QUEENSLAND COURTS

# CORONERS COURT OF QUEENSLAND

# FINDINGS OF INQUEST

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| CITATION: | **Inquest into the death of Taare Tamakehu Rangi** |
| TITLE OF COURT: | Coroners Court of Queensland |
| JURISDICTION: | TOWNSVILLE |
| FILE NO(s): | 2018/3003 |
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| FINDINGS OF: | Nerida Wilson, Northern Coroner |
| CATCHWORDS: | Coroners: inquest, Townsville Hospital Acute Mental Health Unit, Health Service Office vascular restraint, involuntary patient, obese, prone position; cardiac arrhythmia during a restraint; |

REPRESENTATION:

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| Counsel Assisting the Coroner: | Mr A. Luchich |
| Counsel on behalf of Dr Charu Dasgupta, Dr Philippa Noakes, HSO Anthony Beltramelli, HSO Aaron Fitzgerald, Dr James Noon, Dr John Waterfield, Dr Vicnaesh Segaran, OVP Nurse Trevor Laverick and Townsville Hospital and Health Service: | Ms S. Gallagher i/b Corr Chambers Westgarth |
| Counsel on behalf of RN Bincymole Shiju, EEN Andre Snelleman, CN Kelly Harding, RN Michael Munemo, CN Gillian Collier, RN Brittany Marshall: | Ms S. Robb i/b Roberts and Kane Solicitors |
| Counsel for Department of Queensland Health Office of the Chief Psychiatrist: | Ms E. Cooper |
| Counsel for HSO1: | Ms C Grant i/b Anderson Telford Lawyers |
| Counsel for Corianne Richardson: | Mr B Mumford i/b Hall Payne Lawyers |
| Counsel on behalf of Ms Gail Rangi Townsville Community Legal Service Inc: | Ms J. FitzGerald i/b |

# Contents

## Publication

Section 45 of the *Coroners Act 2003* ('the Act') provides that when an inquest is held, the coroner's written findings must be given to the family of the person in relation to whom the inquest has been held, each of the persons or organisations granted leave to appear at the inquest, and to officials with responsibility over any areas the subject of recommendations. These are my 58 page findings in relation to Taare Tamakehu Rangi. They will be distributed in accordance with the requirements of the Act and published on the website of the Coroners Court of Queensland.

## Relevant Legislation

Pursuant to s45(5) of the Act a coroner must not include in the findings any statement that a person is, or may be:

a) guilty of an offence; or
b) civilly liable for something.

The focus of an inquest is to discover what happened, not to ascribe guilt or attribute blame or apportion liability. The purpose is to inform the family and the public of how the death occurred with a view to reducing the likelihood of similar deaths in future.

## Comments and recommendations

Pursuant to the Act: A coroner may, whenever appropriate, comment on anything connected with a death investigated at an inquest that relates to:

46 (1)(a) "*public health or safety*" and

46(1)(c) "*ways to prevent deaths from happening in similar circumstances in the future.*"

## Introduction

1. The inquest examined the death of Taare Tamakehu Rangi aged 44 years, who died on 7 July 2018 while an involuntary inpatient of the Adult Acute Mental Health Inpatient Unit ("AAMHIU") of the Townsville Hospital ("the Hospital"), a facility operated by the Townsville Hospital and Health Service ("the Health Service", now known as the Townsville University Hospital).

2. Mr Rangi died as a result of a cardiac arrhythmia during a restraint effected for the purpose of administering acute sedation.

3. The inquest proceeded pursuant to ss. 8, 9 and 11 of the *Coroners Act 2003* (Qld)("the Act") on the basis that it was a "death in care", thus a

reportable death, because at the relevant time Mr Rangi was being detained in an authorised mental health service as an involuntary patient under the *Mental Health Act 2016* (Qld)("MHA").

4. A pre-inquest conference was held on 23 May 2019.

5. The following issues were identified for consideration at the inquest:-

*1) The findings required by s.45(2) of the Act namely the identity of the deceased, how he died, where he died and what caused his death.*

*2) In relation to the circumstances of the deceased's death, investigation and consideration of:-*

*a) the adequacy and appropriateness of the treatment provided to the deceased in respect of his mental health, following admission to the Townsville Hospital on 6 July 2018, including:-*

*i. the decision to forcibly seek to administer medication to the deceased;*

*ii. the method by which such medication was sought to be administered;*

*b) the adequacy and appropriateness of the physical restraint of the deceased prior to his death, for the purpose of forcibly administering medication, including:-*

*i. the planning undertaken in respect of performing the physical restraint;*

*ii. the performance of the physical restraint;*

*iii. the monitoring of the deceased during the physical restraint and immediately after;*

*iv. the training provided to those persons who performed, or were involved in, the physical restraint;*

*v. whether the restraint was performed in accordance with relevant policy and practice guidelines of the Chief Psychiatrist, Queensland Health and the Health Service's applicable policies, procedures and OVP training;*

*c) the adequacy and appropriateness of the medical treatment provided to the deceased after the physical restraint ceased, including:-*

*i. the time taken to instigate such treatment;*

*ii. the manner in which that treatment was carried out;*

*iii. whether there were any deficiencies in respect of the treatment carried out;*

*d) whether there existed at the time any deficiencies in the Health Service's policies and procedures in respect of the physical restraint of patients;*

*e) whether any recommendations can be made to prevent a death in similar circumstances from happening in the future.*

6. The inquest took place over two sittings in Townsville. Initially from 4 to 7 November 2019 and a second sitting from 27 to 29 November 2019.

7. The inquest had the benefit of oral evidence from the following witnesses:

- Dr Paul Botterill: Senior Staff Forensic Pathologist
- Dr Charu Dasgupta: Psychiatric Registrar
- RN Brittany Marshall: Registered Nurse
- Dr Philippa Noakes: Consultant Psychiatrist
- Dr James Noon: Psychiatric Registrar
- Dr Vicnaesh Segaran: Advanced Anaesthetic Trainee
- Dr John Waterfield: ICU Registrar
- RN Gillian Collier: Clinical Nurse
- RN Michael Munemo: Registered Nurse
- RN Bincymole Shinju: Registered Nurse
- EN Peter Snelleman: Enrolled Nurse
- RN Kelly Harding: Clinical Nurse
- HSO Anthony Beltramelli
- HSO Aaron Fitzgerald
- HSO1[1]
- OVP Nurse Educator Trevor Laverick
- Ms Sharon Kelly
- Dr Jason Lee
- RN Corianne Richardson
- Senior Sergeant DL Hayden and Mr DR Hayworth (who gave their evidence concurrently);
- Dr Jill Reddan: Psychiatrist
- Dr Sean Rothwell: Emergency Physician

8. In the formulation of these findings, I have distilled and referred only to that evidence and material relevant to the basis for my findings and

[1] A non-publication order was made with respect to the name and any particulars that might otherwise identify this witness, these findings are to be read in conjunction with that Order

recommendations. I do not refer to all of the material, evidence or submissions.

9. I have had the benefit of, and regard to, the comprehensive submissions of Counsel Assisting the inquest, Mr Andrew Luchich, and in the main I have incorporated and adopted those submissions. I have also had regard to the submissions of all those with leave to appear and thank them at the outset for their significant contribution to all matters before the inquest.

10. Health Security Officer 1 (HSO) (referred to in these these findings as "HSO1", claimed privilege against self-incrimination in respect of part of his written response to the Form 25 (request for information by Coroner) made of him, and then also during the course of giving his oral evidence from 4.21pm on 27 November 2019.[2] That claim having been made, I was satisfied that it was in the public interest to compel HSO1 to give evidence that would tend to incriminate him pursuant to s.39(2) of the Act. The evidence given by him from that point onwards is not admissible against him in any other proceeding other than for perjury, nor is any derivative evidence, (as that expression is defined), admissible in a criminal proceeding.

11. The inquest also had before it a substantial body of documentary evidence contained in the brief of evidence tendered. Included within that, critically, was both CCTV and body-camera footage that recorded the period leading up to the decision to acutely sedate Mr Rangi, the physical restraint of Mr Rangi that ensued from that decision, and then the subsequent attempts at resuscitation.

12. The visual footage was confronting to view and provided a 'real time' understanding of the events as they unfolded in-situ. Therefore the inquest had the benefit of evidence that was not solely reliant on the recollections of the persons involved in the circumstances surrounding Mr Rangi's death, many months after the fact. The visual footage was played on several occasions to various witnesses during the course of proceedings, often in slow motion. I was aware of (and articulated in open court) the impact and potential for significant distress to those, including all at the bar table who were required to view a number of replays. Mr Rangi's mother and his father and members of their immediate family, were invited to, and chose, to absent themselves during these times.

13. The inquest had the benefit of independent expert reports and oral evidence from a group of highly experienced experts in their respective fields, namely - Dr Paul Botterill (Forensic Pathologist), Dr Jill Reddan (Psychiatrist), Dr Sean Rothwell (Emergency Physician) and Mr Darron

[2] T5-133.

Hayworth together with Senior Sergeant Damien Hayden of the Queensland Police Service, the latter two providing a joint report and then giving their oral evidence concurrently. There was no additional expert evidence obtained contrary to the evidence obtained from these persons and they were of much assistance in understanding the central issues for consideration and investigation.

