from BMHS was evident to Mr Gillett.[625] Mr Gillett told Ms Peart that Ricky's referral would be discussed at the MDTM.[626]

[623] There were a series of calls over the course of the morning of 2 May 2018 involving Ms Stephens, Mr Belshaw and Ms Peart in relation to the anticipated follow up by BMHS. There was some misapprehension (by Ms Stephens and Mr Belshaw) about how early BMHS might revert to Merindah staff, though Ms Peart had not expected to hear from BMHS before about lunchtime. Around 2pm, Mr Belshaw escalated his concern about perceived poor service by BMHS to a colleague who is understood to have contacted the mental health service directly. It is not clear that these attempts to hasten or influence BMHS' process had any effect.

[624] CB, page 3439 and T, page 681. Mr Gillett observed in his evidence at inquest that there is a misconception that mental health services have a role in addressing accommodation issues among people with major mental illness:T, page 683.

[625] CB, 3436 and T, page 683.

[626] T, page 685.

269. Ricky's Triage referral was considered at the MDTM at about 1.30pm.[627] Among the attendees were mental health clinicians Sarah Kerlin and Mr Gillett.[628] During the MDTM, a plan was developed to undertake an 'intake assessment' of Ricky and facilitate his review by a BMHS consultant psychiatrist.[629] Ricky was to be assessed that afternoon and given reports of his recent 'behaviour and mental state,' two clinicians would attend Merindah.[630]

The Assessment by Mr Gillett and Ms Kerlin

270. At about 3.30pm, Ms Kerlin and Mr Gillett arrived at Merindah to assess Ricky, each having reviewed his clinical records.[631] The clinicians had called ahead and were met by Ms Peart and Ms Stephens. They provided a history of Ricky's gradually worsening behaviour over 12 months.[632] They reported marked irritability in the late afternoon;[633] recent poor sleep and intrusive behaviours overnight such as banging doors;[634] Ricky had allegedly assaulted and had been assaulted by other residents in the past few nights;[635] he saw his general practitioner irregularly and reluctantly;[636] he had not been reviewed by a psychiatrist in months;[637] they had concerns about Ricky's compliance with oral medications;[638] and that recent changes to his medication regime appeared to have had a detrimental effect[639] on his mental state.

271. When the clinicians approached Ricky to assess him, they observed his dishevelled appearance, pacing, and that he was mumbling to himself.[640] Ricky was irritable and engaged poorly.[641] He voiced grandiose and delusional thoughts, was illogical and appeared to respond to auditory hallucinations.[642] The clinicians' impression was that Ricky had no insight into his illness and that his judgement was impaired by the 'current acuity of his psychotic symptoms.'[643]

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[627] CB 4272.
[628] Although both Ms Kerlin and Mr Gillett are occupational therapists by training, they were employed as mental health clinicians, Mr Gillett as a senior mental health clinician with more than 12 years' experience in the field: CB, pages 339 (Kerlin) and 335 (Gillett). Both were trained (and expected) to perform mental health assessments as part of their roles: T, page 1185 (Lalitha).
[629] CB page 3437.
[630] CB, page 336.
[631] CB, page 3434 and T, page 627 and 633 (Kerlin) and 678 (Gillett).
[632] CB, page 3434.
[633] CB, page 3434.
[634] CB, page 3434.
[635] CB, page 3434. RPN Clifton gave evidence that he was not informed that Ricky had allegedly assaulted another resident: T, page 610.
[636] CB, page 3435.
[637] CB, page 3435.
[638] CB, pages 3434-3435.
[639] CB, page 336.
[640] CB, pages 336, 340-340 and 3434.
[641] CB, page 3434.
[642] CB, page 3434 and T, page 689.
[643] CB, page 3434.

272. Ms Kerlin and Mr Gillett formed the view that Ricky met the criteria for an Assessment Order and required an involuntary psychiatric admission.[644]

273. According to Dr Lalitha, it is 'very rare' for different clinicians to reach different conclusions about the need for an Assessment Order given the prescriptive framework of the MHA and the practice guidelines in place.[645] Nonetheless, Dr Lalitha observed that psychiatric presentations are dynamic[646] and that the qualitative information on which psychiatric assessments rely is susceptible to interpretation by the clinician in the exercise of their judgement in ways that blood tests or CT scans are not.[647] While there is little evidence that Ricky's presentation had changed materially between 2 and 3 May 2018 (or that he was more readily engaged by clinicians on the later date), Ricky's intrusive behaviours were interpreted by RPN Clifton as "chronic" (if exacerbated by the prospect of eviction)[648] but as linked to his deteriorating mental state[649] by Mr Gillet. Dr Lalitha considered that the different conclusions reached by BMHS clinicians on 2 and 3 May 2018 about Ricky's need for an Assessment Order were explained by Mr Gillett and Ms Kerlin having the benefit of the MDTM recommendations and 'better clinical information' because Ricky was more cooperative with the assessment on 3 May 2018.[650]

274. After the clinicians concluded an Assessment Order was required, Ms Kerlin called the BMHS inpatient unit to ascertain whether a bed was available, because this information was logistically rather than clinically relevant.[651] A bed was available.[652]

275. Ms Kerlin then called the on-call consultant psychiatrist who agreed that Ricky met the MHA criteria for an Assessment Order.[653] She then prepared an Assessment Order,[654] provided a copy to Ricky who promptly walked off, and then updated Merindah staff.[655]

[644] T, page 691 (Gillett)
[645] T, page 1186. I note that RPN Clifton considered it possible for two clinicians assessing the same presentation to reach different conclusions about it: T, page 581.
[646] T, page 1186.
[647] T, page 1188.
[648] T, page 581.
[649] T, page 689.
[650] T, page 1195.
[651] T, pages 637-638.
[652] CB, page 341.
[653] T, page 637 and CB, page 3435.
[654] CB, page 3422.
[655] CB, page 341.

276. Just before 4.00pm, Ms Kerlin called Triple Zero to request police to facilitate Ricky's transfer to BMHS based on his recent history of assault and reluctance to go to hospital.[656] Based on her past experience, Ms Kerlin knew that the mere presence of police often encouraged a compulsory patient's compliance; she had also encountered situations where the police presence had escalated the patient's behaviour.[657] The clinician considered calling for an ambulance, but did not because there was no medical indication such as the need for sedation.[658] Ms Kerlin testified to her belief that Ricky may not ultimately have been transported by police but that police presence was necessary in the circumstances.[659]

277. Both Mr Gillett and Ms Kerlin left Merindah around 4.00pm, with a plan for Ms Kerlin to liaise with the attending police members once dispatched.[660] About an hour later, LSC Davis arranged to meet Ms Kerlin at Merindah at 5.15pm.[661] LSC Davis was aware that police had attended Merindah the day before, and mentioned this to LSC Bergheim, but neither knew any details of the job.[662] LSC Davis testified to an awareness that Ricky had been 'aggressive' with the members who attended the previous day but not the form of the alleged aggression.[663]

278. Both LSCs Bergheim and Davis had received training relating to interactions with mentally unwell people, were aware of the powers of police under the MHA and had been involved in the apprehension of mentally unwell people, including those requiring transport to hospital, in the course of their duties.[664] Both members were also trained to make decisions about the lawful use of force.[665]

Ballarat West 303's Attendance at Merindah

279. Ballarat West 303 arrived at Merindah just before 5.15pm, parking the divisional van in the driveway some distance from the building.[666] Ms Kerlin arrived shortly after.[667]

[656] Multimedia Exhibit (Triple Zero call 3/5/2018) and CB, pages 3723-3728, in particular, page 3726. Mr Gillett also doubted that Ricky would go to hospital willingly: T, page 691.
[657] T, page 644.
[658] CB, page 4314.
[659] T, page 625.
[660] CB, page 3727.
[661] CB, page 346.
[662] CB, pages 358 and 346.
[663] T, page 994.
[664] T, pages 994-996 (Davis) and 1074-1076 (Bergheim).
[665] T, pages 1074-1077 (Bergheim) and 1002-1003 (Davis).
[666] CB, page 346.
[667] CB, page 359.

