CORONERS COURT OF QUEENSLAND

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Bradley Karl COOLWELL**
TITLE OF COURT:	Coroners Court
JURISDICTION:	SOUTHPORT
FILE NO(s):	2011/3161
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FINDINGS OF:	James McDougall, Coroner
CATCHWORDS:	Coroners: inquest, mental and physical care in hospital, security measures, communication with family

REPRESENTATION:

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Nurse Charles Kumar: Nurse Jasbir Sandhu:	Mr Gavin Rebetzke, counsel O/I Roberts & Kane Solicitors
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Introduction

1. Mr Bradley Karl Coolwell was born in Lismore, New South Wales, on 25 January 1972. He was 39 years of age when he died on 12 September 2011. He was the eldest of six children born between 1972 and 1982. Mr Coolwell was an Indigenous Australian. He moved with hisfamily to the Inala area of Brisbane around 1975. He undertook his schooling in Queensland.

2. During his later youth and early adulthood, Mr Coolwell was convicted of a number of criminal offences, primarily property matters. He spent several periods in detention, and during one of those periods (around 1991) was diagnosed with schizo-affective disorder, a psychotic condition involving schizophrenia and other mood disorders. He spent much of the twenty years between 1991 and his death in full-time residential, involuntary mental health care at The Park Mental Health facility. He was discharged from The Park for treatment in the community on 25 November 2010, and lived with his family from that time until his admission to hospital on the day before his death at Logan Community Hospital on 12 September 2011.

Summary of Facts

3. The decision to discharge Mr Coolwell from The Park residential, involuntary treatment was not a contentious issue at the inquest. Evidence provided by West Moreton Area Health Service was not challenged in the course of the inquest and I accept it was an appropriate clinical decision.

4. Following his release, Mr Coolwell lived part of the time with his sister, Shontay Coolwell and part of the time with other relatives on Moreton Island. Ms Coolwell was represented by counsel at the inquest. Mr Coolwell, on the available evidence, did not ever live independently. Having said that, it is clear that he tended to come and go as he pleased, and that he was not in the care of any other person.

5. As part of his treatment regime in the community Mr Coolwell was required to attend an outpatient clinic on a regular basis for injections of risperidone, an anti-psychotic drug. Mr Coolwell had a range of comorbidities which also required regular medication. The most significant of these were the thyroid disorder Hashimoto's disease (which required hormone replacement therapy) and diabetes. Ms Coolwell, according to her oral evidence, had the impression Mr Coolwell was generally compliant with his medication regimen. However the toxicology results undertaken during the autopsy process suggest that risperidone was the only drug present in his body at therapeutic levels. It is not clear, on the available evidence, whether Mr Coolwell was compliant with all his medications, other than risperidone. Non-compliance may have contributed to his poor state of health on admission to hospital.

Events of 11 September 2011

6. Ms Coolwell gave evidence that on the evening of 10 September 2011, her brother Bradley was at home and behaving normally and that he continued to go about his business on the morning of the 11 September 2011. She said nothing unusual had occurred until she received a phone call from Logan Central police to inform her they were taking Mr Coolwell to Logan hospital as he was unwell – suffering from bronchitis.

7. The police version of events is that they received a call (from a member of the public, or Queensland Rail staff) to attend the Kingston railway station on the morning of 11 September 2011, due to concerns for the welfare of a large gentleman wearing superman pyjamas and a superman t-shirt. In oral evidence police clarified that there was no suggestion that Mr Coolwell (who was almost certainly the person on the railway platform) was committing any offence or exhibiting a danger to any person. Police attended to check on the person's welfare. When police arrived at the railway station they learned that the person described had left and it was believed he had boarded a train.

8. At around the same time police state that they received a call from Shontay Coolwell, who sought assistance in relation to her brother. Ms Coolwell's evidence was that no such call was ever made. Police state that in response to that call they attended Ms Coolwell's home and had a conversation with her. Again, Ms Coolwell's evidence was that neither the visit nor the conversation in fact took place. On the police version, Ms Coolwell told them that her brother Bradley had been awake all the previous night and that he had been running around the house, throwing objects, and trying to destroy the TV which he saw as the source of some form of "evil". Police state that while they were speaking with Shontay Coolwell, they received a call that Bradley Coolwell had presented himself to the front counter at Logan Central Police Station and was asking for police to transport him to his auntie's place at Acacia Ridge. Having considered the evidence I find that Shontay Coolwell is mistaken in her recollection of events and I accept the evidence of the police.

