TRANSCRIPT OF PROCEEDINGS

CORONERS COURT

PREVITERA, Coroner

No COR17 of 2003

IN THE MATTER OF AN INQUEST INTO THE
CAUSE AND CIRCUMSTANCES SURROUNDING
THE DEATH OF JULIAN ARASINA LEE

CAIRNS

..DATE 30/09/2004

FINDINGS

WARNING: The publication of information or details likely to lead to the identification of persons in some proceedings is a criminal offence. This is so particularly in relation to the identification of children who are involved in criminal proceedings or proceedings for their protection under the *Child Protection Act* 1999, and complainants in criminal sexual offences, but is not limited to those categories. You may wish to seek legal advice before giving others access to the details of any person named in these proceedings.

CORONER: An inquest having been held into the death of Julian Arasina Lee between the 23rd and 25th of August 2004 it is now incumbent upon me pursuant to the provisions of the Coroners Act 1958 to deliver requisite findings in open Court.

The purpose of any such inquest is limited to establishing as far as practicable: (1) the fact that a person has died; (2) the identity of the deceased person; (3) when, where and how the death occurred; and (4) whether any person should be charged with any of the offences referred to in section 24 of the Act.

It is not submitted by any of the legal representatives for the parties or interested persons that any person should be so charged, and I am satisfied that on the whole of the evidence before me that there is insufficient evidence upon which any person should be committed for trial on any of the charges referred to in section 24 subparagraph 1, subparagraph D of the Coroners Act 1958.

In making my findings I am not permitted under the provisions of the Act to express any opinion on any matter which is outside the abovementioned scope of the inquest except in the form of a rider or recommendation. I should also make it clear that any findings I do make in these proceedings are not to be framed in any way which may determine or influence any

question or issue of liability in any other place, or which might suggest that any person should be found guilty or otherwise in any other proceedings, whatever their nature.

This inquest received into evidence a large number of statements of witnesses, including those of Paul Burns, Brett Dennis, and George Doward, who exercised their right to claim privilege when called to give oral evidence. A number of exhibits were also tendered in addition to which oral evidence was heard from a number of other witnesses, as well as persons involved directly or indirectly in the care of Julian prior to his death.

This Court commends the efforts of the investigating officer, Detective Sergeant Syd Churchill, in undertaking a most comprehensive and thorough investigation which has enabled this inquest to be satisfied that it has been placed in the best position possible to make the necessary findings.

The circumstances giving rise to the tragic incident necessitating these proceedings can be stated as follows: For a couple of weeks prior to the 1st of February 2003 Julian had been exhibiting markedly changed behaviour according to his girlfriend, Renee Croft.

This behaviour escalated to such a degree that after consultation with Dr Nunn, a general practitioner, a recommendation to, and a home visit on the 1st of February 2003 by the CAT team - which is the Mental Health Unit Crisis Intervention Team - duly and voluntarily accompanied Dr Cameron-Kirksmith, and nurses Kirsty O'Carroll and Melinda Hsu to the Mental Health Unit at Cairns Base Hospital. This occurred after assessment of Julian by Dr Kirk-Smith at Julian's father's residence at approximately 3.20 p.m.

Julian was voluntarily admitted to the lower dependency unit at approximately 4 p.m. on that day by Paul Burns, the admissions nurse. While certain medication was prescribed for Julian at that time, he declined to take any at that time.

At approximately 9 to 9.15 p.m. Julian was observed by a number of witnesses playing pool in the lounge of the lower dependency unit, and began to exhibit increasingly agitated behaviours in the presence of Paul Burns and Anne Ripberger, another nurse present in the lounge of the lower dependency unit.

Paul Burns left the room and returned very soon thereafter followed by two other nurses, Brett Dennis and George Doward, a wards man, George Tait, and two security officers, Wayne Gibson and Ross McMurtie. A number of witnesses observed that

when Julian was approached by Paul Burns he became extremely agitated, screaming and yelling, and making threats of physical injury if any person approached him.

A number of witnesses then observed Julian to jump over some chairs in the lounge, run from the room, through the lower dependency unit, along a verandah to the glass doors leading into the special purposes unit where he could not gain entry. He was therefore effectively cornered, or certainly that is how one presumes he must have felt as he had been followed closely by Paul Burns, Brett Dennis and Wayne Gibson, who were followed closely by George Doward, Ross McMurtie, and George Tait.

I accept on the whole of the evidence that what followed then, most unfortunately, was a violent struggle by Julian to avoid restraint, in the course of which he struck Paul Burns in the face, punched Wayne Gibson to the head, and was generally thrashing about in a manner which, I accept, demonstrated extreme agitation, fear, and strength by Julian in his attempts to break free.

I accept on the whole of the evidence that what occurred then involved Brett Dennis, Ross McMurtie, Wayne Gibson and George Tait taking hold of Julian's arms, torso, and one of his ankles respectively, the whole group then fell to the floor,

as a consequence of which Julian was lying stomach-down on the floor with Brett Dennis, Paul Burns and George Doward restraining the upper part of his body, and Wayne Gibson, Ross McMurtie and George Tait restraining the lower end of his body.