280. While LSC Davis provided a situation report via D24,[668] LSC Bergheim obtained a handover from Ms Kerlin. Among the information provided by the clinician was that she had assessed Ricky that afternoon and made an Assessment Order; she did not know his full history, but he had not been violent that afternoon, though he had allegedly recently been aggressive and violent toward other residents; Ricky's behaviour worsened later in the day;[669] his mood had not been stable, and his behaviour had been escalating.[670]

281. LSC Bergheim asked Ms Kerlin 'if an ambulance would be able to transport' Ricky; Ms Kerlin reportedly said that police 'would probably need to do the transport.'[671] LSC Davis was unaware whether an ambulance had been requested to transfer Ricky to hospital but knew that use of a divisional van was 'the least preferred option.'[672] In her experience, transfer by ambulance occurred in the majority of cases[673] but, particularly where a clinician is involved, the role of police is to assist the clinician if the patient is uncooperative: 'it's really up to them.'[674]

282. Indeed, there are two complimentary protocols, in addition to relevant Victoria Police Manual (**VPM**) policies, that guide decisions concerning the transport of mentally unwell individuals to or from a designated mental health service.[675] These documents, particularly the protocols, promote transportation of patients by the least restrictive means possible based on an essentially clinical assessment of the circumstances.[676]

283. Unfortunately, the trigger for involvement of police in the transport of a mentally unwell person is inconsistently formulated across the relevant guidelines as follows:

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[668] Multimedia Exhibit (Police Radio Communications 3/5/2018) and CB, page 3765.
[669] The phrase "Sundowner Syndrome" was used by several witnesses to refer to Ricky's worsening behaviour the later it is in the day but was not considered by any clinician to reflect any formal diagnosis.
[670] CB, page 359.
[671] CB, page 346.
[672] CB, page 359.
[673] CB, page 359.
[674] T, pages 1044 and 1046.
[675] These are: the Department of Health *Protocol for the transport of people with mental illness* (**DoH Protocol**), dated August 2014, at CB, pages 3966-3990; the Department of Health and Human Services-Victoria Police *Protocol for mental health* (**DHHS-VP Protocol**) dated October 2016, at CB, pages 3929-3965; and, the Victoria Police Manual Guideline – *Safe management of persons in police care of custody* (**VPMG Safe management**) dated October 2017 at CB, pages 4000-4040.
[676] DoH Protocol, page 3. The factors to be considered include the: person's mental and/or physical state; immediate treatment needs to prevent serious deterioration in their physical or mental health, or serious harm to the person or another person; the likely effect on the person of the proposed mode of transport; the availability of various modes of transport; and, the person's need for support and supervision during the period of travel, including any potential safety issues.

a. ‘to prevent serious harm’ to any person;[677]

b. where there is a ‘genuine and immediate risk of self-harm or injury to anyone;’[678]

c. where ‘the clinician knows about or has experienced a person’s recent history of violence and a police presence is considered necessary for the safety of those present;’[679]

d. when the person poses a ‘serious and imminent risk of harm to anyone’ based on a clinical risk assessment of current and past behaviour;[680] and

e. when ‘the person poses a risk of harm to themselves or others.’[681]

284. Several modes of transport are contemplated by the protocols ranging from private vehicles to ambulances and police vehicles that reflect a hierarchy of increasing restriction. “Police transport” (that is, using a police vehicle) should ‘only be considered where a person cannot be safely transported by any other means’[682] – based on clinical advice.[683] In contrast, “police involvement” in transport might include police members accompanying the mentally unwell person in a mental health service vehicle or an ambulance, escorting another vehicle and ‘as a last resort,’[684] transporting the person in a police vehicle. Somewhat unhelpfully, the DHHS-VP Protocol (and the VPM) states that police ‘decide the extent of their involvement in transport.’[685]

285. In any event, neither Ms Kerlin nor the police members requested ambulance attendance at this juncture.

286. Other than asking Ms Kerlin whether she thought ‘backup’ (additional police units) was required, there is no evidence that the police members sought additional information – about Ricky or Merindah – from anyone prior to approaching Ricky.[686] Ms Kerlin said she ‘didn’t really know’ if additional units would be required[687] and, as D24 transmissions indicated no other police units were available to attend at that time,[688] LSC Bergheim suggested they have a

[677] DoH Protocol, page 9.
[678] DHHS-VP Protocol, 3.2.
[679] DHHS-VP Protocol, 3.2.
[680] DHHS-VP Protocol, 4.2.
[681] DHHS-VP Protocol, 4.2 and VPMG Safe management, 3.2.
[682] DoH Protocol, page 5.
[683] DHHS-VP Protocol, 4.2.1.
[684] VPMG Safe management, 3.2.
[685] DHHS-VP Protocol, 4.2 and VPMG Safe management, 3.2.
[686] CB, page 346.
[687] CB, page 346.
[688] T, page 980.

chat with Ricky.[689] Ms Kerlin entered Merindah through the main entrance, returning with Ms Peart and Ms Stephens.[690]

287. Merindah's main entrance is centrally located in the roughly C-shaped building, with residents' rooms occupying each wing. The wing in which Ricky's room was located ran parallel to the Midland Highway, with water tanks situated just beyond the wing's end.[691] Ricky's room could be entered through a wooden door on the "highway side" and, on the opposing wall of the room, there is a glass sliding door[692] opening onto a large communal grassed area partially enclosed by the residential wings.[693] The furthest extent of the grassed area is separated from adjacent paddocks by wire fencing.[694] The fencing continues beyond the water tanks and then doglegs[695] such that it runs parallel to the Midland Highway,[696] with a broad, steep, rocky and treed embankment before the edge of the highway.[697]

288. Several residents came out of the main entrance and walked towards their rooms; LSC Bergheim assumed they had just had dinner.[698] Ms Kerlin pointed out Ricky,[699] who was standing not far from the wooden door to his room. When first sighted, Ricky was more than five metres from the police members and Ms Kerlin, with Ms Peart and Ms Stephens about a metre further away. [700]

289. Both police members noted Ricky's untidy appearance and that he was quite 'fidgety.'[701] LSC Bergheim, who was closest to Ricky, heard him 'rambling' and was concerned about an unidentified item he placed in a pocket as the members approached.[702] According to LSC Davis, Ricky was 'aggressive.'[703] From the look on his face, LSC Bergheim thought Ricky was a 'little bit nervous' and 'surprised' to see police.[704] She approached (to within three metres of Ricky)

[689] CB, page 347.
[690] CB, page 359.
[691] Photobook C, photograph 3.
[692] Photobook B, photographs 4 and 8.
[693] Photobook C, photograph 5.
[694] Photobook C, photograph 5.
[695] Photobook C, photograph 4.
[696] Photobook B, photographs 9, 15 and 16.
[697] Photobook B, photographs 20, 21 and 25.
[698] CB, page 347.
[699] The members initially misidentified Ricky: CB, pages 347 and 308-309.
[700] CB, page 347.
[701] CB, pages 347 and 360.
[702] CB, page 347. D/Sgt Bell's investigation of this issue following Ricky's death revealed the item was likely a clasp or buckle.
[703] CB, page 360.
[704] T, page 1082-1083.

in a 'friendly, non-threatening way' and tried to reassure him but could tell that he was not likely to 'come with [them] very easily.'[705]

290. Ms Peart observed a softly spoken, three-way conversation involving both police members and Ms Kerlin in which Ricky was told he needed to go to hospital and that he would have to go with police.[706] LSC Davis estimated that this exchange lasted between one and two minutes.[707] Ricky replied that he had 'done nothing wrong' – police confirmed this was the case – and he started swearing.[708] Ms Stephens saw the police slowly edging towards Ricky apparently trying not to startle him.[709] According to Ms Peart, as Ms Kerlin reiterated that Ricky would have to go with police, one of them reached for his arm[710] and Ricky turned and ran towards his room.[711]

291. LSC Bergheim followed to 'keep eyes on' Ricky, for his safety, and prevent 'a whole new situation unfolding' such as might occur if he managed to lock himself in his room.[712] She reached Ricky's room as the wooden door was closing and stopped it with her foot.[713] LSC Bergheim was unaware of the glass door to the grassed area, the layout of the back of the property, or where Ricky was headed.[714] She was concerned that because he was scared, Ricky was unlikely to be thinking about his own safety.[715]

292. Upon entering Ricky's room, LSC Bergheim yelled out, 'Stop Ricky: just stop.'[716] LSC Davis entered Ricky's room too and both members saw him leave via the glass door into the grassed area and turn left to run the length of the building[717] towards the water tanks. Ricky was running quite fast, with the police members in pursuit and giving verbal commands for him to stop.[718]