9. The police returned to the police station and there found Bradley Coolwell in what was thought by them to be some mental distress. Inspector Parker said in evidence: "*When conversing with him, he was – his speech was slurred. He indicated that he'd been up all night. He'd been battling with Superman, fighting Superman. He also believed he was the Hulk. He produced to me a PCYC card, a Police Citizen Youth Club card and said he's also an undercover police officer. So – and we obviously made a number of assumptions as a result of that conversation.*"

10. Police then took appropriate action under the *Mental Health Act 2000* (s.34) and took Mr Coolwell to hospital under an emergency examination order. They initially thought he may have been drunk, but after checking on QPrime they realized mental health issues were more likely the cause of his behaviour. In her evidence, Ms Coolwell said that it was her understanding that her brother Bradley was taken to hospital as the police were concerned about Bradley's breathing. When questioned about this, the police officer said that if they were concerned about Bradley's physical health, for example his breathing, they would have called an ambulance for urgent attendance, rather than drive him there themselves. I accept this evidence.

11. I find that the police acted appropriately at the time in taking Mr Coolwell to hospital under the emergency examination order. If Ms Coolwell did in fact call for police assistance because of Bradley's behaviour, as I have found she did, then that would have been entirely appropriate in the circumstances as well, and she would have had her brother's welfare at heart.

Presentation at Logan Hospital

12. Upon presentation to the hospital in the company of police, Mr Coolwell was triaged appropriately and then was assessed by a mental health nurse, Shaun Holman, at 12.45pm. Mr Holman's key observation was that Mr Coolwell: *"is clearly psychotic he states that he is Superman and that he has been fighting evil,continues to talk about being the police commissioner and working for the PCYC". "I help people". "I own all the government agencies."* Mr Coolwell was placed under an involuntary treatment order and was admitted to the hospital's Short Stay Unit for assessment of his medical issues.

13. Dr Gail Robinson, who was then Clinical Director of Logan Mental Health Services, explained that Mr Coolwell was kept in the Short Stay Unit because he had other medical issues to be attended to and there was a balance to be struck in determining whether he was best placed in a ward where his physical ailments could be the principal focus. She stated: "*Well, mental health units are not necessarily set out to manage medical comorbidities for acute medical comorbidities just like a medical ward isn't set up to manage acute mental health problems. So I was just a little concerned that if there was evidence in the chart that he'd been sedated and had needed oxygen, and so my feeling is if he's a bit disorganised and walking around the emergency department, and he appeared to be psychotic to me and my staff, that if we needed to sedate him that would be – we'd need to be very careful, and we'd need to manage his sugar. So the recommendation I made with the two junior doctors was we needed to make sure that he was slightly more stable physically, and that's why I went and talked to the emergency medicine doctors."*

14. Dr Robinson gave evidence that while Bradley was physically accommodated in the Short Stay Unit, his treating team was the mental health team. She personally saw Mr Coolwell in the emergency department at 1.30pm. She had discussions with ED staff and then allocated resources to accommodate the new intake of patients into the mental health ward. It was, however, apparent and should have been apparent to the medical staff in the Short Stay Unit that Bradley Coolwell's medical health was problematic.

Analysis of Mr Coolwell's blood gases

15. Before he was transferred to the mental health ward Bradley's blood gasses were analysed. Opinion evidence provided by Dr Kelly, a consultant thoracic and intensive care physician who gave an opinion to Queensland Health suggests some aspects of Mr Coolwell's treatment in the Short Stay Unit were poor. On the morning of 12 September 2011, when Mr Coolwell was reviewed by Dr Chao (who was overseeing Bradley in the Unit), he failed to notice or failed to act upon serious anomalies in Mr Coolwell's blood gas results.

16. In his statement, Dr Kelly states: *The reviewing medical registrar, Dr Chao noted the patient to be "hypoxic", however he did not comment on the arterial blood gas results that were available on 12th September 2011 at 05.35 hours. There was a severely reduced level of oxygen (hypoxemia) with pO2 48mmHg (N>80mmHg). Hypoventilation had resulted in severely increased arterial CO2 pressure (PaCO2 = 100mmHg). The normal level for pCO2 being <45mmHg However, the reduced level of consciousness following intramuscular administration of midazolam resulted in hypoventilation. Coma can occur if the*

pCO2 increases relatively quickly to above 70mmHg. Hence, the pCO2 of 100mmHg may also have contributed to the reduced level of consciousness."