Throughout Julian continued to thrash about, screaming to be released, and exhibiting extreme strength in trying to break free from the various holds upon him. I accept on the whole of the evidence that Brett Dennis had his arm around Julian's head and neck area in such a hold that enabled Julian to bite down hard on Brett Dennis's right forearm, so as to cause a break in the skin. Brett Dennis's forearm was only freed from Julian's grip after George Doward intervened.

I accept the evidence of Wayne Gibson, George Doward and George Tait that whilst Julian remained handcuffed on the floor those handcuffs, having been placed by Ross McMurtie, and that placement being assisted by Wayne Gibson, that Paul Burns sat on Julian's back in the area between Julian's waist and shoulder blades. It is not clear from the evidence whether this occurred prior to any injections, or between the second and third injections.

The first injection was of 10 milligrams of Droperidol, followed immediately by a second injection being two milligrams of Cogentin, both administered by nurse Lyall

Forde, and authorised by Dr Cameron-Kirksmith over the phone. Dr Kirksmith herself then, upon arrival at the hospital, approved a third injection, being five milligrams of Midazolam, which was also administered by Lyall Forde, and in Dr Cameron-Kirksmith's presence.

I accept Dr Kirksmith's evidence that because the Medazolam did not seem to take effect straightaway she left the room, and asked Lyall Forde to draw up and administer 150 milligrams of Clopixol-acuphase, which he did after nursing and security staff had released their restraints. Dr Kirksmith and Anne Ripberger then observed that Julian was not breathing. He was, at this stage, still stomach-down on the floor.

Dr Kirksmith gave a direction that Julian be placed on his back so that CPR could be commenced, and I accept that there was a delay in doing so because of a difficulty in removing the handcuffs which had been placed there under circumstances where there had been no authorisation from medical staff for that particular restraint to be administered.

Dr Kirksmith inserted a guedel airway and Julian was intubated and given adrenalin, but due to a failure to respond to the efforts of a number of the medical staff, those efforts were terminated after approximately 25 minutes, and Julian was declared clinically dead at approximately 10.30 p.m. on the 1st of February 2003.

In relation to the medication authorised and administered, I accept the evidence of Professor Williams, the pathologist who conducted the autopsy, that the quantities of the respective drugs were quite low, so as to rule out death by reason of a medication-related respiratory depression.

Professor Williams also ruled out that the internal bruising to Julian's neck, which is opined by him to be the fatal injury, is not likely to have been associated with the resuscitation attempts. Whilst he does not rule out as a possibility that the sitting by a 100 to 110 kilogram person on the back of Julian - who was approximately 60 kilograms - caused significant breathing difficulties, which may have culminated in Julian's death, Professor Williams does not consider that as significant to the death as the internal injuries to the neck which were caused, in his view, by significant and broad application of force to the front of the neck.

Whether this force was the result of a direct neck hold to Julian by a person or persons, the result of the falling to the floor whilst held by the persons referred to, or some other activity occurring during what can only be described as a violent struggle is unable, unfortunately, to be determined.

Professor Williams is of the view that if the death had been by way of compression of the chest, the evidence upon autopsy would have been markedly different. The coronary arterio-

sclerosis found by Professor Williams upon post-mortem he considers to be incidental to the death.

I therefore make the following findings. The deceased, Julian Arasina Lee, born on the 24th of February 1979 died at the Cairns Base Hospital on the 1st of February 2003 as a result of compression of the neck, secondary to which Julian suffered from coronary arterio-sclerosis. The means by which the compression of the neck occurred, I have already indicated, cannot be determined with any certainty.

At this time the Court again offers its condolences to the family and friends of Julian, who have attended the inquest and are here today. I now intend to comment upon matters that have occurred since the death, but not necessarily consequent upon it with a view to making some recommendations.

Following Julian's death there was an operational review of the Mental Health Unit at Cairns Base Hospital. This was conducted by Dr Jacinta Powell, and the review was tendered into evidence as Exhibit Number 44. Jacinta Powell is the acting director of the Mental Health Unit for the State of Queensland. Highlighted in that review was a change in training for healthcare workers to the aggressive behaviour management training for healthcare workers, and that manual was admitted as Exhibit Number 48 in the proceedings.

The Court accepts the evidence of Joanne Eussen, clinical nurse consultant of the particular ward at the Cairns Base Hospital and Dr Janet Bayley, the director of that unit that not all staff will have completed the five day training package until May 2005.

This training package, amongst other things that the Court will refer to, in the Court's view is significant training given that in the view of Ms Eussen, Dr Bayley and Dr Powell it contains innovative, novel and different management behaviours to be adopted by staff in the event of aggressive behaviours exhibited by patients in the Mental Health Unit since that training package came into existence.

It is of some concern - and I should say great concern - that despite Julian's death on the 1st of February 2003 it will take in excess of two years subsequent to that event for all staff to be trained in these techniques.

I accept the evidence of Dr Bayley that funding considerations are relevant in the staggered approach taken in relation to the training of all staff, that there is apparently some question mark over funding for refresher or ongoing training and likewise a question mark over funding to provide relief staff whilst other staff are completing the training.