293. Ricky did not stop. Both LSCs Bergheim and Davis were concerned about the proximity of the highway and the danger it posed to Ricky: this was the reason they continued to pursue him.[719] If Ricky had run in another direction – towards the paddocks behind Merindah – the members

[705] T, page 1083.
[706] T, pages 900-901 and 913.
[707] T, page 981.
[708] T, page 901.
[709] T, page 958.
[710] T, page 901 and 913.
[711] T, page 1084.
[712] T, page 1085.
[713] CB, page 348.
[714] T, page 1085.
[715] T, page 1085.
[716] CB, page 348.
[717] CB, pages 360 and 348.
[718] T, page 1088.
[719] T, pages 1086 (Bergheim) and 997 (Davis).

considered the need to apprehend him would have been less urgent; they might have stopped, reassessed the situation, sought the assistance of other police units and the patrol supervisor in the hope Ricky might tire and be more amenable to dialogue.[720]

294. Ricky continued past the residential wing and the water tanks. At the water tanks, LSCs Bergheim and Davis separated: LSC Bergheim continued on the same trajectory as Ricky, between the tanks and the fence line, and LSC Davis passed to the other side of the tanks, running between them and the Midland Highway. LSC Davis sought to prevent Ricky reaching the busy highway, particularly as it was overcast and starting to get dark.[721]

295. After passing the water tanks, at 5.23pm, LSC Bergheim provided a situation report via D24.[722] Sounding winded, she reported that Ricky had 'done a runner' and the members were on foot and trying to 'negotiate with him.'[723] LSC Bergheim clarified during her evidence at inquest that at the time of this transmission, the members had not yet caught up with Ricky but were "negotiating" by directing him to stop.[724] She was advised via D24 that Ballarat 302 and Ballarat 251 (Patrol Supervisor A/Sgt Mark Dunne) would deploy to Merindah.[725]

296. LSC Davis was aware that she was some distance ahead of her colleague as Ricky, and then she, reached the dogleg in the fence line.[726] The terrain in this area is uneven and undulating with a downward slope,[727] save for the embankment adjacent to the highway. The ground was covered by tufts of tall dry grass and debris.[728]

297. LSC Davis saw Ricky fall down face-first 'forcefully,' without bracing himself.[729] She observed him spring up 'like a coil' and a 'moment' later, fall again having apparently lost his footing.[730] Between the first and second fall, LSC Davis stated that she approached to within about three metres of Ricky. He was facing her and yelling delusional things about his mother; he was aggressive, moving on the spot with his hands in motion around chest height.[731] She held her hands up, palms towards Ricky, and gestured for him to lie down while yelling at him

[720] T, pages 1001-1002 (Davis), 1082 and 1086 (Bergheim).
[721] CB, page 361 and T, page 982.
[722] T, page 1088.
[723] Multimedia Exhibit (Police Radio Communications 3/5/2018) and CB, page 3772.
[724] T, page 1088.
[725] Multimedia Exhibit (Police Radio Communications 3/5/2018) and CB, pages 3773.
[726] CB, page 361.
[727] CB, page 361.
[728] Photobook B, photograph 18.
[729] CB, page 361.
[730] T, pages 1020-1021.
[731] CB, page 362 and T, page 1021.

repeatedly to 'get down on [his] stomach.'[732] When Ricky did not comply, LSC Davis threatened to deploy capsicum spray.[733] It was when Ricky was on the ground the second time that LSC Davis became aware that her colleague had caught up with them.[734]

298. LSC Bergheim caught up with Ricky and LSC Davis in time to see him on the ground, by her account, 'on his knees.'[735] She did not see Ricky fall to the ground (the first fall described by LSC Davis) because her colleague was in her line of sight: LSC Bergheim did see Ricky 'stumble'[736] before next seeing him on his knees. She directed him to 'stay on the ground' while Ricky rambled delusional statements.[737] LSC Bergheim considered her tactical options and withdrew her capsicum spray from its pouch, showed it to Ricky, and threatened to use it if he did not comply.[738] Ricky 'hesitated' just long enough to enable the police members to move in and take hold of his arms.[739] LSC Bergheim replaced the cannister of capsicum spray in its pouch without using it.[740]

299. Neither LSC Bergheim nor LSC Davis considered it appropriate to just remain with Ricky and talk to him.[741] They were concerned he may abscond again if left unrestrained and were then only about ten metres from the Midland Highway.

300. Ms Stephens, who had followed Ricky and the police members at a distance, arrived in time to see and hear what occurred just before LSCs Bergheim and Davis moved in to restrain Ricky.[742]

301. The police members each took hold of one of Ricky's arms and manoeuvred him onto his stomach.[743] At about this time, at 5.24pm, LSC Bergheim transmitted a situation report that they had 'hands on'[744] Ricky, who was on the ground but 'not compliant.'[745] He was 'thrashing around and aggressively resisting' police.[746] Ricky was lying, based on LSC Bergheim's description, on the slope of the embankment, face-down, with his head towards its crest;

[732] CB, page 362.
[733] T, page 1022.
[734] T, page 1021.
[735] T, page 1089.
[736] T, page 1089.
[737] CB, page 349.
[738] CB, page 349.
[739] CB, page 349.
[740] T, page 1062.
[741] CB, page 349 (Bergheim) and T, pages 1021-1022 (Davis).
[742] T, page 959. Upon reaching their location near the highway, Ms Stephens recalled first seeing Ricky on the ground (though described him 'casually laying there') with the police members two or three metres from him. She did not see Ricky go to the ground: T, page 972.
[743] T, page 969.
[744] T, page 1089.
[745] Multimedia Exhibit (Police Radio Communications 3/5/2018) and CB, page 3773.
[746] T, pages 985-986.

Ricky's position on the slope, his constant movements and the loose volcanic rock from which the embankment was constructed complicated the effort to restrain him.[747]

302. LSC Davis withdrew her handcuffs and she and her colleague attempted to cuff Ricky's hands behind his back. Although able to apply a cuff to one of his wrists, when Ricky flung his arm the unsecured cuffs were thrown several metres.[748] The handcuffs were returned to the members by Ms Stephens, and they recommenced the effort to handcuff Ricky.[749] Ricky continued to resist, rolling and thrashing on the embankment facedown.[750] According to Ms Stephens, LSC Davis straddled Ricky's hips but Ricky continued to 'squirm' and kick her and so she intervened, encircling Ricky's lower legs with her arms to prevent him kicking.[751] At one point during the struggle, LSC Davis called out that Ricky had hold of her gun but removed his grip.[752]

303. When Ricky rolled onto his right side, LSC Bergheim secured a cuff to one of his wrists and, together with LSC Davis, secured the second cuff to his other wrist in front of his body.[753] LSC Bergheim recalled having to use 'all [her] might' to handcuff Ricky.[754] It took the members approximately three minutes to handcuff Ricky, who was then in police custody.

304. At 5.27pm, breathing heavily,[755] LSC Davis advised D24 that Ricky had been handcuffed and they planned to retrieve the divisional van and take him to BMHS.[756] However, less than a minute later she asked if another unit could transport Ricky given their position several hundred metres from where the van was parked.[757] Then, at about 5.29pm, LSC Davis informed D24 that an ambulance would be of assistance because Ricky may require sedation.[758] In her oral evidence, LSC Davis explained that she considered sedation might be desirable because Ricky was 'constantly thrashing around' and she was concerned about his and the members' safety.[759]

[747] CB, pages 349-350.
[748] T, page 1066.
[749] T, page 1066.
[750] T, page 1066.
[751] T, page 956.
[752] T, pages 986 (Davis), 1066 (Bergheim) and 956 (Stephens).
[753] T, pages 1067 (Bergheim) and 1012 (Davis).
[754] T, page 1066.
[755] T, page 988.
[756] Multimedia Exhibit (Police Radio Communications 3/5/2018) and CB, page 3776.
[757] Multimedia Exhibit (Police Radio Communications 3/5/2018) and CB, page 3777.
[758] Multimedia Exhibit (Police Radio Communications 3/5/2018) and CB, page 3778.
[759] T, page 1014.