17. Dr Chao, however, states that he did in fact have regard to the blood gas results; and that he also had regard to subsequent tests undertaken in the ward. In his mind, those tests indicated that the earlier blood gas results may have been primarily the result of Mr Coolwell having been administered Midazolam, and that as that drug had dissipated in Mr Coolwell's system, the hypoxia had resolved: "*I concluded in my opinion, and as documented accordingly, that he had early hypoxic event, and that likely contributed on Midazolam: the medication he was given for sedation. But that had seemed to have worn off, as documented by the fact that his oxygen saturation, when I assessed him, was good and adequate in room air, and also a separate nursing observation at 3 pm, after my review, also noted that his oxygen saturation remains within the normal range on room air. So it seems to confirm, yes, the patient has significant hypoxic issue; however, partly it improved because the Midazolam effect has worn off. However, because he's got his obesity and the presence of the respiratory infection had [indistinct], it would have righted itself within a few hours, that he is at risk of further event. Therefore, we – our management plan was made accordingly; not just to – in response to the earlier event of low oxygenation. We also make plans and safeguards in place because we recognise he is at risk of further issues, and hence I've made a subsequent plan and I'll go through it when you – when you sort of ask me the plan that we've made. But the – the plan we've made was completely in response – in recognition of the early hypoxic event. We recognise that he's improved, and that time, at my assessment, he did not require any more oxygen and he was medically stable. However, because of his other medical issues such as obesity and respiratory tract infection, he is at high risk of further issue. So that needs to be monitored and addressed and rectified completely if – should that happen again."*

18. Dr Chao then stated that, as there were no observable difficulties with Mr Coolwell's oxygen levels at the time of his observations, there was no need for a respiratory physician to be consulted prior to Mr Coolwell being reviewed again the following morning.

19. Dr Kelly describes the events after Mr Coolwell was administered the midazolam as follows: *"Severe acute respiratory failure followed the administration of an intramuscular injection of midazolam, a short acting benzodiazepine. The deceased was noted to have low oxygen saturation and reduced level of consciousness. The severity of the reduced level of consciousness is reflected in the nursing staff being able to insert a nasopharyngeal airway."* He also noted that Mr Coolwell was given oral diazepam (Valium) on the 11 September 2011.

Absconding during time in the short stay unit

20. While he was in the Short Stay Unit, Mr Coolwell left his bed on two occasions and required the intervention of security guards, who on each occasion were required to physically manhandle Mr Coolwell. After each of those occasions, Mr Coolwell experienced difficulty breathing and required oxygen therapy. There is no evidence to suggest that the intervention or actions of the security staff was inappropriate and they behaved in a proper and professional manner.

21. Of great concern though is the effect each of these incidents had on Mr Coolwell's breathing difficulties. Oxygen was administered in each case (despite some difficulty securing Mr Coolwell's compliance with the need to wear the oxygen mask) but there do not seem to have been any further attempts taken to identify the reason for these collapses, other than the blood gas analysis the results of which did not, it appears, influence medical staff. He required the administration of oxygen which, in my view, should have rung alarm bells for the emergency medical staff and Dr Chau. Given the earlier blood gas results, Mr Coolwell's continuing breathing problems should have put staff on notice that his breathing difficulties were serious and required medical intervention, not just observation. He was not medically fit to be transferred to the mental health ward where no specialist treatment was available and continued observation of him by mental health nurses was not necessarily going to be directed towards his immediate physical wellbeing. Although Dr Mir in his evidence says he told staff in the Mental Health ward to be cognisant of Mr Coolwell's breathing difficulties.

22. Dr Chau attributed his earlier poor blood gas results to the dose of the sedative midazolam which he was given on arrival. As I understand it, midazolam may cause respiratory depression and/or respiratory arrest. Mr Coolwell was being sent to an environment – the mental health ward – where he was very likely to be administered sedatives such as midazolam and possibly anti-psychotics such as olanzapine, which were the very medications likely to exacerbate his already serious breathing difficulties.

Circumstances of transfer to the mental health unit

23. When Mr Coolwell was assessed by Dr Chao around 2.00pm on 12 September 2011, under the heading "Plan" Dr Chao made the following entry:- *Continue psych admission* è *psych* - *Not for transfer to Medicine at this stage*

24. This was interpreted by a staff member (whose identity is not known) working in the bed flow management system as being a clearance to transfer Mr Coolwell to the mental health unit (Ward 2C) if a bed should become available.

25. Dr Chao, in his evidence, indicated that he did not in fact have a view one way or another as to whether Mr Coolwell should have been kept in the Short Stay Unit or transferred to the Mental Health Unit. I find this statement difficult to reconcile with Dr Chau's apparent responsibility to only allow the transfer to take place if Mr Coolwell had no medical issues that would or should have prevented such a transfer until resolved and it was safe to do so. Someone had that ultimate responsibility and if not Dr Chau, who then?