I intend now to make a number of recommendations in relation to that training as well as a number of other matters which in the Court's view had they been implemented as at the date of

Julian's death would well have decreased the risk to him and the consequent sadness and irretrievable loss to his family and friends.

These recommendations are made with a view to avoiding any further occurrence of this kind to people in Julian's position and those in the position of his family and friends.

In making these recommendations I urge the relevant authorities to consider each and every recommendation as a minimum requirement and the totality of them as an absolute necessity.

The recommendations are as follows:

1. That funding be made available for all staff of the Mental Health Unit including security staff to undertake the Aggressive Behaviour Management Training;
2. That instead of security staff attaching to the hospital as a whole there be dedicated security staff attached specifically and permanently to the Mental Health Unit so that these staff have a particular understanding of the very special needs of those persons admitted to the unit;
3. That the Aggressive Behaviour Management Training be recognised as a long term training project for all staff and that funding be made available for

ongoing training by way of refresher courses on a regular basis;

4. That Queensland Health make funding available to fill positions necessarily vacant while staff in those positions undertake the training and refresher courses, that this funding be made available on an urgent basis so that there is no further delay and certainly not the delay until May 2005 before all staff are trained in this necessary manner;

5. That all newly recruited staff and commencing staff including medical staff, all other health professionals and security staff undertake this Aggressive Behaviour Management Training prior to commencing employment;

6. That the document titled "Management of adults with severe behaviour disturbance, guidelines for clinicians" which was admitted as Exhibit Number 38 subparagraph K in these proceedings, also be distributed to all health professionals prior to commencement of employment at the Cairns Base Hospital Mental Health Unit. It contains highly relevant and indeed crucial information as to how such persons ought be treated and managed whilst in the Mental Health Unit;

7. That a policy be developed in relation to the implementation of a more effective means of communication between the staff on the ward and the treating doctor in relation to the approval or otherwise of particular restraints, and in this case

there was no doctor on the ward but communicating by telephone at least for the initial part of the drama that unfolded and I will say more about that later;

8. That the Aggressive Management Behaviour Training manual be reviewed so as to remove the ambiguity arising in relation to whether, upon restraint, individuals are to be placed in the prone position, that is on their stomachs as Julian was or otherwise. Page 171 of the current participant manual states that individuals must never be placed in the prone position when restrained whilst page 189 advocates that prone positioning provides the greatest safety;
9. That Queensland Health undertake a complete review of the literature concerning the policies and procedures for the management of incidents of aggression in the various Mental Health Units to ensure that it does accurately reflect those policies and procedures and does not provide any means by which any person could be ever confused about the way in which patients are to be restrained;
10. That in so far as the word "takedown" is used in any literature to describe a restraint of a client that such phrasing be removed and replaced with the word "restraint" to reflect the more humane and appropriate manner in which patients are to be considered and treated;
11. That a policy and procedure officer be appointed to

undertake this review and to be responsible on an ongoing basis for the proper and timely communication to all staff of the policies and procedures;

12. That an incident management officer be appointed to the Mental Health Unit on a full-time basis to monitor clients of the Mental Health Unit upon admission and subsequent to admission for the purposes of more effectively managing any potential incidents with a view to preventing same. Perhaps if there had been such an officer upon Julian's admission there may very well have been facts and circumstances known then to the staff of the Mental Health Unit which would have resulted in a different treatment regime;
13. That Queensland Health provide funding for a male indigenous health worker to be available on the ward to cater for any special needs of indigenous male clients. Again, as a Papua New Guinean Julian was such a client and his particular needs and circumstances might have been better known if such a worker had been available;
14. That Queensland Health undertake a review of the appropriate staffing levels for all professional staff. It may be that if there had been a doctor on the ward present at the time when the incident first erupted that matters may have been differently dealt with;
15. That Queensland Health provide funding for

additional medical staff in the Mental Health Unit;

16. That Queensland Health undertake a review of the manner in which incidents of aggression are monitored and recorded;

17. That Queensland Health introduce the establishment of committees within Mental Health Units whose task it is to analyse trends in relation to reported incidents of aggression in the units so that there might be seen to be a pattern evolving from which information can be gleaned and steps can be taken to reduce and hopefully eradicate any further occurrences of this kind;

18. That Queensland Health provide funding to enable such architectural renovation to occur which will provide a clear view from the nurses' station to the end of the ward in each unit of the Mental Health Unit. This is not the case in the Mental Health Unit of the Cairns Base Hospital. Smoother management could only result from staff at the nurses' station being able to view what is going on in the totality of the ward at all times;

Those are the recommendations which I make. I know that it is too late for Julian but hopefully upon the authorities taking those recommendations into account that persons such as Julian can be saved and that persons who are his family and friends can be spared the anguish that I know has been experienced by this incident and the inquest.

I offer you the Court's condolences in relation to Julian's death and hope that in some way this might provide some closure, if not comfort, in relation to his death.

I would like to thank again Detective Sergeant Syd Churchill and Dr Janet Bayley whose evidence greatly assisted the Court in formulating recommendations which have now been made.

I would like to thank all of the legal representatives for their assistance to me during the inquest and unless there is anything further I will close the inquest.