305. Ambulance Victoria records confirm that an ambulance was dispatched, Code 2 – urgent, at 5.30pm.[760]

306. The evidence of LSCs Bergheim and Davis (and that may be inferred from that of Ms Stephens) is that they and Ricky remained in approximately the same positions from the time he was mechanically and manually restrained on the ground until the arrival of the Ballarat 302 members about seven minutes later.[761] That is, Ricky was positioned on his right side on the incline of the embankment, with his head towards its crest and his arms extended in front of his body, hands cuffed. LSC Bergheim had tucked her right knee into Ricky's armpit to prevent him from rolling forward and held down his outstretched arms with one hand and applied pressure to Ricky's left cheek with the other to prevent him from lifting his head.[762] LSC Davis was on the other side of Ricky's body level with his hips and applying pressure to his body to maintain his position as he continued to struggle.[763] Ms Stephens was at Ricky's feet, controlling his lower legs.[764] Ricky was agitated and … breathing heavily.[765] He was verbally abusive when the police members tried to calm him with reassurance that they were there to help him.[766]

307. Neither LSC Bergheim nor LSC Davis considered it safe to reposition Ricky. The members were 'exhausted' and LSC Bergheim was concerned that they would 'lose control of the situation again.'[767] LSC Davis testified that 'at no point' did she consider the situation 'under control.'[768] Both members testified to being careful about how much force they applied to Ricky's body, and where, to ensure his safety while maintaining control of him.[769]

308. Around 5.30pm, each police member provided D24 with a situation report: Ricky was conscious and breathing and had a small abrasion to the head from a fall, neither member was injured and Ms Kerlin, who had arrived with Ms Peart, had been asked to wait near the highway to flag down Ballarat 302.[770]

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[760] CB, page 3881.
[761] T, pages 1067-1069 and 1106 (Bergheim), 1018 and 1023 (Davis) and 961 (Stephens).
[762] T, pages 1067-1068.
[763] T, page 1016.
[764] T, pages 962-964.
[765] T, page 1068.
[766] T, page 1023.
[767] T, page 1099.
[768] T, page 1017.
[769] T, pages 1068 and 1098 (Bergheim), and 990 and 1024 (Davis).
[770] Multimedia Exhibit (Police Radio Communications 3/5/2018) and CB, page 3779-3780.

309. At 5.34pm, LSC Bergheim asked D24 if there was an estimated arrival time for Ballarat 302 because Ricky was still struggling.[771] Thirty seconds later, Ballarat 302 advised D24 that it was 'approaching the address now.'[772]

310. Following the foot pursuit, Ricky had vigorously resisted restraint for about ten minutes.

Ballarat 302's Arrival at Merindah

311. Ms Stephens testified that she noticed Ricky's resistance to restraint had diminished by about the time she heard a police siren,[773] which according to LSC Bergheim, was audible from some distance and before the arrival of the second police unit was imminent.[774] Ms Stephens said that Ricky's resistance 'didn't really stop' until she heard, but could not yet see, the Ballarat 302 members, SC Richard McKenna and Constable Rory Mitchell, alight from their vehicle.[775] LSC Davis testified that Ricky stopped resisting 'before the [Ballarat 302] van stopped … as it was pulling up.'[776] LSC Bergheim recalled that Ricky stopped struggling as she told him the other police were coming and so formed the view that the two things were related, that Ricky was 'faking it.'[777]

312. The assumption that Ricky might be faking unconsciousness or 'foxing' was one shared by LSCs Bergheim and Davis and Constable Mitchell based on their experience with people in police custody resisting, then pretending to be unconscious, only to start 'fighting again.'[778]

313. Constable Mitchell alighted from the Ballarat 302 divisional van just before 5.35pm.[779] Twenty seconds earlier he had activated his body worn camera (**BWC**), equipment issued to some police members as part of a trial in 2018.[780] Thirteen seconds after alighting, his BWC captures the first clear view of Ricky and LSCs Bergheim and Davis, and sound recording had commenced.[781] Within 20 seconds of arriving at the scene, SC McKenna had relieved LSC

[771] Multimedia Exhibit (Police Radio Communications 3/5/2018) and CB page 3782.
[772] Multimedia Exhibit (Police Radio Communications 3/5/2018) and CB, page 3783.
[773] T, pages 962-963. The siren can be heard on the D24 transmissions at 5.34pm (and 41 seconds): Multimedia Exhibit (Police Radio Communications 3/5/2018) and CB, page 3783.
[774] T, page 1099.
[775] T, pages 962-963.
[776] T, page 1035.
[777] T, page1107.
[778] T, page 1103 (Bergheim), 1026-1027 (Davis) and 1365 (Mitchell).
[779] The timestamp on Constable Mitchell's BWC footage is T:07:34:35 when it commences and he alights from the van 21 seconds later at timestamp T07:34:56: Multimedia Exhibits (BWC 1 – Mitchell).
[780] T, pages 1375-1376.
[781] Multimedia Exhibits (BWC 1 – Mitchell) timestamp T07:35:08, at 0.34 seconds into the file. At first, only Ricky's head is visible due to the positions of the police members. LSC Davis is sitting on her haunches on the right side and perpendicular to Ricky's body level with his abdomen, with her back to the highway; she appears to have one hand

Bergheim and was applying pressure to Ricky's shoulders, and Constable Mitchell was in position to relieve LSC Davis.[782] The initial plan was to remove the handcuffs and re-cuff Ricky's hands behind his back.[783]

314. The members first attempted to roll Ricky onto his back before lifting him to a standing position, during which he did not weight-bear, and then placed him on the ground on his back.[784] Throughout these manoeuvres, police members encouraged Ricky to stand and respond verbally but Ricky remained silent[785] and made no discernible voluntary movement visible on the BWC footage.[786]

315. Around this time, Constable Mitchell formed the view that Ricky 'wasn't pretending'[787] and LSC Davis 'knew something wasn't right.'[788] That is, at about the same time LSC Bergheim requested an ambulance 'ASAP' via D24 at 5.36pm (and 41 seconds)[789] which is also captured on BWC footage.[790] She explained to D24: 'this male's now become a bit unresponsive. We're not sure if he's just playing up or whether he's … or whether he's not actually in a good way.'[791] At inquest, LSC Bergheim confirmed that her view at the time of the transmission was that Ricky was unresponsive, agreeing that un/responsiveness is a binary state.[792]

316. As Ricky was now on his back, the members had a clear view of his face, which is captured by the BWC footage.[793] Ricky appears to be unconscious. He does not react – by voluntary or reflexive movement – when SC McKenna shook, first his left shoulder and then his head; indeed, his facial muscles appear slack.[794] Nor does Ricky react when LSC Davis shook his

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on Ricky's back. LSC Bergheim appears to be kneeling parallel to the left side of Ricky's body (her right shoulder level with her colleague) and is leaning forward, with her right hand on the back of Ricky's head and her left hand on his outstretched cuffed wrists. Though it is difficult to be sure, it appears that Ricky's right cheek is on the ground (rather than being face down). At 0.52 seconds into the file, as Constable Mitchell moves in to relieve LSC Davis, Ms Stephens is visible kneeling to the left of Ricky's ankles with her hands on his calves.

[782] Multimedia Exhibits (BWC 1 – Mitchell) timestamp T07:35:28.

[783] Multimedia Exhibits (BWC 1 – Mitchell) timestamp T07:35:45.

[784] Multimedia Exhibits (BWC 1 – Mitchell) timestamp T07:35:52 to T07:36:31.

[785] LSC Davis testified that Ricky was 'mumbling' that this point (denying that the BWC footage depicted him making no sound) but that she did not know when he stopped mumbling: T, page 1028.

[786] Multimedia Exhibits (BWC 1 – Mitchell) timestamp T07:35:52 to T07:36:31.

[787] T, page 1367.

[788] T, page 1030.

[789] Multimedia Exhibit (Police Radio Communications 3/5/2018) and CB, page 3785.

[790] Multimedia Exhibits (BWC 1 – Mitchell) timestamp T07:36:44-49.

[791] Multimedia Exhibit (Police Radio Communications 3/5/2018) and CB, page 3785.

[792] T, page 1100. LSC Bergheim explained during her oral evidence [T, page 1100] that 'in the stress of everything … I've started to say something different, but then I'm like, "no, I need to let them know he's just unresponsive." So, unresponsive should have been the word but there's a pause there which is why … when you read it it looks like I'm saying, "a bit unresponsive" but that certainly wasn't the case.' There is not a pause in her transmission between 'a bit' and 'unresponsive' but I accept that LSC Bergheim was doing her best to accurately convey her observations to D24 in a stressful situation.