26. Later during the evening, a bed did become available and Mr Coolwell was admitted to the mental health ward at approximately 6.30pm. I make no criticism of the administrative staff involved in this part of the process. However, there was a difference in the understanding of Dr Robinson and Dr Chao on the question of where Mr Coolwell should have been accommodated. Dr Robinson, in her evidence, indicated that the proper place for Mr Coolwell was the Short Stay Unit until his comorbidities had resolved. On the other hand, Dr Chau's note did not say specifically that Mr Coolwell should be moved to the Mental Health unit. It is a reasonable interpretation when one has regard to the progress notes. His notation in the progress notes might reasonably have been interpreted as a "release" to the Mental Health unit.

27. On his arrival, Mr Coolwell was initially seen by the Senior Nurse, Valerie Broekman, along with Nurse Jasbir Sandhu. Nurse Broekman recalls that he was uncooperative with the admission process, that he refused to allow his observations (such as his blood pressure) to be taken, and that he was demanding a cigarette. She recalled in oral evidence that he was agitated and waving his arms around but she did not recall his behaviour being particularly threatening.

28. The evidence indicates that it would be normal during this admission process for a patient who used tobacco to be advised that they would be allowed only one cigarette per hour. Nurse Sandhu stated in oral evidence that he told Mr Coolwell this during what was an interrupted and difficult admission process. Given his state of agitation, it is unlikely Mr Coolwell would have comprehended this. This was put to Nurse Sandhu who ultimately concluded in oral evidence that Mr Coolwell had "possibly" comprehended the advice he was given.

29. In order to calm Mr Coolwell he was allowed out into the smoking courtyard to have a cigarette. While he was doing so, Nurse Broekman was relieved for a break and Nurse Sandhu was left alone with the patients. Nurse Sandhu indicated that while smoking in the courtyard, Mr Coolwell's level of agitation did indeed cease, and that he interacted normally with other patients in the courtyard.

Mr Coolwell's Superman pyjamas

30. Before moving to discuss the events immediately preceding Mr Coolwell's death, it is necessary to discuss the Superman clothing which Mr Coolwell was wearing while at the hospital, and the significance which he attached to it. The significance which he invested in his clothing had a direct impact upon his distress at having that clothing removed. Grandiose delusions sometimes occur in patients suffering schizophrenia. Evidence suggested that Mr Coolwell has a long history of experiencing this symptom. He had taken on the appellation "The Man Himself" when he performed his music, and he had expressed the intention of changing the world with his musical abilities.

31. Hospital records say Mr Coolwell also periodically believed himself to be Superman, or another comic book and movie superhero called "The Incredible Hulk". He expressed the view that he had a special relationship with the Police Commissioner, and on occasion indicated that he was himself the "boss" of the police. He also indicated that he was able to draw some form of power from the lights in the hospital, and that he could share that power with others by shaking their hands.

32. Dr Terry Stedman from The Park said that these ideations of Mr Coolwells were long-standing and that he reinforced his Superman persona with a costume. This behaviour is consistent with the behaviours reported to police and witnessed by them on the morning of 11 September 2011.

33. Ms Coolwell also gave evidence of her unhappiness at what she considered was staff at The Park mocking Mr Coolwell by giving him a name tag stating that he was "The Man Himself". Ms Coolwell's view is understandable. It is inevitable that in general society a person believing themselves to be a

superhero might attract ridicule which in turn may cause some pain to the person holding those beliefs.

34. I am persuaded to the view that Bradley Coolwell did hold these beliefs at the relevant times and that he attached great significance to his clothing. This of importance in understanding the events which followed and, in particular, the extent of his struggle to prevent security personnel from removing this special uniform.

The decision to place Mr Coolwell into seclusion

35. A short time after Mr Coolwell was admitted to the mental health ward he approached the nursing station seeking additional cigarettes. Nurse Sandhu gave evidence that when Mr Coolwell approached the nurse's station and was told that he was not yet due for another cigarette, he entered the nurse's station and began pulling drawers out looking for cigarettes. There can be no doubt that for Nurse Sandhu, Bradley Coolwell would have presented an imposing and frightening sight. He was not welcome in the nurse's station under those circumstances and that he was refusing to leave. There was no evidence that he injured any person, or threatened to injure any person, and there is no evidence that he damaged any property, nor even attempted to do so. He was simply distressed by the lack of cigarettes and was looking to find them, and perhaps a cigarette lighter. The situation was sufficiently concerning to Nurse Sandhu that he sounded a duress alarm. As others responded to that alarm, Mr Coolwell was enticed into the courtyard.