## Applicable Legislative, Policy and Procedure Framework

14. At the time of his death Mr Rangi was the subject of a Treatment Authority under the MHA, which meant that he was an involuntary patient of the AAMHIU. The Hospital was an authorised mental health service under the MHA. Relevantly then as an involuntary patient ss. 268 to 270 of the MHA applied. Those sections state:

***268 Meaning of physical restraint***

(1) Physical restraint, of a patient, is the use by a person of his or her body to restrict the patient's movement.

(2) However, physical restraint of a patient does not include—

(a) the giving of physical support or assistance reasonably necessary—

(i) to enable the patient to carry out daily living activities; or

(ii) to redirect the patient because the patient is disoriented; or

(b) physical restraint of the patient that is authorised under a law other than this part; or

(c) physical restraint of the patient that is required in urgent circumstances.

***269 Offence***

A person must not use physical restraint on a patient other than under this Act.

Maximum penalty—200 penalty units.

***270 Requirements for use of physical restraint***

An authorised doctor, or a health practitioner in charge of an inpatient unit or other unit within an authorised mental health service, may authorise the use of physical restraint on a patient for 1 or more of the following purposes if there is no other reasonably practicable way to achieve the purpose—

(a) to protect the patient or others from physical harm;

(b) to provide treatment and care to the patient;

(c) to prevent the patient from causing serious damage to property;

(d) for a patient detained in an authorised mental health service—to prevent the patient from leaving the service.

15. The use of physical restraint on an involuntary patient can be authorised by either a doctor or a health practitioner in charge of an inpatient unit or other unit within an authorised health service. A "health practitioner" is a person registered under the *Health Practitioner Regulation National Law (Qld)* ("the National Law"), or another person who provides health services, including, for example, a social worker.[3]

16. Mr Rangi's treating Psychiatrist was not the only person who could authorise his physical restraint. It was open, also for the team leader of the mental health unit in which Mr Rangi was an involuntary patient to authorise his physical restraint.

17. At the time the relevant policy and procedure framework with respect to the acute sedation of patients and the use of physical restraint was contained in the following documents:-
    - "Acute behavioural disturbance management (including acute sedation) in Queensland Health Authorised Mental Health Services (adults)" – Queensland Health Guideline QH-GTL-452:2017 (the "acute sedation guideline");[4]
    - "Restraint - Mental Health Service Group (MHSG)" – procedure, Townsville Hospital and Health Service THHSCLI161110v2 (the "restraint procedure");[5]
    - "Duress response to an aggressive or potentially aggressive situation within the Adult Acute Mental Health Inpatient Unit (AAMHIU) & Secure Mental Health Rehabilitation Unit (SMHRU)" – procedure, Townsville Hospital and Health Service THHSCLI110546v3 (the "duress response procedure");[6]

[3] See Schedule 3 of the MHA.
[4] Ex C9(k).
[5] Ex C9(g).
[6] Ex C9(a).

- "Occupational Violence Prevention (OVP) Mental Health Service Group (MHSG)" – procedure, Townsville Hospital and Health Service THHSSUP110534v4 (the "OVP procedure");[7]
- "Physical Restraint" – policy, Chief Psychiatrist (the "Chief Psychiatrist's physical restraint policy");[8]
- "Physical Restraint" – practice guidelines, Chief Psychiatrist (the "Chief Psychiatrist's physical restraint practice guidelines").[9]

18. It is necessary to say something about the substantive content of each of these policies and procedures.

19. The "acute sedation guideline" relevantly provided as follows (bold emphasis added):-
    - It described the best practice processes for a systemic and safe approach to the administration of acute sedation when de-escalation of acute behavioural disturbance has not been successful;
    - The expression "acute sedation" was defined as referring to the emergency administration of psychotropic medications to a consumer in an authorised mental health service setting **to relieve distress, bring severe behavioural disturbance under control to protect the consumer or other people from immediate or imminent risk to their safety, or to facilitate comprehensive diagnostic assessment and management**;
    - That acute sedation may be the only clinically appropriate treatment option **when consumers are extremely agitated, threatening violence, are actually violent and/or are a danger to themselves or others**;
    - That acute sedation should only occur after attempts to manage the behavioural disturbance with de-escalation techniques and oral medication have proven unsuccessful;
    - **That acute sedation must be used only when clinically indicated**, it must not be used as a form of punishment, **for convenience**, or as a substitute for other more appropriate treatments;
    - That a medical assessment should be performed on admission and again, where possible, prior to acute sedation;
    - That there was a four step process for sedation – the first being non-medication measures (de-escalation), the second being oral medication (the preferred medication option), the third being short acting intramuscular medications (with the stipulation to only proceed to this step if the patient was not accepting oral

[7] Ex C9(i).
[8] Ex C9(e).
[9] Ex C9(f).

medications or the response to step two was unsatisfactory) and fourthly intravenous medications.

20. The "restraint procedure" relevantly provided as follows (*bold emphasis added*):-
    - That it was to be read in conjunction with the duress response procedure and the Chief Psychiatrist's physical restraint practice guidelines;
    - A procedural guide for clinical staff within the mental health service group relating to the documentation and management of physical or mechanical restraint;
    - That restraint of any type carried a risk of injury to both consumers and staff and that physical restraint of a person in a prone (face down) position was a significant risk and could cause asphyxia;
    - The risk factors that could contribute to physical restraint related injury or death;
    - That physical restraint should be considered a medical emergency and that the Hospital used a two minute threshold for prone restraint;
    - That **restraint of adults required regular monitoring of the consumer's vital signs** and clinical consideration as to whether a MET call is necessary;
    - That in all prone restraints continuing efforts should be made to move the consumer from the prone restraint position;
    - That in **restraints ongoing efforts should be made to cease restraints safely and as soon as possible**;
    - That any restraint of a consumer within the mental health service group **should only occur with OVP trained staff that should use approved techniques to the maximal extent possible**;
    - That **restraint of any kind is a last resort intervention when there is imminent risk to the consumer, staff, visitors, fellow consumers** etc and that all possible strategies to prevent a restraint should be considered and used prior to the decision to intervene in a coordinated physical intervention;
    - That the duress response procedure described how a response team would be structured and allocated.

21. The "duress response procedure" relevantly provided as follows (bold emphasis added):-
    - Clarity for team members based on OVP, the process and roles for a duress response to an aggressive or potentially aggressive situation within the AAMHIU;
    - The **roles for a duress response team including that of a response team leader**;
    - That the **response team leader would allocate positions and responsibilities within the team**;

- That the **response team leader was responsible for protecting the person's head and airway and physical observations until allocated to another team member**;
- That **health security officers would act under the direction of the response team leader**.

22. The "OVP procedure" relevantly provided as follows (bold emphasis added):-
    - That all staff members employed by the mental health service group **were required to have current OVP training**;
    - Where possible all direct care staff rostered to work in the AAMHIU would be current to five modules of OVP training which included managed behavioural emergencies in the team - module 5.

23. The "Chief Psychiatrist's physical restraint policy" relevantly provided as follows (bold emphasis added): -
    - That the **use of physical restraint was a last resort** where less restrictive interventions had been unsuccessful or were not feasible;
    - That physical restraint should only be used for the minimum period of time necessary and that **all staff actions should be justifiable and in proportion to the patient's behaviour**;
    - That if physical restraint is to be used for a patient, **no more physical force is used than necessary and reasonable in the circumstances**;
    - That if a physical restraint is to be used for a patient, the prone (face down) position should be avoided wherever possible and where it occurs it must not exceed two minutes;
    - That **if a physical restraint is to be used for a patient there should be no direct pressure on the neck, thorax, back or pelvic area**;
    - That if a physical restraint is to be used for a patient **there should be observation for indications of physical or mental distress and clinical concerns appropriately escalated** and appropriate treatment and care provided;
    - That **if a physical restraint is to be used for a patient there should be monitoring of airways, breathing, consciousness and body alignment at all times**.

24. Finally, the "Chief Psychiatrist's physical restraint practice guidelines" relevantly provided substantially to the same effect as the other policies and procedures described immediately above.

## Taare Rangi

25. Mr Rangi was born on 20 January 1974 and was 44 years of age at the time of his death.

26. Mr Rangi resided with his mother Gail Jeanette Rangi in Charters Towers in the State of Queensland. He had been living at that address with his mother for approximately 11 years. He was born in New Plymouth Hospital, New Plymouth, New Zealand. His father is Drage Rujanoski.

27. Both Ms Rangi and Mr Rujanoski, together with extended family members, attended the inquest throughout.

28. According to the autopsy report he was 1.81 metres tall with a body weight of 180 kilograms, producing a Body Mass Index of 55.[10] Mr Rangi was considered to be obese. There was some family history of mental health disorders, but the extent of that history is unclear with information only available from Mr Rangi's mother's side.

29. According to Ms Rangi her son did not show any signs of having mental illness until about 2013.[11] By the time of Mr Rangi's death he was known to the Health Service. In 2014 he was diagnosed with Bi-Polar Affective Disorder ("BPAD") hypomanic. In 2015 the diagnosis of BPAD was confirmed this time with schizophreniform features.