[793] Multimedia Exhibits (BWC 1 – Mitchell) timestamp T07:36:37, at 2:02 into the file.

[794] Multimedia Exhibits (BWC 1 – Mitchell) timestamp T07:36:38-46. Also, T, page 1037 (Davis) and 1356 (Mitchell).

right shoulder and asked him about his mother in an effort to elicit a verbal response.[795] Constable Mitchell also shook Ricky and heard another member say, 'there's movement;'[796] but the only movement he observed was 'just his tongue.'[797]

317. It was the colour of Ricky's face and that he was expressionless, and unresponsive, that concerned the police members, particularly LSC Bergheim.[798] Ricky's unresponsiveness was a trigger for the removal of handcuffs according to LSC Bergheim,[799] but the cuffs were not removed for about another six minutes.[800]

318. The members then moved Ricky into a seated position,[801] with SC McKenna supporting his back and noticing Ricky's head slump forward and that his body was 'really floppy and heavy, it was almost like a dead weight.'[802] The police members loosened Ricky's many layers of clothing, including pulling up his jumpers to expose his abdomen.[803] Constable Mitchell placed a hand on Ricky's chest to ascertain if it was moving but was unsure if what he felt was breathing or movement caused by the actions of his colleagues.[804] The BWC footage then depicts Ricky taking one breath, about two and a half minutes after the Ballarat 302 members arrived at Ricky's side, which was interpreted and articulated by a male police member as 'he's breathing.'[805]

319. Further attempts to elicit verbal or reflexive responses from Ricky continued until he was placed in the recovery position at about 5.38pm,[806] following a direction via D24 from A/Sgt Dunne.[807]

320. Almost immediately after he was placed in that position, the BWC footage depicts an exchange between the police members: (female's voice) 'Is he breathing?' (male's voice) 'Yep: there we

[795] Multimedia Exhibits (BWC 1 – Mitchell) timestamp T07:36:46-T07:37:00.
[796] Multimedia Exhibits (BWC 1 – Mitchell) timestamp T07:36:46-T07:37:00.
[797] Multimedia Exhibits (BWC 1 – Mitchell) timestamp T07:36:37:00 and CB, page 377 and T, page 1368.
[798] T, page 1111-1112 (Bergheim) and 1367 (Mitchell), and CB, pages 366 (Davis) 373 (McKenna) and 378 (Mitchell).
[799] T, page 1102.
[800] Multimedia Exhibit (Police Radio Communications 3/5/2018) and CB, page 3789-3790.
[801] Multimedia Exhibits (BWC 1 – Mitchell) timestamp T07:37:14.
[802] CB, page 373 and Multimedia Exhibits (BWC 1 – Mitchell) timestamp T07:37:13-40.
[803] Multimedia Exhibits (BWC 1 – Mitchell) timestamp T07:37:13-40.
[804] CB, page 377.
[805] Multimedia Exhibits (BWC 1 – Mitchell) timestamp T07:36:46-T07:37:39, at 3.03 into the file.
[806] The members call out to Ricky and there are sounds suggestive of someone tapping Ricky's face (which accords with the account provided by SC McKenna in his statement) but the camera is obscured: Multimedia Exhibits (BWC 1 – Mitchell) timestamp T07:37:54 to T07:38:11 (Ricky is in the recovery position by timestamp T07:38:20).
[807] At 5.37pm: Multimedia Exhibit (Police Radio Communications 3/5/2018) and CB, page 3785.

go.'[808] At about this time (5.38pm), LSC Bergheim relayed to D24 that Ricky was 'breathing but very shallow.'[809]

321. Twenty-three seconds later, the BWC footage depicts Ricky taking another breath.[810] There are no visual or aural cues captured on BWC footage (or elsewhere) suggestive of any other respirations by Ricky before, between or after those mentioned.

322. A minute later, at 5.39pm, just under five minutes after the Ballarat 302 members reached Ricky's side, Constable Mitchell turned off his BWC because he had formed the view Ricky was not breathing and anticipated that CPR was about to be commenced.[811] However, a further five minutes elapsed before CPR began.[812] There is no clear evidence, notwithstanding the members' conclusion that Ricky was unconscious and their concern about whether or not he was breathing, that any action had, to this point, been taken to ascertain if he had a pulse.

323. At 5.41pm LSC Bergheim made a further D24 transmission to request 'a hurry up on this ambulance. He's not looking flash at all.'[813] Ambulance Victoria records confirm that the ambulance dispatched was upgraded to Code 1 – time critical.[814]

324. Both SC McKenna and LSC Bergheim felt for a pulse. SC McKenna stated that he was not sure he could feel a pulse at either Ricky's wrist or neck but may have said aloud that he 'thought [he] could feel a faint pulse.'[815] Although in her statement LSC Bergheim recalled that when she removed a glove to feel for a pulse in Ricky's neck she 'couldn't find one,'[816] during her oral evidence she stated that she 'kept checking to make sure' and, just before the relevant situation report to D24, she 'did believe … [she] felt a pulse.'[817]

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[808] Multimedia Exhibits (BWC 1 – Mitchell) timestamp T07:38:23.
[809] Multimedia Exhibit (Police Radio Communications 3/5/2018) and CB, page 3787.
[810] Multimedia Exhibits (BWC 1 – Mitchell) timestamp T07:38:46.
[811] T, page 1370-1371. and CB, page 378. Constable Mitchell stated that turning off the BWC at his juncture, though not in line with Victoria Police policy, was a 'human response' to the situation in which he was concerned about Ricky's privacy: T, page 1374. The relevant policy is the Chief Commissioner's Instructions, CCI 01/08 and *Body Worn Camera Operation Guidelines* dated 30 June 2017. Constable Mitchell testified that this was his first shift wearing a BWC and only the second time he had activated it operationally: T, page 1374. He observed that if he were confronted by the same situation again, he would not deactivate the BWC but leave it to record until the incident was complete, in line with policy: T, page 1376. I am not critical of Constable Mitchell's deactivation of his BWC in the circumstances on 3 May 2018.
[812] The evidence of police members at inquest was that the D24 transmission indicating CPR had commenced (closest time stamp on the Multimedia Exhibit (Police Radio Communications 3/5/2018) is 5.44pm) would have occurred at or very shortly after CPR commenced.
[813] Multimedia Exhibit (Police Radio Communications 3/5/2018) and CB, page 3788.
[814] CB, page 3795; see also CB, page 3801 which suggests the Code 1 was activated at 5.44pm when CPR was known to be in progress.
[815] CB, page 373.
[816] CB, page 353.
[817] T, page 1132.

325. At 5.42pm, LSC Bergheim notified D24 that the handcuffs had been removed and the members were trying to remove some of Ricky's clothing.[818] She also reported that she had felt 'a very faint pulse.'[819]

326. LSC Davis recalled that once Ricky's torso was exposed, she could not see his chest rise or fall.[820]

327. Due to the sounds of traffic on the highway, LSC Bergheim did not hear until just before 5.43pm D24's advice that the ambulance was still five kilometres from the scene.[821]

328. About a minute later, at 5.44pm, LSC Bergheim informed D24 that CPR had commenced.[822] That is, five minutes after Constable Mitchell anticipated commencing CPR, six minutes after Ricky was last noted to breathe, eight minutes after it was clear to members that Ricky was unconscious, and nine minutes after Ricky had stopped resisting restraint.