36. Dr Tahir Mir, the Mental Health Registrar, was among those who responded and he took the lead in dealing with Mr Coolwell. He negotiated with Mr Coolwell, offering an additional cigarette in return for Mr Coolwell taking a tablet. Mr Coolwell countered by demanding the rest of his packet. Ultimately he consented to an intramuscular injection of olanzapine in return for a cigarette. Around this time, Dr Mir made the decision to place Mr Coolwell in seclusion.

37. A person may be placed in seclusion only under the circumstances outlined in section 162M of the *Mental Health Act 2000*. Two conditions must be met. First, it must be necessary to protect the patient or other persons from any physical harm; and second, there must be no less restrictive way ensuring the safety of the patient or others. Seclusion is controversial within the mental health profession, and that the trend of clinical practice is to move away from its use. The *Mental Health Act 2016*, which is yet to come into force includes new restrictions on when and how seclusion and other forms of restraint can be authorized. These provisions did not, of course, apply at the time of Mr Coolwell's seclusion.

38. Dr Mir completed the documentation for a seclusion order. That documentation required him to indicate his reasons for placing Mr Coolwell in seclusion, and listed the statutory test on the form. Dr Mir gave his reasons as follows:
    - *Patient aggressive and destructive towards hospital property*
    - *Cannot be contained in open ward of AOA20*

39. Taken at face value, these reasons do not appear to satisfy the requirements of the Act. There is little indication in these reasons that Dr Mir considered Mr Coolwell to present a threat to himself or to any other person (the Act does not

contemplate seclusion to protect property); and there is no indication that Dr Mir had considered options other than Mr Coolwell being “contained in open ward of AOA”. Mr Coolwell could have been allowed to remain in the courtyard with free access to cigarettes until he settled down.

40. In oral evidence, Dr Mir gave two further explanations of his decision to place Mr Coolwell in seclusion. First, he stated: “*I explained the things to him that because you’ve been refusing to take the tablets, you know, there’s a potential, you know, threatening the staff, and you already came into the nursing staff office, you destroyed the hospital property and you threatened to assault them, you are verbally aggressive towards them, we have to ensure the safety of the staff and other patients. And I explained the things, you know, you have to – we have to give you injection and take you to the seclusion room. He agreed.”*

41. Later in evidence Dr Mir further acknowledge that the Olanzapine may take 6 hours to have an effect. He commented: “*Correct. But at the same time, you know, I sent him to the seclusion room because the injection was given to him. But at the same time, you know, he was kept into the isolation [indistinct] a separate room to ensure the safety of him and the staff so that he doesn’t come out of the seclusion room.”*

42. While Mr Coolwell’s behaviour was aggressive and uncooperative he was not actually physically threatening. Although Nurse Broekman states that Mr Coolwell was: “*swearing at us and calling us all the names under the sun and then he started to threaten”* but she indicated this happened after the decision to place him in seclusion. On a strict legal construction of s.162M of the *Mental Health Act 2000* may not have been met. However it is necessary to take into account of the circumstances which Dr Mir was attempting to manage at the time. On his understanding, he had entered the nurse’s station, where he should not have been, and had acted in a way which was physically imposing and frightening. It would have been very reasonable for Nurse Sandhu to have been concerned for his own safety at that time. Having regard to all of the circumstances prevailing at the time, I find the decision to place Bradley in seclusion at the time was reasonable.

The manner of placing Mr Coolwell into seclusion

43. Dr Mir was not present when Mr Coolwell was actually placed in seclusion. This might initially seem somewhat surprising, as it would usually seem appropriate for the person ordering the seclusion to remain in place until seclusion had been accomplished. On this occasion Dr Mir left the area in order to reduce the distress he was causing to another nearby patient. Mr Coolwell was left in the company of Nurse Broekman, Nurse Sandhu, Nurse Kumar (who had responded to Nurse Sandhu’s duress alarm), and three security personnel (Benjamin Turner, Jan Matthews, and Joshua Federoff).

44. Dr Mir’s instructions on the seclusion order were to maintain observations of Mr Coolwell at no more than 15 minute intervals. He also gave evidence that he “*reiterated to the nursing staff the need for regular monitoring when he was moved into the seclusion room and I explained the risk of respiratory compromise to the nursing staff due to his past hypoxic state, his obesity and current chest infection.”* This evidence indicates that Dr Mir had some knowledge, no doubt from reviewing Bradley’s chart, of his medical comorbidities.

45. From this point, Nurse Broekman was in overall charge of Mr Coolwell as he was placed in seclusion. Evidence from all participants was that Mr Coolwell walked into the seclusion room on his own, with no more than minor guidance from staff. On Nurse Broekman's evidence, he then lay on the bed to receive the intramuscular injection of Olanzapine. Security had their hands on him at this time but in Nurse Broekman's view they did this as a means of protecting her, should Mr Coolwell lash out and they were not in fact controlling Mr Coolwell by force.