30. According to Ms Rangi, Mr Rangi's mental illness initially manifested itself when he started to do things like washing the car at 2.00am in the morning and showering six times per day. He ultimately came to be admitted to the AAMHIU. Ms Rangi recalls that he remained an inpatient for approximately two weeks before being released on an involuntary treatment order ("ITO") under the MHA. He had to attend community mental health meetings once per month and take medication morning and night.

31. Ms Rangi recalls that her son never told her why he was taking medication, but she believed it was for BPAD. According to Ms Rangi her son attended his doctors once per month to get prescriptions filled in Charters Towers. She recalls that he remained under the ITO for approximately six months and spoke to Psychologists in Brisbane via video link. The ITO was eventually ceased, but Mr Rangi continued on his medication regime.

32. According to the CIMHA records Mr Rangi was admitted to the AAMHIU from 21 October 2014 to 10 November 2014. He was then case managed

[10] Ex A5 the autopsy report of Dr Botterill dated 12 March 2019.
[11] Ex B4 (page 3).

by the Charters Towers Community Mental Health Service until 27 October 2015. He was subject to the ITO from 27 October 2014 to 13 March 2015.[12]

33. Ms Rangi says her son was initially compliant with medication, but slowly started stopping until he completely ceased. This was probably about November 2015. Her belief is that this was not deliberate, but rather he would forget to take the medication once or twice and would still feel fine, so would keep forgetting to take the medication until he ceased doing so entirely. Ms Rangi's recollection is that when Mr Rangi recommenced his treatment he was back to normal, as if things had never happened. That would be consistent with the evidence of Dr Noakes as to Mr Rangi's likely prognosis described below.

34. According to the Form 1 (report of death to Coroner) completed by the Queensland Police Service ("QPS") Mr Rangi's occupational status at the time of his death was not indicated.[13] There are references though to him working as a Cleaner at the Charters Towers Hospital for about eight years prior to the initial onset of his mental illness. The Form 1 also indicates that Mr Rangi was a permanent resident of Australia who had no criminal history.

35. There was nothing in the CIMHA records of the Health Service in respect of Mr Rangi's previous admission and treatment to suggest a particular history of aggression or violence with respect to his family, staff or other patients. What was recorded was a history of some intrusive and disruptive behaviour.[14] The evidence of Dr Noakes was that there is no association between a previous history of intrusive behaviour and violent or aggressive behaviour.[15]

36. It is noted that one witness RN Munemo gave evidence of being informed of a history of previous violent behaviour.[16] However, that was based on his recollection of what the written handover document (produced for the benefit of the nursing staff working the late shift on 7 July 2018) supposedly recorded. That document was not able to be produced by the Health Service as it was not then recorded and kept in the precise form it existed at the time the late shift commenced.[17]

37. There was no history of violence or aggression recorded in the CIMHA records associated with Mr Rangi's previous admission. None of the other witnesses gave evidence of having been made aware of any such history whether from the handover document or otherwise. There was no suggestion from any of the staff who gave evidence, from the preceding shift

[12] Ex C2 page 8 under the heading "psychiatric history".
[13] Ex A1.
[14] Ex C2 pages 8 and 9 under the heading "psychiatric history".
[15] T1-59 L42.
[16] Ex D9 para 8 and T3-5.
[17] T7-36.

to that of RN Munemo, of Mr Rangi being violent or aggressive. I am unable to reconcile RN Munemo's recall with the balance of the evidence available to me.

38. That longitudinal history is relevant because as was noted in the Health Service's OVP training material current at the time of Mr Rangi's death, the single most accurate predictor of violence and aggression is previous behaviour of violence and aggression.[18] Dr Reddan also referred to the importance of the absence of such a longitudinal history when considering the critical issue of whether the acute sedation that ultimately came to be administered to Mr Rangi, leading to the need to physically restrain him, was clinically warranted.[19]

***Cause of Death: Autopsy and Toxicology***

39. Dr Paul Botterill, Senior Staff Specialist Forensic Pathologist, carried out the post-mortem examination of Mr Rangi. His autopsy report was dated 12 March 2019 and the autopsy certificate dated 14 March 2019.[20]

40. Dr Botterill concluded the direct cause of death was cardiac arrhythmia during restraint. He did not nominate any antecedent causes. With respect to other significant conditions contributing to the death, but not related to the underlying cause, he listed obesity in the autopsy certificate.

41. In the summary section of his report Dr Botterill said this:- (bold emphasis added)

> "*In my opinion, at the time of autopsy,* ***the cause of death was most probably cardiac arrest occurring during restraint in a morbidly obese subject****, but the possible contribution of concurrent drug toxicity was difficult [to] completely exclude at the time of autopsy examination. Further investigations were subsequently performed. Microscopic examination showed heart muscle cell enlargement and patchy heart muscle scarring, lung congestion and severe liver fatty change. No drugs, including alcohol, were detected in ante-mortem blood, and only a low blood level of painkiller (paracetamol) was detected in post-mortem blood. The actual cause of death remained difficult to isolate.* ***Although some pathologists regard deaths in these circumstances, often with many significant contributing elements (restraint, neck compression, fear and stress, obesity, cardiac enlargement, coronary artery disease) to be best described with the general term "cardiac arrest during restraint", it is not possible to state with certainty that one of***

[18] See the evidence of Mr Laverick at T3-103 L10 and Ex D7 page 8 of 101.
[19] T6-61.
[20] Ex A5 and A5.1.

***those contributing elements has been the most important factor resulting in the death.*** *In addition, the inadvertent intubation of the oesophagus during attempted resuscitation has prevented a successful outcome to that resuscitative effort. There was nothing to suggest that the urgent administration of "pharmacological" restraint has significantly contributed to the death.*"

42. With respect to the possible contribution of concurrent drug toxicity referred to in the quoted section above, Dr Botterill explained in his oral evidence that this part of his report was recording the opinion he held immediately after performing the autopsy, but before completing further investigations. Those further investigations included obtaining toxicology results. Dr Botterill explained that having obtained those results, which revealed only the presence of a painkiller (paracetamol), he was then able to exclude concurrent drug toxicity as a contributor to Mr Rangi's death.[21]

43. In relation to Mr Rangi's toxicology results, Dr Botterill also explained that the absence of any drug besides paracetamol was unsurprising, i.e. the absence of the lorazepam in the results was because it had been injected into Mr Rangi's muscle and fat as opposed to directly into his blood stream. Accordingly, because Mr Rangi died very shortly after the injection of that medication it did not have a chance to enter his blood stream and therefore to be identified in the toxicology results.[22]

44. Otherwise, Dr Botterill confirmed in his oral evidence the opinion expressed in his report regarding the significant contributing factors to Mr Rangi's death.

45. Those significant contributing factors were:-
the fact of a physical restraint being performed (there was no contribution from the medication administered as part of the restraint process as noted above);

- the compression of Mr Rangi's neck during the restraint;[23]
- the fear and stress Mr Rangi would have experienced during the restraint;
- the fact of his obesity;
- the fact he had an enlarged heart; and
- the presence of coronary artery disease, although Dr Botterill thought this last factor was perhaps less significant than the other contributing factors.[24]

[21] T1-13 L15.
[22] T1-14 L45 to T1-15 L15.
[23] In relation to the neck compression the autopsy relevantly revealed bilateral multifocal bruising of Mr Rangi's neck: Ex A5 (page 8).
[24] T1-10 L35 to T1-11 L20; T1-15 L40.

46. The evidence of Dr Botterill is unchallenged, and I find that those six factors were each significant contributing factors to Mr Rangi's death.

47. As Dr Botterill carefully explained in his evidence he was not able to say, either from performing the autopsy, or having the benefit of viewing the body-camera footage, which he did, that any one of the significant contributing factors had a more significant impact or contribution than another.[25]

48. Dr Botterill's opinion was that all of the factors described contributed to Mr Rangi's death, but any one of them could have explained it in isolation if none of the others had been present.[26] The significant contributing factors "all had a role to play" as he described it.[27]

49. Finally, it is relevant to note that by the time Mr Rangi's body came to undergo a CT scan prior to the autopsy, the endotracheal tube ("the ETT") that had been inserted during the course of the resuscitation was located in the oesophagus rather than the trachea. Dr Botterill referred to the "inadvertent intubation of the oesophagus" (assuming that that is in fact what occurred, i.e. there was an inadvertent intubation of the oesophagus during the course of the resuscitation).

50. I accept Counsel Assisting's submissions that the weight of evidence requires a finding that there was **not** an inadvertent intubation of the oesophagus during attempted resuscitation, but rather that there was displacement of the ETT after Mr Rangi's death such that it was in the position of the oesophagus when the autopsy was carried out. Thus no issue of inadvertent ETT intubation during the resuscitation contributing to cause of death arises. Even if there had been inadvertent intubation of the oesophagus during attempted resuscitation, it would not have been relevant to cause of death for the reasons explained by Dr Rothwell, which are also discussed in greater detail below.

### *Lead-Up to AAMHIU Admission*

51. According to the evidence of his mother, around 26 June 2018 Mr Rangi started acting in the same manner he had prior to being taken to the Hospital when his initial diagnosis of BPAD was made.[28] He was going for random walks at strange hours, (3.00am in the morning), taking six showers a day, cleaning and watering at irregular hours and being very secretive about what he was doing.