329. Each of the police members who gave evidence at inquest was invited to reflect on the apparent slow appreciation of and response to Ricky's deterioration from the timeline established by Constable Mitchell's BWC footage and the D24 transmissions. LSC Davis responded:

> Obviously, there was a period of time that we thought that he needed to be cuffed and that's why they remained on him … he was cuffed to the front [while in the recovery position] … there [were] four members there at the time. So, I'm unsure why it wasn't a decision by someone to remove the cuffs any earlier[823]
>
> … and obviously, we got to the point where it's the handcuffs are off and then we need to have a look at him properly … my recollection of events is that we acted in a timely manner to try and get him help when we did actually realise that there was no reaction to what we were asking him and those sorts of things.[824]

330. LSC Davis conceded, based on Constable Mitchell's BWC footage, that police members were slow to recognise the seriousness of Ricky's condition.[825]

331. LSC Bergheim was more willing to engage in reflection. Although she did not consider earlier removal of the handcuffs was a greater priority than assessing Ricky's condition,[826] she

[818] Multimedia Exhibit (Police Radio Communications 3/5/2018) and CB, page 3790.
[819] Multimedia Exhibit (Police Radio Communications 3/5/2018) and CB, page 3790.
[820] CB, page 367.
[821] Multimedia Exhibit (Police Radio Communications 3/5/2018) and CB, page 3791.
[822] Multimedia Exhibit (Police Radio Communications 3/5/2018) and CB, page 3792.
[823] T, pages 1032-1034.
[824] T, pages 1040-1041
[825] T, page 1034.
[826] T, page 1116.

conceded doing so would have enabled police to take off some of Ricky's clothing and this, in turn, would have enhance members' ability to assess him.[827] She went on to say:

> Well, I – as I said, I have had that thought that he had that breath or that he was breathing because of that stomach moving. So, when he was laid there, we were still trying to just manage the situation itself and, obviously, there are updates awaiting on the ambulance, yeah. And then we were still trying to work out whether he was – did he have a pulse. Like, we were constantly checking. We didn't just lay him there and stand there and look over him and not do anything. We were still trying to see if there could be a response, checking for vital signs, all that sort of stuff, which is why, when the decision was made that we couldn't get that pulse, we couldn't find anything – any response in him at all, then, obviously, the discussion was had that we need – well, not a discussion but like comments made that, yes, we need to -- we need to start CPR on this fellow.[828]

332. Constable Mitchell confirmed only seeing 'one breath'[829] taken by Ricky and agreed that it took the members 'a long time' to realise that Ricky required CPR,[830] though noting that it did not feel like a long time.[831] He considered that the fragmentary and sequential nature of the observations of Ricky's presentation contributed to the delayed initiation of CPR.[832] Although the evidence suggests Constable Mitchell appreciated the need for CPR as early as 5.39pm, when he deactivated his BWC, as the most junior member in attendance, the formal rank structure was an impediment to him "taking charge."[833] Ordinarily, directions are given by a senior officer.[834] Although not critical of his more senior colleagues and agreeing that he could 'speak up' despite his rank, he did not feel able to do so on 3 May 2018 due to the 'manic' nature of the incident.[835] The LSCs were the members of highest rank and some of their evidence is suggestive of a decision-making vacuum after the Ballarat 302 members arrived, even accepting that the four members were thereafter working collaboratively.[836]

333. Constable Mitchell observed that the first aid training police members receive involves two members in a sterile environment[837] – on any view, circumstances far removed from the real-

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[827] T, page 1119-1120.
[828] T, page 1125.
[829] T, page 1368.
[830] T, page 1370.
[831] T, page 1370. LSCs Bergheim and Davis (implicitly) made similar observations: T, pages 1103 (Bergheim) and 1034 and 1050 (Davis).
[832] T, page 1370.
[833] T, page 1377.
[834] T, page 1372.
[835] T, page 1377.
[836] LSCs Bergheim uses the phrase 'the decision was made' (for example, T, pages 1111, 1125) but, when pressed, identified certain decisions that she herself made, for instance determining to the need for an ambulance 'ASAP' upon seeing Ricky limp and his expressionless face (T, page 1111); in contrast, and Davis testified that it 'wasn't my call' to remove the cuffs (T, page 1033) or determine whether/when Ricky was unconscious (T, page 1038). Accepting that each member can only take responsibility for the decisions made by them, there is no evidence of a discussion about who would make which decisions.
[837] T, page 1372.

life situations first responders encounter or that the members experienced on 3 May 2018. Coordination of effort while providing first aid is not part of the training.[838] Constable Mitchell reflected that the time between deactivation of his BWC in anticipation of CPR and CPR commencing might have been reduced if, rather than 'four members doing different things,' someone had taken charge and said, 'this is what we are doing.'[839]

334. Submissions filed on behalf of the Chief Commissioner of Victoria Police (**CCP**) characterise the process of identifying Ricky's deterioration and responding to it as 'less than ideal' but urge me to make no criticism of the police members given the context.[840] Consistent with those submissions, I accept that the members were confronted with a stressful situation, and to the extent that the situation ultimately required CPR, it was unusual. I also accept that the environmental conditions – the terrain and fading light – were challenging but I do not accept that the light conditions were so poor as to prevent the members from making pertinent observations about Ricky's condition or were otherwise materially different to what is captured on BWC footage. Indeed, their evidence demonstrates that there was sufficient light for them to observe changes in Ricky's skin tone. [841]

335. I cannot accept the submission, in essence, that because the members did not know why Ricky had lapsed into unconsciousness (that is, in the absence of any reason to suspect significant trauma or particular risk of positional asphyxia), they had no reason to conclude his unconsciousness was a serious medical emergency. Unconsciousness is a serious medical emergency: the VPM's Medical Checklist says as much;[842] unexplained unconsciousness surely should heighten not diminish the concern of those responding to it.

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[838] T, page 1372.
[839] T, page 1371.
[840] Submissions filed on behalf of the Chief Commissioner of Police dated 29 November 2022. I am urged to assess the reasonableness of the police members' actions in a realistic manner that accounts for decision making made quickly, under pressure and in emergencies without reference to hindsight – and to consider the five important factors articulated in paragraphs 22-27 of the submissions (among others).
[841] Although LSC Davis gave some evidence that the BWC footage appeared 'quite light' compared to the 'actual' conditions, [T, pages 1051], she agrees that Constable Mitchell's BWC footage is a 'fair reflection' of the light available at the time [T, page 1052].
[842] CB, page 4000-4040. The VPMG Safe management contains a Medical Checklist applicable to 'ALL persons in the care or custody of police at ALL TIMES' (at CB, page 4004). It requires members to assess the person's 'best verbal response' using a scale linked to 'required action.' 'Nil response' – a coma scale score of 1 – requires the following medical action: 'URGENT action required, send by ambulance to hospital'. While it is evident that the members' conclusion that Ricky was unresponsive prompted LSC Bergheim's request for an ambulance 'ASAP', that deals with the second clause of the required medical action not the first. Though what constitutes "urgent action" is not specified in the checklist the VPM, at 2.2, prompts members to consider if the person is 'breathing *well*.' [all emphases in original, save the last]. I, of course, accept that the members sought to establish signs of life while waiting for the ambulance to arrive.

336. The CCP's related submission[843] seeks to respond to that of Counsel Assisting who submitted that there was a clear failure by all four police members to recognise Ricky's deterioration and to take action to remove handcuffs and commence CPR, with the duration of that failure being difficult to watch on BWC footage and hard to understand.[844] The CCP submitted that Ricky did not 'initially' present as a person 'who was in cardiac arrest or otherwise requiring immediate CPR' and so members' actions in attempting to obtain a response from him and assess his status, rather than immediately administer CPR, was appropriate.[845] The submission asserts that 'all the evidence indicates that the police members … believed he was breathing and they had located a pulse.'[846]

337. While I accept that it was appropriate for the members to assess Ricky's status before "immediately" administering CPR, and that there is some evidence of a belief that he "was breathing" and that members had "located a pulse" – including that the effort to ascertain vital signs was ongoing – the CCP's characterisation of the evidence is something of an overstatement. Though I acknowledge that information emerged at intervals and was fragmentary, within two minutes of Ballarat 302's arrival it was clear to the members that Ricky was not "foxing" but was unconscious.

338. The members who observed respiration saw "a breath," with the BWC footage suggesting as many as three breaths in about as many minutes, which although interpreted as "breathing" cannot be considered normal breathing. The only evidence[847] as to the detection of a "very faint pulse" is LSC Bergheim's belief that she felt one (absent from her near contemporaneous statement) just before her D24 transmission at 5.42pm: to be clear, I do not doubt the honesty of her belief. In short, there is scant evidence of unequivocal or even reassuring signs of life in an unconscious man over a period of about eight minutes.