46. Following the injection, the process of placing Mr Coolwell into what is known as "security linen" clothing commenced. The nature of security linen is that it cannot be torn by hand and therefore cannot be used by a suicidal patient to form a ligature. No witness – particularly, neither Dr Mir nor Nurse Broekman – indicated that they had specifically made the decision to place Mr Coolwell into security linen. All witnesses treated it as a matter of course that a patient in seclusion would be placed in this clothing.

47. There does not appear to be any specific policy in relation to the use of security linen. The key policy document in relation to seclusion, Exhibit H6 – *Policy statement on reducing and where possible eliminating restraint and seclusion in Queensland mental health services* - does not deal with clothing in seclusion. There was a practice of placing all patients in security linen once they were under a seclusion order, there was no stated policy requirement to have done so. However, the risk of suicide by hanging or strangulation is an ever present and very real risk in mental health wards, as past coronial experience demonstrates all too clearly.

48. In Mr Coolwell's case, the decision to place him in seclusion clothing appears to have had a dramatic effect on him, perhaps for the reasons discussed earlier in these findings. What was happening, and what Mr Coolwell perceived to be happening to him, caused his violent reaction and struggle and the more he resisted the greater the effort to make him comply by the security guards tasked with making him comply. There is no evidence that he tried to strike the security personnel. He struggled and resisted to the point where force was applied first in an effort to bring him down. Security officer Federoff used what was called a "peroneal strike" to the leg. This is a physical blow to the leg, more accurately to the peroneal nerve. Thus disabling the nerve and causing the leg to collapse or at least make it difficult to stand. A second such blow was delivered to the other leg causing Mr Coolwell to collapse to the floor, face down.

49. This resistance by Mr Coolwell must have used up most, if not all of his energy reserves. He then folded his arms across his chest and thus resisted the removal of his shirt. His arms were then secured behind his back by a guard and Ms Mathews managed to remove the shirt while the other security officers continued to restrain him. After this was achieved, security officers left the room. At this stage Mr Coolwell was naked and had been lying in a prone position for several minutes. The seclusion clothing was left for him to dress himself.

50. Dr Mir gave evidence that he had already told Nurse Broekman and Nurse Sandhu that they should be alert in relation to Mr Coolwell's breathing. Nurse Broekman acknowledged that she was aware of this, and indeed her evidence was that while the security personnel were restraining Mr Coolwell she told them "don't hold him down long, he's medically compromised." It is therefore

reasonable to assume that at least some of those responsible for Mr Coolwell's clinical care during the seclusion process was aware that he had experienced difficulty breathing.

51. Nurses Broekman, Sandhu and Kumar then give slightly different accounts of what happened immediately after staff left the seclusion room. Nurse Broekman indicates that immediately after Mr Coolwell had been placed in seclusion she observed his chest to be rising and falling (as though breathing) but that he was only half on the bedding mattress. She states that he was unresponsive and she became concerned for him at that point and told Nurse Sandhu that the two of them should go in and check on Mr Coolwell. He was unconscious, but a carotid pulse could be detected. On the basis of his unexpected unconsciousness, however, a "code blue" emergency was called.

52. Nurse Kumar says that after Mr Coolwell was placed in seclusion, he was asked to watch Mr Coolwell, by which he understood he was to continuously observe Mr Coolwell (as opposed to the 15-minute periodic observations instructed by Dr Mir). He states that Mr Coolwell did not move or respond to the fact that he was in seclusion, and that he became concerned within perhaps thirty seconds of the room being closed. He asked Nurse Sandhu to accompany him into the room, where they found Mr Coolwell to have no pulse (and Nurse Kumar was uncertain whether he recalled seeing the rise and fall of chest). They called a "code blue" and commenced resuscitation.

53. Finally, Nurse Sandhu agrees that Nurse Kumar watched Mr Coolwell, and very quickly alerted Nurse Sandhu to his concerns. Nurse Sandhu says that he then briefly discussed the best approach with both Nurse Kumar and Nurse Broekman, and then he entered the seclusion room alone. He found Mr Coolwell was unresponsive. The other nurses entered and 'code blue' was called.

54. At the inquest there was no challenge to the efficacy of the resuscitation attempts which were, sadly, unsuccessful. The evidence also establishes that Mr Coolwell was under observation from the time he entered the Mental Health Unit until his death.