[25] T1-11 L1-5 and T1-18 L40 to T1-19 L10.
[26] T1-16 L35.
[27] T1-19 L5.
[28] Ex B4.

52. Ms Rangi says that at approximately 8.30am on 3 July 2018 she was at home and received a call from her work who had been informed by the QPS that they were looking for her in relation to making enquiries about her motor vehicle.

53. Police informed her that her motor vehicle had been located outside the Ravenswood Hotel with all the doors open. Ms Rangi says that motor vehicle was used by her son, but was registered in her name. Ms Rangi recalled that she had seen Mr Rangi at home the night before watching television, but the motor vehicle was not present. Ms Rangi attempted to contact Mr Rangi by telephone, but there was no answer. She therefore completed a missing person report, which was lodged and returned home. At about 1430 hours that afternoon the QPS returned Mr Rangi to his residence.

54. Mr Rangi's strange behaviour continued over the next few days, including on the evening of 5 July 2018 when he was inappropriately giggling while watching television, together with generally bizarre and disorganised behaviours. Ms Rangi sought assistance from the Charters Towers Community Mental Health Service during this time.

55. On the morning of 6 July 2018 Mr Rangi removed everything from his room and placed the items in doona covers before putting them in the backyard. A home visit was undertaken by the Charters Towers Community Mental Health Service. Mr Rangi declined to speak with the clinicians and was found to be lying on his bed facing away from the door, refusing to meaningfully engage.

56. Arrangements were ultimately made, after discussion with the Townsville Acute Care Team, for him to be assessed with the assistance of the QPS. The Queensland Ambulance Service ("QAS") was tasked to attend Mr Rangi's residence and collect him. They transported him to the Charters Towers Hospital uneventfully.

57. Mr Rangi was assessed by Dr Kiran who concluded he was suffering from BPAD, manic. Mr Rangi was noted to be non-compliant with his medication. The notes made by Dr Kiran record a presentation of medically stable, requiring further psychiatric assessment, but without a need for sedation for transfer as Mr Rangi was happy and compliant. Mr Rangi's care was thus transferred to the Health Service.[29]

58. According to the QAS records Mr Rangi was transported again uneventfully and arrived at the Hospital (approximately 135 kilometers from Charters Towers) at 2246 hours on the evening of 6 July 2018.[30]

[29] Ex C5.
[30] Ex C11.

### *AAMHIU Admission*

59. On arrival at the Hospital Mr Rangi was admitted to the High Dependency Unit ("HDU") of the AAMHIU.

60. The AAMHIU is comprised of both a HDU and a Low Dependency Unit ("LDU"). The HDU was an eight bed locked unit that allowed for more intensive observation and nursing. The LDU had capacity for 28 patients.[31] There was, a higher ratio of nurses to patients in the HDU in that ordinarily three nurses would care for the eight patients in the event the unit was full.

61. Mr Rangi was assessed by the on-call Psychiatric Registrar working the night shift of 6/7 July 2018, Dr Charu Dasgupta. Initially Dr Dasgupta attended the HDU at 0050 hours on 7 July 2018 to assess Mr Rangi, but he was asleep. She returned at approximately 0110 hours after being advised that Mr Rangi was awake.

62. Dr Dasgupta reviewed the available clinical notes from CIMHA recording the recent events and the previous psychiatric history. She then interviewed Mr Rangi who was cooperative, but only superficial rapport was established. Dr Dasgupta undertook a physical examination and concluded Mr Rangi's vital signs were within normal limits, i.e. temperature, blood pressure, respiration and pulse. Mr Rangi had bruises on his feet, which would be consistent with the observation made by Ms Rangi of him walking with his boots in his hand when he was returned home by the QPS a few days earlier. Dr Dasgupta's physical examination also included listening to Mr Rangi's chest with a stethoscope, a limited central nervous system assessment and an assessment of the abdomen. The physical examination did not identify anything of concern.

63. Dr Dasgupta diagnosed Mr Rangi as suffering from BPAD, currently hypomanic. Mr Rangi was not violent or aggressive during interview with Dr Dasgupta.[32] There was no sense of threatening behaviour.[33] Her initial management plan was to admit him to the HDU on a Recommendation for Assessment under the MHA with the on-call psychiatric team to undertake a more comprehensive review in the morning. Dr Dasgupta prescribed "as required" ("PRN") medications for Mr Rangi being 5 to 10 mgs of oral olanzapine[34] and 1 to 2 mgs of oral lorazepam[35] in the event Mr Rangi became agitated prior to consultant review the next day. She assessed Mr Rangi as being a low risk of harm to himself and others.[36]

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[31] T1-57 L25-35.
[32] T1-24 L10-15.
[33] T1-25 L40.
[34] An atypical antipsychotic primarily used to treat schizophrenia and bipolar disorder, sold under the brand name zyprexa.
[35] A benzodiazepine used to treat anxiety disorders, amongst other symptoms, sold under the brand name ativan.
[36] Ex D3 page 14 of 20 and T1-25 L45.

64. Dr Dasgupta says she prescribed those medications on the basis of Mr Rangi's previous admission history. Mr Rangi also recalled that he had taken medication called saphiris.[37] Dr Dasgupta noted that having prescribed those PRN medications the on-call consultant psychiatric team would then review them during the day with a view to ongoing treatment. No issues were raised with Dr Dasgupta about Mr Rangi over the balance of her shift following the initial assessment.[38]

65. At the conclusion of her shift Dr Dasgupta provided a verbal handover to the on-call consultant psychiatric team comprised of Consultant Psychiatrist, Dr Philippa Noakes and Psychiatric Registrar, Dr James Noon.

66. Dr Noakes was the on-call Consultant Psychiatrist for the period from 1630 hours on Friday, 6 July 2018 through to 0800 hours Monday, 9 July 2018. Part of her responsibility was to review new admissions over the course of the weekend for the purposes of putting in place an interim management plan, pending review by the weekday team.

67. Dr Noakes recalled the handover from Dr Dasgupta. Dr James Noon was also present although he could not recall in his evidence anything about the handover. Dr Noakes recalled that Dr Dasgupta stated that there had been no management problems on the ward with Mr Rangi or any issues or concerns raised by staff about his behaviour overnight. Blood tests had been ordered, but all the results were still not available. Dr Noakes explained that blood tests are ordinarily ordered for every patient admitted to the AAMHIU for the purpose of excluding organic causes for a patient's presentation. Specifically, she said blood tests were ordered to look for any abnormalities including anaemia, infection, inflammation and assessing liver and renal function.

68. Prior to reviewing Mr Rangi, Dr Noakes reviewed Dr Dasgupta's admission notes and the prior discharge summary from the Health Service in relation to the pre-existing diagnosis and treatment. On the basis of that information Dr Noakes concluded Mr Rangi was experiencing a relapse of his BPAD and that if provided with correct treatment he would rapidly recover and return to normal functioning as he had done in the past.[39]

69. Dr Noakes also said that prior to assessing Mr Rangi she spoke with RN Brittany Marshall, who reported no management issues on the ward including no aggression or violence exhibited by Mr Rangi. There was a description of what was said to be some bizarre behaviour involving scratching of feet on the corners of walls although Dr Noakes agreed that

[37] Also an atypical antipsychotic primarily used to treat schizophrenia and acute mania associated with bipolar disorder, the generic being asenapine.
[38] T1-28 L25.
[39] T1-60 L35.

given Mr Rangi had some wounds on his feet that was not necessarily the case, i.e. the behaviour was not necessarily bizarre.[40]

70. Dr Noakes assessed Mr Rangi at approximately 1115 hours with RN Marshall in his bedroom of the HDU. He had refused to come to the interview room. Dr Noakes found him to be smiling, appearing to be happy or pleased with himself, consistent with an elevated mood. She attempted to engage with him, but he was evasive and not willing to engage in the interview process. Dr Noakes examined his feet and prescribed some treatment for them.

71. Dr Noakes informed Mr Rangi that she was placing him on a Treatment Authority under the MHA and that she would prescribe him two medications by reference to his previous history and discharge summary, namely sodium valproate[41] and asenapine. Dr Noakes' diagnosis following her face to face assessment of Mr Rangi was to confirm her pre-assessment impression that he was having an episode of BPAD, manic. She formed the view that his risk of violence and aggression was low at that time. Dr Noakes made the point in her statement and oral evidence that it is the nature of the condition that during manic episodes the level of agitation and risk of aggression can fluctuate.[42]

72. As noted above the effect of the Treatment Authority under the MHA was to make Mr Rangi an involuntary patient of the AAMHIH. Thus, medical treatment could be administered to him without his consent and he could be forcibly physically restrained for that purpose.

73. Consistent with the management plan, Dr Noakes prescribed 600 mgs oral valproate twice daily and 10 mgs of oral asenapine twice daily. She also prescribed paracetamol for the foot pain. The timing of the administration of the valproate and asenapine was to be at 0800 hours and 2000 hours, i.e. no 'regular' medication was proposed to be administered until 2000 hours (8.00pm) that evening.

74. In that regard, Dr Noakes says that her management plan included the instruction that a review of the blood tests be undertaken before the evening medications were administered. That was because there was some risk that sodium valproate can affect liver function if there is evidence of existing liver compromise. She says that although some of the blood tests were available, not all of them were at the time she looked on the system. The blood tests that were available indicated Mr Rangi was not anaemic, there was no infection and were otherwise normal. Dr Noakes also wanted an ECG undertaken to assess Mr Rangi's cardiac status.