339. That said, the CCP's submission that Ricky did not present as a person "who was in cardiac arrest or otherwise requiring immediate CPR" is more complicated, even leaving aside what I am to understand by the qualifier, "initially." Accepting LSC Bergheim's belief that she detected a very faint pulse at about 5.42pm and so Ricky was not then "in cardiac arrest" does

[843] Submissions filed on behalf of the Chief Commissioner of Police dated 29 November 2022, at paragraph 27.
[844] Final submissions of Counsel Assisting the Coroner dated 7 October 2022, at paragraphs 53 and 54, in the latter of which Ms Ellyard submits that it is open on the evidence for me to find that there was a lost opportunity to commence CPR and potentially a lost opportunity to save his life.
[845] Submissions filed on behalf of the Chief Commissioner of Police dated 29 November 2022, at paragraph 27.
[846] Submissions filed on behalf of the Chief Commissioner of Police dated 29 November 2022, at paragraph 27.
[847] The evidence of SC McKenna is equivocal; neither LSC Davis nor Constable Mitchell detected/felt for a pulse.

not dispose of the assertion that he was not "otherwise requiring immediate CPR" nor Counsel Assisting's submission that there was a lost opportunity to commence CPR earlier.

340. There is evidence that Constable Mitchell appreciated a need for CPR to commence at 5.39pm, a conclusion he must have reached based on his first aid training.[848] Without understanding the content of the first aid training provided to Victoria Police members – whether unconsciousness, unconsciousness and abnormal breathing or cardiac arrest is the prescribed indication to commence CPR – I cannot identify with precision the point before 5.44pm when "earlier" CPR should have commenced. Nonetheless, I consider the submission that there was a lost opportunity to begin CPR earlier persuasive.

Administration of CPR

341. CPR was commenced at 5.44pm. A minute or so later, A/Sgt Dunne and SC Birthisel arrived at the scene. They were equipped with BWCs which were activated prior to their arrival, and upon seeing the red recording lights, Constable Mitchell re-activated his own BWC.[849]

342. While A/Sgt Dunne received a briefing from LSC Davis, SC Birthisel stopped the traffic on the Midland Highway to enable the ambulance that had overshot the location to turn around and park.[850]

343. Advanced Life Support paramedics were escorted to the scene. Paramedic Lee Watson observed Ricky lying parallel to the highway while SC McKenna and Constable Mitchell performed 'effective, vigorous' chest compressions and LSC Bergheim administered expired air resuscitation through a pocket mask.[851] He directed the members to continue CPR while he and his colleague set up their equipment and were briefed on the circumstances.

344. On examination by paramedics, Ricky was unconscious and in cardiac arrest, with the cardiac monitor indicating he was in asystole.[852] Paramedic Watson applied defibrillation pads and administered intravenous adrenaline while his colleague managed Ricky's airway.[853] At about this time, at 5.55pm, the first of two Mobile Intensive Care Ambulance units arrived.[854]

[848] T, pages 1372-1373: Constable Mitchell describes, though not in detail, the mandatory annual first aid training he is required to undertake as a police member.
[849] Multimedia Exhibits (BWC 3 – Mitchell) timestamp T07:46:03.
[850] CB, page 383.
[851] CB, page 401.
[852] CB, page 401.
[853] CB, pages 401-402.
[854] CB, page 395.

345. Paramedics managed Ricky's resuscitation for a further 45 minutes without any change to his condition.[855] In accordance with Ambulance Victoria Clinical Practice Guidelines, CPR was then ceased, and Ricky was declared dead at 6.35pm on 3 May 2018.[856]

346. A crime scene was established, with a coronial investigation commenced by a D/Sgt Bell and oversight by Victoria Police's Professional Standards Command. The investigation was broadly in line with Victoria Police policy and guidelines relating to death or serious injury incidents involving police.[857]

SYSTEMS CHANGES SINCE 2018

347. At the time of inquest in 2021:

    a. The Victorian Government had announced a $5.3 billion investment for the "Big Housing Build" which will deliver 12,000 new social housing properties and other affordable housing, in addition to refurbishment of existing public housing and 1,000 new public housing dwellings in rural and regional Victoria.[858]

    b. The Victorian Government had committed to implement all of the Recommendations made by the Royal Commission into Victoria's Mental Health System (**RC-MH**), which relevantly include:

        i. Integrated regional governance, including the establishment of multi-agency panels in regional Victoria as required for the delivery of multiple mental health and wellbeing services to enhance communication and coordination between services (Recommendation 5);[859]

        ii. Integrated treatment, care and support;[860]

[855] CB, page 397.
[856] CB, pages 397 and 3804.
[857] The relevant policies are Victoria Police Manual, Policy Rules – *Death or serious injury/illness incidents involving police* and Procedures and Guidelines – *Death or serious injury/illness incidents involving police* (**VPMPG DSI**), both dated 31 August 2015. LSCs Bergheim and Davis were not initially 'separated and isolated' from one another as required by the VPMPG DSI; indeed, they were conveyed from the scene in the same vehicle. The purpose of the above-mentioned VPMPG DSI requirement is to prevent collusion. The evidence of both members is that they did not discuss the incident before finalising their statements: T, pages 1073 (Bergheim) and 994 (Davis). While there was an opportunity for collusion, there is no evidence that collusion occurred. Further, when asked about BWC footage depicting him speaking to civilian witnesses 'as a group' he conceded his awareness of the VPMPG DSI requirement for separation by that he was not trying to obtain witness accounts, only an operational overview to enable him to manage the incident: T, pages 1393-1395.
[858] AM, page 582.
[859] T, pages 1245-1246. Recommendation 5 of the Royal Commission into Victoria's Mental Health System.
[860] AM, page 268. Recommendation 6 of the Royal Commission into Victoria's Mental Health System.

iii. Mental health services provide needs identification and initial support functions, including comprehensive needs assessment and planning discussions (Recommendation 7);[861]

iv. Affordable housing for people living with mental illness, including assignment of 2,000 dwellings from the Big Build to such people (Recommendation 25);[862]

v. Resourcing and monitoring mental health services including by commissioning demonstration projects in Victoria regions where providers deliver multiple services to people living with mental illness who require short-term treatment, care or support and who are in the "missing middle."[863]

c. As part of its implementation of the Recommendations of the RC-MH, the Victorian Department of Health will establish 60 Local Adult Mental Health and Wellbeing Services across Victoria to provide a "front door" to mental health support including a range of therapies and wellbeing treatment. The staged model of care anticipates a lower threshold for access – less acuity[864] – than entry to the (tertiary) Area-based mental health services, will take a multidisciplinary approach to management and facilitate connections with primary mental/health providers and provide oversight so that any disconnection in service is detected.[865]

d. As part of its implementation of the RC-MH Recommendation 25, the DFFH will consider establishing a "segmented" public housing waiting list to assist prioritisation of people whose mental health contributes to their need for social housing.

e. The DFFH had also commenced development of new Standards to regulate social services, including SRSs. A focus of the new Standards will be 'outcome-based requirements' that ensure safe service delivery and the protection of the human rights of service users.[866]

f. The NDIA had:

[861] AM, page 270. Recommendation 7 of the Royal Commission into Victoria's Mental Health System.
[862] AM, page 288. Recommendation 25 of the Royal Commission into Victoria's Mental Health System.
[863] AM, page 314. Recommendation 51 of the Royal Commission into Victoria's Mental Health System.
[864] That is, people who are chronically unwell could access these services: T, page 1540.
[865] T, pages 1538-1543.
[866] AM, page 584.

i. Just completed a review of support coordination with the objective of clarifying the role and the responsibilities of support coordinators and improving services provided to participants.[867]

ii. Introduced a 'light touch' review for minor changes to a participant's plan.[868]

iii. Established a new support known as a 'psychosocial recovery coach'. A psychosocial recovery coach is a qualified mental health worker who can support a participant to build resilience and capacity to achieve their goals, and understand how the NDIS operates within 'a broader ecosystem' of mainstream and community supports. Subject to the participant's preferences, a psychosocial recovery coach may among other things:

    1. support the participant to develop goals for their life through recovery planning;

    2. coach the participant to improved sills and decision making;

    3. provide information and advice;

    4. collaborate with broader service systems to ensure supports are responsive to the participant's recovery goals

    5. link a participant with mental health, health and other services, particularly when they are unwell.[869]

iv. Updated the SDA Operating Guidelines to provide more transparency in decision making in relation to SDA funding and remove barriers to participant choice in SDA living arrangements.

v. In July 2020, created within the NDIA a Housing Supports team to centralise all planning decisions relating to housing support needs, inclusive of SDA, home modifications, SIL and independent living options.[870]

[867] T, pages 1721-1722 and AM, pages 595-619.
[868] T, page 1725.
[869] CB, page 4324 and T, page 1684.
[870] T, pages 1726-1727 and CB, pages 4325-4326.

vi. Updated the NDIA Standard Operating Procedures to prompt consideration of SDA where "housing" is a plan goal.

vii. Introduced 'Participant Check-ins' by the NDIA (directly) to connect to participants, check on their wellbeing and ensure NDIS supports meet their needs.[871]

viii. In 2019 (in Victoria), established an independent NDIS Quality and Safeguards Commission to respond to concerns, complaints and reportable incidents, including abuse and neglect of participants.

g. BMHS had established an acute response team where patients are provided with better access to assessment and assistance in developing automated mental health plans to assist in crisis in response to RC-MH Recommendation 7.[872]

FINDINGS/CONCLUSIONS

348. The standard of proof for coronial findings of fact is the civil standard of proof on the balance of probabilities, with the *Briginshaw* gloss or explications. [873]

349. Adverse findings or comments against individuals or institutions are not to be made with the benefit of hindsight but only on the basis of what was known or should reasonably have been known or done at the time, and only where the evidence supports a finding that they departed materially from the standards of their profession and in so doing caused or contributed to the death under investigation.