Cause of death

55. It appears clear from the autopsy that Mr Coolwell suffered respiratory failure and a cardiac arrest; however it is not clear which of these came first in time. Dr Storey was quite frank in both his autopsy report and in his oral evidence that he was unable to identify a specific cause of death. His view was that the cardiac arrest is likely to have come first in time, and to have been followed by the respiratory arrest. Dr Storey canvassed two possibilities for this arrest, each of them relating to the fact that Mr Coolwell was held in restraint prior to his death. These possibilities are excited delirium and positional asphyxia. Each of these proceeds from the fundamental perspective that restraint causes stresses on the body which interfere with the normal operations of the heart and the lungs. However it was clear that Dr Storey did not wish to be held to these observations. He said in evidence that some of the conditions for excited delirium were not present and while he explained the mechanism for positional asphyxia, Dr Storey stopped well short of expressing the view that positional asphyxia had been responsible for Mr Coolwell's death.

56. Dr Wayne Kelly, whose opinion was sort as to the cause of death observed that the concentration of carbon dioxide in Mr Coolwell's blood was dangerously high, and that this was likely due to a reduction in the blood transfer capacity of his lungs, that is, their capacity to extract carbon dioxide from his blood and to filter oxygen into his blood. This may explain Mr Coolwell's periods of deep sleep while in the short stay unit; and his transition from resistance to the security guards, to his sudden unresponsiveness and death.

57. Dr Kelly's report was reviewed by Dr Storey. Dr Storey accepted the observations made by Dr Kelly that the high concentration of carbon dioxide in Mr Coolwell's blood led to torpor and sleep, and then ultimately to respiratory failure. However given Mr Coolwell's substantial comorbidities, an initial cardiac failure cannot be ruled out.

58. The most likely cause of death is respiratory failure due to reduced blood gas transfer capacity in Mr Coolwell's lungs, leading to cardiac arrest. However a second possible cause of death is a cardiac arrest occurring in the presence of reduced respiratory capacity, with the two factors then combining to precipitate death. I find that Bradley Karl Coolwell died from the combined effects of respiratory and cardiac failure.

Contact with family on the night of 12 September 2011

59. A key concern of the Coolwell family is the manner in which the death of Mr Coolwell was communicated to them, in particular to Ms Shontay Coolwell. Ms Coolwell says that she was at the hospital until around 5.00pm and had then left. Mr Coolwell would therefore have been transferred into the Mental Health Unit between an hour and 90 minutes after Shontay Coolwell left the hospital. At approximately 7.30pm Ms Coolwell called the hospital, but felt she was being "messed around" by hospital staff. It is not clear whether she was put through to the Emergency Department (where Mr Coolwell had been when she left at 5.00pm) or whether she was put through to the Mental Health Unit. She made a second call. On the assumption that she was ultimately put through to the correct location, her call would have come at approximately the time that Dr Mir, the nursing staff, and the security staff were negotiating with Mr Coolwell in the courtyard. The nursing station, at this time, would have still been in a state of disarray after Mr Coolwell went through it looking for his cigarettes. It seems to follow that calls to the Mental Health ward in that time may have gone unanswered; or, if answered, that there would have been little staff could say about Mr Coolwell's rapidly-changing circumstances.

60. Ms Coolwell's evidence is that she received a telephone call from a staff member at Logan Hospital, in which she was told her brother Bradley Coolwell had died. The delivery of a death message requires particular sensitivity; this is particularly so in regards to the cultural needs of indigenous deceased. The Queensland Health publication *Sad News, Sorry Business*, is now in its second edition. The first edition came out at approximately the time of Mr Coolwell's death. It is to be hoped that future deaths of indigenous people in Queensland Health facilities are handled in accordance with that publication.

Changes to Systems at Logan Hospital

61. A number of the issues raised by this death have been overtaken by the subsequent policy developments in the nearly-five-years since Mr Coolwell

died – for instance, the *Mental Health Act 2016* will fundamentally change the use of seclusion and the policy *Sad News, Sorry Business* has changed the way in which Queensland Health deals with the families of indigenous patients who have died.