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[40] T1-61 L10.
[41] An anticonvulsant used to treat epilepsy but also bipolar disorder.
[42] T1-63 L20-45.

75. Dr Noakes further explained in her oral evidence that it would take approximately four to seven days for the regular medications prescribed to have a particularly significant effect on Mr Rangi's mental state. Given that, the short delay to check the blood tests and perform an ECG was not significant.[43] Dr Noakes explained in her evidence that she asked the Psychiatric Registrar Dr Noon to follow up the results of the blood tests, which he did. The results were reported to her by Dr Noon as normal about 30 to 45 minutes prior to 2000 hours.[44]

76. Having regard to those matters the decision by Dr Noakes not to immediately commence the prescribed medications was entirely reasonable. Even if they had been commenced immediately, assuming Mr Rangi agreed to take them, which he may not have, they would not have made any (immediate) difference to him.

77. In addition to these regular medications, Dr Noakes also wrote an order for 1 to 2 mgs of PRN oral lorazepam for agitation. She says her intention was to add to the oral lorazepam already ordered by Dr Dasgupta in the form of an intramuscular dose for use in the event of escalation of an episode of agitation. However, she (inadvertently) wrote up the incorrect route, i.e. oral administration, when she intended to write intramuscular administration, thus replicating the existing order of Dr Dasgupta.

78. Dr Noakes explained that because Mr Rangi was being placed on a Treatment Authority it was standard practice to write an order for an intramuscular medication to provide as acute sedation in the event the patient's behaviour escalated in the future.[45] It was not something she intended to prescribe because of any particular concern she had about Mr Rangi's behaviour escalating into violence or aggression although that was a potential given the nature of his condition.[46] The point was to provide the treating team with another pharmaceutical option in the event there was an escalation of Mr Rangi's behaviour and oral PRN medications were being declined.[47] Otherwise, Dr Noakes plan was to next review Mr Rangi on the morning of Sunday, 8 July 2018.

79. Mr Rangi was then cared for by RN Marshall during the day shift on 7 July 2018. He was one of two patients allocated to RN Marshall during that shift. Her observations of Mr Rangi were that she can recall seeing him interacting reasonably well with other patients and was smiling and laughing. She did not observe aggression, agitation, violence, escalating or threatening

[43] T1-65 L35-50.
[44] T1-68 L25-50.
[45] T1-71 L35-50.
[46] T1-72 L1-15.
[47] T1-70 L20.

behaviour during the shift.[48] Her recollection is that he seemed accepting of the treatment recommended by Dr Noakes including recommencement of the sodium valproate.

80. Furthermore, RN Marshall can recall Mr Rangi giving blood for testing and that he engaged in a playful and light hearted joke with the pathology collector and cooperated by sitting in a chair and extending his arm to enable blood to be extracted.[49] Notwithstanding these matters, RN Marshall says that her overview and impression of Mr Rangi was that given his symptoms, his level of risk appeared to be highly changeable.[50]

81. Following completion of the day shift, once the staff roster changed, the HDU was then comprised of nursing staff made up of Clinical Nurse Gillian Collier, RN Michael Munemo and RN Bincymole Shiju. They were to work the late shift from 1230 hours to 2100 hours on 7 July 2018 although RN Shiju only took over from RN Marshall at around 1500 hours, because she had worked the preceding shift in another ward and needed a break before starting the late shift in the HDU. CN Collier was the clinical lead in the HDU. The LDU was comprised of other nursing staff. The clinical lead there was Clinical Nurse Kelly Harding. She was also the shift coordinator for the AAMHIU.

82. At the time of handover to the late shift, the information provided was that Mr Rangi had a diagnosis of BPAD and was hypomanic due to non-compliance of his prescribed medication, but there were no issues of concern. Allocations of specific patients were made to staff. Mr Rangi was allocated to RN Shiju. RN Shiju successfully administered 1 gm of oral paracetamol to him at 1600 hours. RN Shiju was in fact allocated to do all the medications within the HDU for each patient. Otherwise, 15 minute observations were made of Mr Rangi throughout the shift.

83. Prior to the scheduled administration of medication at 2000 hours, another patient in the HDU reported to the nursing team that Mr Rangi had either been looking through the window of a female patient's room or trying to go into that female patient's room. None of the nursing staff actually saw Mr Rangi attempt to enter this female patient's room. (None of this behaviour was borne out in CCTV footage). The patient who reported these matters was displaying a level of anger towards Mr Rangi, and himself had a history of aggression.

84. CN Collier and RN Shiju spoke with Mr Rangi. He denied looking through the window of the female patient's room. RN Munemo and RN Shiju said they thought Mr Rangi was agitated and irritable and pacing the unit. The

[48] T1-40 L10-30 and T1-46 L15-30.
[49] T1-41 L10-30.
[50] Ex D8 para 34.

CCTV evidence that is available in the period immediately leading up to the decision to seek an order for intramuscular lorazepam does not demonstrate that. Rather it shows Mr Rangi sitting for reasonably long periods of time and walking around the HDU from time to time not in fast paced or agitated way.[51]

85. Mr Rangi was offered PRN medication in the form of 2 mgs of oral lorazepam. He declined that medication. He also declined, it would seem, on about four occasions his regular medication scheduled for 2000 hours which the nursing staff had commenced offering him. Each of RN Shiju and RN Munemo made attempts to have Mr Rangi take his regular medication.

86. When CN Collier and RN Shiju spoke to Mr Rangi, after the complaint by the other patient, he compliantly went from the corridor where he was standing, to the lounge of the HDU when asked to do so. The CCTV footage shows that between 8.13pm and 8.25 pm (when staff entered the lounge to administer the IM), a period of 12 minutes, Mr Rangi was seated on a chair with his back to a wall in the HDU lounge. He was still, he was calm, and did not appear agitated. He did not react in any way when approached by two persons (separately) during this interlude (RN Munemo to offer oral medication, and the patient mentioned above, whose body language on CCTV appeared to be almost confrontational in his approach to Mr Rangi).

87. Mr Rangi was not concerned by either approach and remained seated. There he remained calmly in the chair prior to the restraint team entering the lounge.

88. Whilst Mr Rangi was calmly sitting in the HDU lounge, CN Collier telephoned Dr Noon and informed him that Mr Rangi was becoming agitated, refusing his regular scheduled night medication and PRN medication of oral lorazepam. She says she requested an order for intramuscular lorazepam 2 mgs, because it had not been written up by Dr Noakes as it would ordinarily have been. That order was confirmed by Dr Noon by telephone and witnessed by RN Shiju. RN Shiju says she was present for, but did not listen to, the substance of the telephone call to Dr Noon, although she confirmed his telephone order for the administration of intramuscular lorazepam 2 mgs.

89. The evidence of Dr Noon is that he recalls receiving a telephone call from the nurse in charge of the HDU at approximately 2015 hours. He says he was informed that Mr Rangi was “perving” on young girls, acting threateningly, being combative with staff and refusing to take oral medication. Dr Noon says he was asked for an order for intramuscular lorazepam. Dr Noon says he asked a comprehensive series of clarifying

[51] Ex B3.8, B3.10, B3.11 and B3.12.

questions as to whether the patient required intramuscular injection and whether lorazepam was an appropriate choice.

90. CN Collier agreed that Dr Noon did ask her to explain her rationale for wanting to do so, which she did.[52] There is a dispute between Dr Noon and CN Collier as to what exactly she told him by way of explanation in that regard. It is not possible to resolve that dispute. Regardless, Dr Noon felt the assessment of the senior clinical nurse was a sufficient basis to make the requested order. By doing so Dr Noon was not authorising the physical restraint of Mr Rangi. That was a decision made by CN Collier. (Although if Dr Noon felt that such a course of action was not clinically warranted it would have been incumbent on him to say so and refuse the requested order).

91. Having obtained the IM order, CN Collier set about requesting the assistance necessary to forcibly restrain and administer the intramuscular lorazepam to Mr Rangi in the event that was necessary, i.e. if Mr Rangi did not agree to the intramuscular injection. She contacted CN Harding and requested the assistance of additional staff and Endorsed Enrolled Nurse Peter Snelleman was allocated to the HDU. She also sought the assistance of Health Security Officers ("HSOs") and three ultimately were tasked to attend the HDU.

92. CN Collier says that CN Harding told her to be careful if a restraint was required of Mr Rangi, because of his size. CN Collier also says that CN Harding told her that the restraint should be performed either with him sitting or standing.

93. The three HSOs who were dispatched to the HDU were HSO Anthony Beltramelli, HSO Aaron Fitzgerald and HSO1. Once they were present, together with EEN Snelleman, a short meeting occurred in the nurse's station of the HDU. The meeting was led by CN Collier. She says she explained to the team what they were going to do, and that Mr Rangi was to be seated or placed on his side for the giving of the injection. CN Collier in her evidence also says that she told the team that Mr Rangi was not to be placed in the prone position due to his size and stressed this a number of times.