350. Having applied the applicable standard of proof to the available evidence, I find that:

a. The identity of the deceased is Ricky James Broughton, born 28 January 1971, aged 47 years.

b. Ricky died at 7096 Midland Highway, Buninyong on 3 May 2018.

c. The medical cause of Ricky's death is complications of acute agitation in the setting of a prolonged struggle in an acutely psychotic man with a history of chronic schizophrenia.

[871] CB, page 4325 and T, page 1725.
[872] T, pages 1245-1246.
[873] *Briginshaw v Briginshaw (1938) 60 C.L.R. 336 especially at 362-363. "The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding, are considerations which must affect the answer to the question whether the issues had been proved to the reasonable satisfaction of the tribunal. In such matters "reasonable satisfaction" should not be produced by inexact proofs, indefinite testimony, or indirect inferences…"*

d. Accordingly, I direct the Principal Registrar of the Coroners Court of Victoria notify the Registrar of Births, Deaths and Marriages of this change in the cause of death.

e. Due to his psychosocial (and suspected cognitive) disability Ricky required support to identify and meet his needs. He had never lived independently as an adult and was at perpetual risk of homelessness. Indeed, his relocation from the Barwon region to Ballarat in February 2017 was precipitated by the unavailability of suitable accommodation.

f. The decision of Barwon MHS to discharge Ricky from the service upon his relocation to Ballarat was reasonable in the circumstances. While an open referral of Ricky to BMHS may have influenced how BMHS viewed subsequent referrals (by Mr Smyth and Ms Avraam in particular), it is a matter for conjecture whether a Barwon MHS referral would have been accepted, and if it were, how long any period of case management by BMHS might have lasted.

g. Ricky was supported to meet his housing, medical and mental health, care and community engagement needs by a range of individual and entities while in Ballarat. While key pillars of Ricky's formal support team – Kallara, Dr Taylor and Wellways – were in place within three months of his arrival, any stability they might have afforded was disrupted by Ricky's multiple relocations in Ballarat between July and August 2017, which occurred with little or no warning to members of his support team having formal coordination roles.

h. The BMHS response to the four referrals received in relation to Ricky between May and August 2017 was reasonable given the circumstances prevailing at the time. However, the fact that none of the referrals prior to 2-3 May 2018 resulted in a determination that Ricky's presentation was sufficiently acute for entry to specialist mental health services highlights the obstacles faced by the so-called "missing middle' cohort of mentally unwell people seeking access to the public mental health system and the challenges faced by formal and informal support networks trying to assist them.

i. Following his move to Merindah, Ms Peart and Ms Stephens played a key role in meeting Ricky's housing and care needs, exceeding the limits of their formal responsibility, and relaying concerns about mental health and disruptive behaviours to his NDIS support coordinators.

j. The support coordination provided by Wellways was consistent with industry practice at the time and was reasonable in the circumstances. Ms Avraam worked diligently to support Ricky to maintain his accommodation at Merindah by coordinating supports to assist him with activities of daily life and occupy him during the day programs and link

him to a private psychiatrist while she tried to identify more suitable accommodation. After Ms Avraam's departure, her replacements tried to maintain the day-to-day supports she had established with diminishing engagement from Ricky and, in the case of Mr Sentance, misinformation about the funds remaining supports in his NDIS Plan 2.

k. Due to a communication breakdown between Ricky's private psychiatrist and other members of his care team, between October 2017 and May 2018, there was a lost opportunity to intervene and prevent deterioration of his mental health.

l. Based on the information he recorded in clinical records, RPN Clifton's psychiatric assessment of Ricky on 2 May 2018 was reasonable.

m. The decision of Ms Kerlin and Mr Gillet to make Ricky subject to an Assessment Order on 3 May 2018 was reasonable.

n. Ms Kerlin's request for police to assist with Ricky's transfer to hospital was reasonable.

o. The failure of Ms Kerlin or LSCs Bergheim and Davis to request an ambulance around 5.15pm on 3 May 2018, before they approached Ricky, was inconsistent with the guidance provided in the DoH and DHHS-VP Protocols and VPM to transport mentally unwell individuals to a designated mental health service by the least restrictive means possible.

p. That said, there is an unhelpful ambiguity in those documents about both the threshold for police involvement, and the point at which a clinical assessment of risk is transformed into a police decision about the extent of their involvement in transportation. Put another way, the documents presently allow for conflation of the concepts of *police involvement* and *police transport* and undermine the use (or consideration) of a less restrictive practice.

q. When Ricky ran from police attempting to execute the Assessment Order, LSCs Bergheim and Davis acted appropriately by first pursuing and then mechanically and manually restraining him as he continued to resist until the arrival of additional police members.

r. The use of handcuffs to restrain Ricky after it was evident to the attending police members that he was unconscious was inappropriate and impeded their ability to accurately assess his condition and identify his deterioration.

s. Notwithstanding the genuine efforts of LSCs Bergheim and Davis, SC McKenna and Constable Mitchell to ascertain Ricky's vital signs between 5.36pm and approximately 5.43pm, in the absence of unequivocally reassuring signs of life and in the context of increasingly urgent requests for an ambulance via D24, there was a collective failure to commence CPR in a timely way.

t. Although the weight of available evidence leads me to conclude that CPR was unreasonably delayed, it does not enable me to find to the applicable standard that Ricky's chances of survival would have materially improved or that his death might have been prevented if CPR had commenced earlier than it did.

RECOMMENDATIONS

Pursuant to section 72(2) of the ***Coroners Act 2008***, I make the following recommendations, including recommendations relating to public health and safety or the administration of justice:

1. That, given the recent entry into force of the new *Mental Health and Wellbeing Act* 2022, the Department of Health consider, in consultation with Victoria Police and Ambulance Victoria, the need to revise the *Protocol for the transport of people with mental illness* to ensure its guidance to clinical and emergency service responders is sufficiently clear to enable decisions to be made about the conditions under which a mentally unwell person is transported to or from a designated mental health service consistent with the principle of least restrictive practice. In particular, it appears that clarification of the distinction between 'police involvement' and 'police transport' may be required.
2. That the Chief Commissioner of Victoria Police consider the need to clarify, reinforce or enhance the guidance and/or training provided to its members to equip them to respond to life-threatening emergencies in a person in their care or custody, in particular:
    a. Recognition and response to a deterioration in their state;
    b. Management of an unconscious person;
    c. When to commence CPR; and
    d. Coordination of effort by multiple responding members;

PUBLICATION OF FINDING

Pursuant to section 73(1) of the Act, unless otherwise ordered by the coroner, the findings, comments and recommendations made following an inquest must be published on the internet in accordance with the rules. I make no such order.

DISTRIBUTION OF FINDING

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

Ricky's family

Barwon Health

Ballarat Mental Health Service/Grampians Health

Wellways

Dr Scott Taylor, Ballarat Group Practice

Mind @ Home Psychiatry

Chief Commissioner of Victoria Police

National Disability Insurance Agency

Department of Families, Fairness and Housing

Department of Health

Office of the Chief Psychiatrist

Signature:

Paresa Antoniadis Spanos

Deputy State Coroner

Date: 8 December 2023

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