62. Following the death of Mr Coolwell, Metro South Division of Queensland Health conducted a review and that review recommended a number of changes to their operations. Those changes can be summarised as follows:-

    a. The hospital should implement an admission policy based on a consultant to consultant or director to director discussion in order to reach agreement to admit to the most appropriate department to meet the needs of the patient.

    b. The hospital should implement a review of admission processes and patient flow within the Integrated Mental Health Service (IMHS) during business hours and after hours including linkages between acute services and Community Mental Health.

    c. The hospital should continue to work with the Queensland Psychotropic Medication Advisory Committee to develop Acute Sedation Guidelines including arrangement with the Emergency Department (ED), Intensive Care and IMHS to ensure better alignment of acute sedation guidelines in all areas.

    d. The hospital should consider establishing a mental health clinical position in the ED being a senior nurse to provide guidance to junior staff, particularly in relation to patients admitted to the Short Stay Unit (SSU).

    e. Metabolic monitoring is to be implemented in Community Mental Health and mental health inpatient settings. A process of auditing adherence to metabolic monitoring guidelines is to be implemented.

    f. The definition of 'medical clearance' is to be clarified including an indication of the level of support a patient will need when admitted.

    g. Case management practices to be reviewed to ensure a culturally appropriate recovery focus.

    h. A process of operational supervision is to be implemented to ensure that case managers apply contemporary case management strategies.

63. I am informed by counsel for Queensland Health that these recommendations have now all been implemented and that they have been incorporated into the Inpatient National Standards Implementation Project. Admission procedures were reviewed, endorsed and published on the Queensland Health intranet. The admission procedure was updated in November 2014. Admission and patient flow processes and procedures are again under review in order to incorporate the Mental Health Call Service and work that has been undertaken by the Mental Health NEAT Strategic Planning Group to improve transfer of care processes within the IMHS.

64. A change in policies incorporating the lessons learned from procedure reviews and improved understanding following the death of Mr Coolwell were also

implemented These include new Sedation Guidelines and a mental health clinician in the ED. Also changes were made regarding metabolic monitoring and the definition of medical clearance.

65. The issue of Seclusion and Restraint have been addressed in the new *Mental Health Act 2016,* which is to come into force in March 2017. The Health Service has also addressed cultural issues which have arisen in this case.

Findings required by S45.

66. In accordance with s.45(2) of the *Coroners Act 2003* I make the following findings:

    (a) The deceased person is Mr Bradley Karl Coolwell. He was born on 25 January 1972.

    (b) Bradley Karl Coolwell died from respiratory failure and cardiac arrest.

    (c) Bradley Karl Coolwell died at approximately 7.30pm on 12 September 2011.

    (d) Bradley Karl Coolwell died at Logan Community Hospital, in Meadowbrook in the State of Queensland.

Findings and Recommendations

67. I find that the police acted properly in relation to Mr Coolwell, and that the decision to take him to hospital under an Emergency Examination Order was appropriate in the circumstances. Mr Coolwell came to no harm while in the care of police. I also find that in the original triage process an adequate assessment was made of both Mr Coolwell's mental and physical state.

68. I find that the CIMHA database, which was utilized during that triage process, was of limited utility and that Mr Holman, assessing Mr Coolwell on admission to Logan Hospital, had little practical knowledge of Mr Coolwell's treatment history available to him other than an awareness of his previous admission to The Park.

69. I find that there may have been some confusion between medical and mental health teams as to whether Mr Coolwell was ready for transfer to the Mental Health ward on the evening of 12 September 2011.

70. As previously set out in these findings I find that the decision to transfer Mr Coolwell to the Mental Health ward from the Short Stay unit was premature and failed to recognise Mr Coolwell's serious respiratory illness and that in doing so exposed him to grave risk.

71. I acknowledge there are inherent difficulties in requiring tobacco-addicted patients to give up tobacco on admission to hospital, particularly where those patients are experiencing disordered thinking.

72. I find that the decision to place Mr Coolwell into seclusion was not in strict accordance with the requirements of the statute but was nevertheless a

reasonable decision, made in a reasonable attempt to comply with those statutory requirements.

73. I find that the decision to remove Mr Coolwell's clothing and to change into security linen caused him great distress, however I find this was an understandable decision arising out of concern for the patient's welfare and the risk of self-harm.

74. I find that after he had been placed in seclusion, nursing staff kept Mr Coolwell under continuous observation and responded very quickly when they perceived the risk of a medical emergency and that resuscitation attempts by the immediate nursing staff, and by the resuscitation team, were appropriate.

Recommendations

75. That the CIMHA system should be reviewed and optimized in order to provide information summarizing the mental health history of any patient who has been subject to an Involuntary Treatment Order, in order to assist a practitioner making a subsequent Emergency Examination Order under the *Mental Health Act* and that the CIMHA system should be available to (at least some) police on a read-only basis.

76. I note the review undertaken by Queensland Health and the recommendations arising out of that review and I endorse those recommendations. I also note the changes to seclusion orders in the *Mental Health Act 2016.*

    I offer my condolences to the Coolwell family for their sad loss.

I close the inquest.

James McDougall
Coroner
SOUTHPORT
4 April 2017