94. CN Collier says she informed the group that RN Shiju was to do the talking and to give the injection to Mr Rangi. She says she told RN Shiju that she was to be the "number 1" which in accordance with the Hospital's OVP training would have made her the team leader.[53] This is vigorously disputed by RN Shiju.[54] CN Collier also says that she told the team that she would supervise the other patients in the HDU while the restraint was being

[52] T2-36 L20.
[53] T2-62.
[54] T4-29.

undertaken, although that is contrary to the evidence of RN Munemo and RN Shiju, who say they were surprised by the fact that CN Collier was not present when the actual restraint was initiated.[55]

95. I do not accept the evidence of CN Collier and find that RN Shiju did not receive handover or notice from CN Collier that she would be 'number 1' during the restraint. CN Collier either made a spur of the moment decision not to enter the fray, or never intended to do so, and did not adequately convey her intentions to her nursing team. I find that CN Collier abrogated her role as clinical lead in the restraint.

96. During the course of this short meeting RN Munemo raised with CN Collier the prospect of a further attempt to convince Mr Rangi to take his medication rather than forcibly administering an intramuscular injection. In response she said the time for negotiation was over and that the decision had already been made.[56] This exchange was also visually captured by CCTV in the nurses station. I accept RN Munemo's evidence on this point.

97. It is evident from the available body-camera video footage (once inside the LDU lounge) that RN Shiju tried to convince Mr Rangi that it would be better if he complied with the order for an intramuscular injection and accept it. She did not though offer Mr Rangi the further opportunity to take oral lorazepam.[57]

98. The team of six persons, comprising three nurses and three HSOs, then entered the lounge area where Mr Rangi had been quietly and calmly sitting in the same spot since being directed there (12 minutes prior) by CN Collier and RN Shiju. They triangulated themselves around Mr Rangi. A number of the HSOs described Mr Rangi as appearing calm when the group entered the lounge. The CCTV and body-camera video evidence revealed what then transpired.

99. Mr Rangi at first remained seated with his back to the wall as five of the six persons in the room formed a semicircle around him, standing back at a distance of approximately 2-3 metres. The sixth team member (RN Snelleman) stood further back out of the circle at this time.

100. In short, RN Shiju spoke with Mr Rangi and tried, as noted, to convince him to agree to the intramuscular injection. Mr Rangi repeatedly declined and said he did not need the medication. He also asked to speak with the doctor who had ordered the injection. RN Shiju declined to arrange for that to occur and said she would get the doctor once the injection had been given.[58]

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[55] T4-31 (Shiju) and T3-29 (Munemo).
[56] T2-63.
[57] Ex B3.1 and the aide memoire transcript.
[58] Ex B3.1 and the aide memoire transcript.

101. The verbal interaction between RN Shiju and Mr Rangi continued for a period of some minutes. Mr Rangi became verbally combative during the interaction with RN Shiju. He clearly did not want to receive the intramuscular injection.

102. After a lapse of almost 3 minutes, HSO Beltramelli, (standing immediately to Mr Rangi's right, and who was then still seated), stepped forward. HSO1 and Fitzgerald almost immediately did likewise. This had the effect of closing down the space between the group and Mr Rangi (just beyond arms reach). Without invitation, HSO Beltramelli also took over the role of speaking with Mr Rangi from RN Shiju. He was not asked or directed by any person to do so.[59]

103. I formed a view having viewed the footage that Nurse Shinju did not have control of the situation and her intercessions for Mr Rangi to acquiesce to an unwanted injection, were ineffectual. I am of the view that HSO Beltramelli sensed that, and he took it upon himself to 'assist' and attempted to convince Mr Rangi to have the injection. Mr Rangi continued to decline.

104. At 2028 hours Mr Rangi stood from his seated position.[60] I formed a view that Mr Rangi stood in response to HSO Beltramelli stepping forward into his space. By now the three HSOs having stepped in and closed the space, were now in close proximity to Mr Rangi. HSO Beltramelli said he felt threatened by Mr Rangi standing.[61] That might well be accepted, as it might also be found that the act of the HSOs, who had encircled Mr Rangi, stepping in and closing the space around him, probably caused him to feel threatened.

105. After Mr Rangi stood the video evidence shows that HSO Beltramelli reached out with his right hand towards Mr Rangi's chest and placed his left hand onto Mr Rangi's right arm. I find this action by HSO Beltramelli initiated and instigated the restraint. Although HSO Beltramelli disputed that he instigated the restraint in that way it seems clear from the video evidence that is what occurred.[62] This was the commencement of what came to be referred during the inquest as the "first phase" of the restraint.

106. After approximately three minutes of unsuccessfully trying to convince Mr Rangi, at 8.25pm, HSO Beltramelli reached out towards Mr Rangi with his arms and Mr Rangi raised his arms in response. The other two HSOs physically engaged Mr Rangi evidently in an attempt to restrain him. What can only best be described as a melee, then ensued.

[59] T5-25.
[60] Ex B3.12.
[61] T5-26.
[62] T5-26.

107. Mr Rangi and HSO1 fell to the ground. It appears from the video evidence that Mr Rangi grabbed onto HSO1's legs as they fell to the ground. Mr Rangi was duly restrained on his right side by the group save for RN Shiju. HSO Beltramelli secured Mr Rangi's right arm. HSO Fitzgerald secured Mr Rangi's left arm. RN Munemo and EEN Snelleman secured Mr Rangi's legs attempting to unsuccessfully perform what is known as a "figure 4 leg lock". HSO1 was at the head of Mr Rangi's body.

108. During this first phase of the restraint, HSO1 pinned Mr Rangi's head to the ground with his left knee by placing it against one side of the head with the floor of the HDU on the other side. Mr Rangi having been secured, RN Shiju then gave the intramuscular injection into Mr Rangi's left buttock area. While doing so she tells him (on at least 10 occasions) to "*relax*" and to "*concentrate on your breathing*".[63]

109. The nurses who were holding Mr Rangi's legs then let go and withdrew seemingly at HSO Beltramelli's direction. That concluded the 'first phase' of the restraint which lasted approximately one minute from the time of Mr Rangi standing to the time of the nurses releasing his legs. The period during which Mr Rangi's head was pinned to the ground against the floor by HSO1's knee was approximately 35 seconds. HSO1 is heard to say to Mr Rangi "*And if you do anything stupid*…." To which Mr Rangi replied "*Nah, I won't*" HSO1 then says "*we'll drop you again. Alright? Do anything stupid*…"

110. The nurses released Mr Rangi's legs and what came to be known as the "second phase" of the restraint then occurred. The HSOs either reapplied (because they by then had relaxed their respective holds to some extent), or continued to apply the restraint to Mr Rangi. Their collective evidence was that Mr Rangi was resisting the restraint after the injection was given.[64]

111. There was evidence from HSO Beltramelli that Mr Rangi "violently lashed out". I do not accept that evidence. It is not corroborated by either body worn footage or video footage. Instead I find that at no time was Mr Rangi ever given an opportunity regroup or regather himself. Whilst under labour of breathing and having endured a 35 second knee pin to the head against the concrete floor, and the application of other physical restraints on each limb of his body, I have been asked to accept that this 180kg man violently lashed out and posed a further threat to staff.

112. I find Mr Rangi was never entirely released from the restraint applied in the 'first phase'. Upon viewing all footage it appeared to me that the event was part of one continuous sequale, punctuated only by the administration of an

[63] Ex B3.1 and the aide memoire transcript.
[64] T5-29 (Beltramelli), T5-100 (Fitzgerald) and T6-14 (HSO1).

injection. There is no complete release of Mr Rangi between the so called phase 1 and 2, which in fact was to move Mr Rangi from his side to his back.

113. HSO1 remained in contact with Mr Rangi at all times and after releasing the knee pin to his head he then almost immediately applied a headlock. I find that HSO1 remained in control of Mr Rangi's head at all times and closed off any ability or prospect for Mr Rangi to recover after the injection. I find that any perceived or actual resistance offered by Mr Rangi was to reposition himself so as to take in breath and / or to instinctually shake off the team so as to recover from 'phase 1' of the restraint.

114. I find that at all times Mr Rangi was completely and absolutely defenceless and had no opportunity to comply with any direction, noting he was by then clearly labouring. Mr Rangi weighs 180kgs. I do not believe that Mr Rangi could have come to either a seated or standing position between so called phases 1 and 2 unassisted. He was not given any opportunity to catch his breath, get up or roll over. He was not a threat to any persons safety. Had the restraint teams stood back I am confident Mr Rangi would have remained stranded on the floor.

115. I find that any resistance put up by Mr Rangi after the injection was in response to "undue stress and immense pain" he likely experienced as a consequence of HSO1's knee pin to his head forcing it against the ground, and other measures deployed at the time.[65] I agree with Counsel Assisting that it would be not at all surprising that Mr Rangi would try and free himself of the restraint having experienced that knee pin to the head for about 35 seconds.

116. During the course of the second phase of the restraint, Mr Rangi came to be rolled over onto his left front side, i.e. in the prone position. That was a particularly risky position for him given his body habitus. All involved in the restraint team appreciated that risk from their collective OVP training. As the restraint commences HSO Beltramelli was heard to say "The only thing that we worry about with you mate, is the fact you can't be on your belly."

117. During the second phase of the restraint RN Munemo and EEN Snelleman re-engaged and again applied a restraint to Mr Rangi's legs. HSO Fitzgerald came to restrain Mr Rangi's left arm by placing his left knee on the forearm and right hand on his wrist. HSO Beltramelli secured Mr Rangi's right arm. HSO1 remained at the head of Mr Rangi's body.

118. HSO1 applied a restraint by wrapping his right arm around Mr Rangi's neck under the chin. During the course of doing so HSO1's position meant his body weight was leaning back away from Mr Rangi, effectively pulling his

[65] Ex B1 (page 6 of 26).

head back and hyperextending the upper vertebrae of the neck.[66] This second phase of the restraint, including the neck restraint applied by HSO1 continued for approximately almost 60 seconds, during the course of which Mr Rangi can be heard gurgling and gasping.[67] His face also appears to change colour. The body-camera video evidence demonstrates the clear and obvious physical distress Mr Rangi was in during this time.

119. The second phase of the restraint was then ceased and the restraint team withdrew. HSO1 appears to lean in one final time before being the last person to disengage.

120. Mr Rangi was left in the prone position (stomach) with his left arm under his chin seemingly against his neck. His legs were crossed at the ankles and up against the fixed chair in the lounge. I note that he was in a state of partial undress at this time. His T shirt was up around his neck and shoulders, and his shorts were pulled partially down exposing his buttocks. No effort was made by any person to preserve Mr Rangi's dignity. He was left unattended, laying on the floor of the HDU lounge in that state as the restraint team withdrew to the nurses station.

121. No person remained continuously with Mr Rangi to monitor his vital signs, including his breathing and it was not until about 45 seconds later that members of the team were sufficiently concerned by Mr Rangi's lack of movement to return directly to his side (encircling him and walking around him ) at which time EN Snelleman can be heard on the body-camera audio saying that Mr Rangi was holding his breath.[68] Mr Rangi was then rolled over onto his back. There are three references by staff to Mr Rangi "*holding his breath*". There are further references by EN Snellmen "*we need to roll him over*"

122. It is at that point that the critical nature of the situation was realised and a medical emergency was called. The medical practitioner who appears to have responded first to the emergency was Dr Noon. He says he arrived in the HDU expecting Mr Rangi to be actively restrained, which is what he had been told was occurring. Instead he found active resuscitation occurring.

123. Dr Noon took control of the resuscitation. He had been a registrar in emergency medicine for about seven years prior to obtaining a position in psychiatry. He provided active resuscitation while waiting for members of the MET team to arrive.

124. The MET team arrived and included Dr John Waterfield, Dr Vicnaesh Segaran and Dr Emma Kanaganayan. Dr Segaran was responsible for Mr Rangi's airway. It was also he who inserted the ETT into the airway.

[66] Ex B1 (page 9 of 26).
[67] Ex B3.1.
[68] Ex B3.1 and the aide memoire transcript.

125. Dr Segaran says he was satisfied the ETT tube was in the correct location, because he observed fogging of the tube, heard breath sounds on auscultation of both sides of Mr Rangi's chest, asked for and received confirmation from a colleague of the presence of breath sounds and was given the results of monitoring $CO^2$ levels via a portable capnometer, which detected it in the expired gas, consistent with correct placement of the ETT in the trachea.[69]

126. Active resuscitation occurred until 2105 hours when the collective decision of the team, now made up of a large number of persons, was to cease and Mr Rangi was declared deceased. He was heart rhythm was consistently in asystole meaning that the defibrillator was not used, because the heart was not in a shockable rhythm.

[69] Ex D13.

## Inquest Issues

### *Coronial Issue 2 – Circumstances of Death: Adequacy of Medical Treatment Prior to Restraint*

> *In relation to the circumstances of the deceased's death, investigation and consideration of:-*
>
> *(a) the adequacy and appropriateness of the treatment provided to the deceased in respect of his mental health, following admission to the Townsville Hospital on 6 July 2018, including:-*
>
> *(i) the decision to forcibly seek to administer medication to the deceased;*

127. I find that the medical treatment of Mr Rangi, up until the point in time when the decision was made to acutely sedate him, was adequate and appropriate.

128. When Mr Rangi was admitted to the HDU he was appropriately reviewed by Dr Dasgupta. The review by Dr Noakes was adequate and appropriate. The decision to apply for a Treatment Authority under the MHA was entirely reasonable and necessary given Mr Rangi's diagnosis and presenting clinical condition. The clinical course approved by Dr Noakes and the requirement for blood testing results prior to administering medication complies with best practice.

129. The decision to administer the intramuscular lorazepam on the evening of 7 July 2018, i.e. to acutely sedate Mr Rangi was CN Collier's decision.[70] It was she who organised a team of nurses and security officers to implement that decision, including to conduct a physical restraint should it become necessary if Mr Rangi refused to consent to an injection.[71] The decision to acutely sedate Mr Rangi went hand in hand with the prospect of having to do so forcibly, thus necessitating physical restraint. It is critical then to consider the basis on which CN Collier made the decision that acute sedation was clinically warranted.

130. According to the acute sedation guideline the circumstances in which it is clinically appropriate to sedate a patient is when consumers are extremely agitated, threatening violence, are actually violent and/or a danger to themselves or others.[72]

[70] Ex D2.1.
[71] Ex D2.1.
[72] See paragraph 16 above.

131. Furthermore, it was clearly noted, as was known to CN Collier, in the Hospital's restraint procedure that restraint of any kind was a last resort intervention when there was imminent risk to the consumer, staff, visitors and fellow consumers and that all possible strategies to prevent restraint were to be considered and used prior to the decision to intervene in a coordinated physical intervention.[73]

132. CN Collier's reasons for seeking the order from Dr Noon to acutely sedate Mr Rangi by way of intramuscular injection were said to be threefold. First, because Mr Rangi was agitated. Second, because he was not taking his regular medications. Third, because he declined to take the prescribed oral PRN medications. CN Collier accepted in her evidence that these three matters were not of themselves sufficient to justify the physical restraint of Mr Rangi in the event he refused the intramuscular injection of lorazepam.[74]

133. I find that Mr Rangi's behaviour was not such as to clinically warrant him being acutely sedated by an intramuscular injection of lorazepam. Dr Reddan in evidence concluded there was a lack of a sense of impending crisis, or need for haste, during Mr Rangi's admission to warrant a physical restraint.[75]

134. The absence of any escalation or worsening behaviour on Mr Rangi's part or conduct that would have clinically warranted his acute sedation was confirmed by RN Shiju and RN Munemo. At best they described Mr Rangi as demonstrating some underlying irritability. RN Shiju agreed that at the time CN Collier was seeking an order from Dr Noon for the injection of lorazepam, Mr Rangi was not an imminent risk to himself, staff or other consumers.[76] RN Menumo was likewise concerned about that decision by CN Collier and sought a further opportunity to obtain Mr Rangi's agreement to take oral medication immediately prior to the team being dispatched by CN Collier to administer the injection.[77] That request was refused by CN Collier as noted above.

135. Despite being given the opportunity to explain why she thought Mr Rangi clinically warranted acute sedation, potentially with physical restraint, CN Collier was unable to provide any real justification for doing so in accordance with the applicable policies and procedures.[78]

136. It is noted that CN Collier described in her evidence that earlier in 2018 she suffered a medical condition. She said in her oral evidence that she had lost

[73] See paragraph 17 above.
[74] T2-48 to T2-49.
[75] Ex A7.2 and T6-64.
[76] T3-23.
[77] T3-36 and 3-38.
[78] See for instance her evidence at T2-48 L20 through to T2-49 L25.

a bit of confidence.[79] She did not include in either her primary statement or her supplementary statement, provided on the morning she gave evidence, any explanation that her critical decision making was impaired by confidence because of her earlier medical condition. The evidence of CN Richardson was that CN Collier had not raised any such issues upon her ultimate return to work.[80] It seems unlikely then that CN Collier's prior medical event or condition was of any relevance to her decision making at that time.

137. In the circumstances then, the decision to acutely sedate and forcibly administer the intramuscular lorazepam to Mr Rangi was not appropriate. It was not clinically warranted. It was contrary to the acute sedation guideline and the restraint procedure. It should not have occurred that evening. There was no particular reason why Mr Rangi's refusal to take his regular prescribed medication could not have been noted in the record for consideration by Dr Noakes the following day when she next reviewed him.

138. Given that the regular prescribed medications would not start to have any particular significant effect on Mr Rangi's mental state for four to seven days, there would have been no particular harm in him not taking such medication that night. As Dr Noakes explained, the refusal to take prescribed regular medication would simply mean there was a delay in the date of discharge from the Hospital because the treatment was slightly delayed. There was no rush in that regard. In any event, the acute sedation by way of intramuscular injection of lorazepam would not have involved the actual administration of Mr Rangi's regular prescribed medication unless it brought about a change in his attitude to taking such medication.

139. The other issue of note in relation to the decision to acutely sedate Mr Rangi concerns the events immediately before the physical restraint was performed in the lounge. The team that approached Mr Rangi in the lounge of the HDU did not include CN Collier.

140. RN Collier abrogated her role as clinical lead. It was left to RN Shiju to speak with Mr Rangi really by default as the person who was to administer the injection. I question RN Shiju's decision to step in to the role of the clinical lead during the restraint. In such a situation senior nursing staff are required to have the presence of mind to question the state of affairs and not acquiesce by default.

141. RN Shiju attempted to convince Mr Rangi to agree to the injection. During the course of that interaction Mr Rangi asked on a number of occasions to speak with the medical practitioner who had ordered the injection that he was being told he had to receive. Notwithstanding those requests, neither

[79] T2-83.
[80] T7-45.

RN Shiju nor any of the other persons present made a decision to stand down and accede to Mr Rangi's request.

142. In the circumstances, particularly given the absence of any escalating behaviour on Mr Rangi's part, his request was an entirely reasonable one. It reflected a real opportunity to de-escalate the situation and potentially avoid a physical restraint, which as the restraint policy states should always be considered a last resort. The evidence of Dr Noon was that he would have been amenable to coming and speaking with Mr Rangi to explain the situation.[81] Given the absence of any behaviour to indicate that acute sedation was clinically warranted, it can be reasonably inferred that had Dr Noon reviewed Mr Rangi he would have determined that acute sedation was not warranted and the physical restraint of Mr Rangi that evening would not have occurred. However, he was not given that opportunity.

143. It fell on RN Shiju to be the person to make the decision to stand down the team given she was the person who was effectively the team leader although not by choice. It was she who was speaking with Mr Rangi and to whom the request was made to speak with the doctor who had prescribed the injection, but she elected not to do so. Saying that I also note that no other person (nurse or HSO) present intervened either. No one intervened or interceded on behalf of the patient.

144. I agree with Counsel Assisting that the decision to acutely sedate Mr Rangi appears to stand in stark contrast to the fact that the other patient who had made the complaint about Mr Rangi to nursing staff, who had a known history of aggression, and was evidently being aggressive and threatening to Mr Rangi that evening, was seemingly not acutely sedated. Why the decision was not made to acutely sedate this other patient instead of Mr Rangi remains unexplained, but is perhaps demonstrative of the serious deficiency in the decision making on the evening in question. I in fact questioned during the course of the Inquest whether nursing staff had identified the correct patient for sedation.

***(ii) the method by which such medication was sought to be administered.***

145. Once the decision was made to acutely sedate Mr Rangi the method of administration given his refusal to take oral lorazepam was via an intramuscular injection according to the acute sedation policy. Thus the method by which the medication for acute sedation was administered was consistent with the applicable policies and procedures. The critical issue though is that dealt with immediately above, i.e. that such a course of action should not have been decided upon and then implemented in the first place.

[81] T1-99.

***Coronial Issue 3 - Circumstances of Death: Restraint***

*In relation to the circumstances of the deceased's death, investigation and consideration of: -*

*(b) the adequacy and appropriateness of the physical restraint of the deceased prior to his death, for the purpose of forcibly administering medication, including:-*
*(i) the planning undertaken in respect of performing the physical restraint;*

146. The planning undertaken in respect of performing the potential physical restraint of Mr Rangi was neither adequate nor appropriate.

147. As described above, a brief meeting of the persons who came to form the team who ultimately restrained Mr Rangi took place in the nurse's station. The duress response procedure and the Hospital's OVP training required that all present for that meeting were allocated positions and responsibilities within the team for the restraint by the team leader.[82] The response team leader was otherwise known as "number 1". The response team leader was responsible for protecting the patient's head and airway and physical observations until allocated to another team member.

148. The clear intent of the duress response procedure and the Hospital's OVP training was that each member of the team would know the specific role and responsibility that had been allocated to them by the response team leader and who was the response team leader for the restraint. It may well be that those roles and responsibilities change during the dynamic course of a physical restraint, but it was evidently important that there be an initial allocation of roles and responsibilities in a planned restraint of the kind proposed in this case.

149. In this case, there was essentially no designated response team leader or number 1. That role should have been performed by CN Collier. She accepted in her supplementary statement that she made an error in judgment in not attending the administration of the injection so that there was an independent senior nurse present to monitor Mr Rangi's airway and breathing in the event the restraint was necessary.[83] That error of judgment on CN Collier's part was a significant one. I do not accept that CN Collier allocated the number 1 to RN Shiju. It is against the weight of the evidence. No other person present at the meeting corroborated that assertion. Rather, to the contrary, both RN Shiju and RN Munemo assumed, consistent with their training, that CN Collier would not only be the response team leader, but would be present during the restraint.

[82] See paragraph 19 above.
[83] Ex D2.1.

150. It is likely though that as the team walked from the nurse's station into the lounge area CN Collier told at least RN Shiju that she was not going to be present. I do not accept that RN Shiju only came to know that CN Collier was not present after she gave the injection. It is fundamentally inconsistent with her written statement given relatively soon after the events in question.

151. Furthermore, none of the HSOs seemingly had any particular allocation of positions or responsibilities within the restraint team given to them. There was evidence that that was a not uncommon occurrence in respect of planned restraint briefings.[84]

152. The absence of a designated response team leader whose specific role it was to protect Mr Rangi's head and airway and monitor his physical observations was a serious departure from the duress response procedure and the Hospital's OVP training. It is possible that had CN Collier been present that Mr Rangi's request to speak with the doctor who had ordered his injection may (although unlikely) have been acceded to noting her expressed attitude to others that no further negotiation would be undertaken.

153. CN Collier's absence from the restraint team notionally to ensure that other patients located in the HDU did not interfere with the restraint and the deficient manner in which the pre-restraint briefing was conducted represented a serious lack of leadership on her part. It compounded the already flawed decision she had made to acutely sedate Mr Rangi.

154. It is also concerning that RN Shiju, did not raise any issue as to the absence of the person whom she assumed would be the response team leader. It is concerning that there was overall, insufficient awareness by all present upon entering the HDU lounge that Nurse Collier was not present.

155. In essence then the planning undertaken in respect of performing the physical restraint of Mr Rangi was neither adequate or appropriate and was not in accordance with the duress response procedure.

***(ii) the performance of the physical restraint;***

156. There were a number of aspects of the performance of the physical restraint of Mr Rangi that were seriously inadequate and inappropriate and at times reckless.

157. As noted above the restraint comprised two phases.

158. After the initiation of the physical restraint during the first phase, Mr Rangi came to be restrained by the team on his right side. The two particularly concerning matters that arise in respect of the first phase of the restraint

[84] T5-143.

were the attempted application of a "figure 4 leg lock" by RN Munemo and EEN Snelleman, and the use by HSO1 of a knee to pin Mr Rangi's head to the ground against the floor of the HDU.

159. With respect to the first matter, it was the evidence of Mr Laverick that a figure 4 leg lock was taught during OVP training to be used in circumstances where a patient had been placed in the seclusion room, as a mechanism for staff to safely exit the seclusion room. It was not a technique that was to be deployed generally during restraints as it was sought to be in this case.[85] That evidently represented a misunderstanding on the part of RN Munemo and EEN Snelleman as to when that technique was to be applied. The application of that technique likely though had no particular bearing on the outcome. Any additional pain that may have been experienced by Mr Rangi from the application of that technique was not likely to have been of any relevance in his cause of death.[86]

160. The far more significant issue concerned the application of the knee pin by HSO1. He knew at the time of doing so that it was not a restraint technique authorised by the Hospital.[87] HSO1 in evidence said that he placed his knee on Mr Rangi's head to control his head to stop it moving around. He said he did so out of fear. The particular fear to which he referred was of being bitten on which his little finger by a patient during the course of a restraint previously. He prioritised his own safety, i.e. the risk of being bitten, over Mr Rangi's safety at that point in time.[88]

161. Regardless of whatever fear HSO1 may have had about being bitten as a consequence of a previous incident, the application of the knee pin to Mr Rangi's head was entirely unacceptable and potentially dangerous. It was not, as noted, a restraint technique authorised by the Hospital as part of the OVP training. Undoubtedly because there was a potential for risk of injury from applying such a technique.

162. The joint opinion of Mr Hayworth and Senior Sergeant Hayden was that given the body position of HSO1 as demonstrated by the video evidence, the amount of body weight being concentrated directly down through HSO1's thigh, which was straight under his hip and torso, would have caused "undue stress and immense pain".[89] At the time HSO1, who was about 6 feet 4 inches tall, weighed approximately 95 kilograms.[90]

163. According to Mr Laverick, the OVP training that had been provided to staff as at the date of Mr Rangi's restraint included techniques that could be

[85] T4-92.
[86] T1-19 L35.
[87] T5-128 L10.
[88] T5-152.
[89] Ex B1 (page 6 of 26).
[90] T5-151.

deployed to stabilise the patient's head without placing any pressure on it.[91] The alternate technique described by Mr Laverick was consistent with the preferred option described by Mr Hayworth/Senior Sergeant Hayden to control the head of the person being restrained to prevent injury to that person and injury to the restraining officers, for instance from a risk of biting.[92]

164. The evidence of HSO1 was that he applied no more force with his knee pin than he had when he initially placed his hand against the side of Mr Rangi's head to stop it from moving. I accept Counsel Assisting's submission that I should reject that evidence. The notion that significant force was not being applied to the side of Mr Rangi's head from the knee pin is implausible and contrary to the evidence of Mr Hayworth/Senior Sergeant Hayden particularly as noted by them having regard to HSO1's body position. The application of that unauthorised (and prolonged) knee pin represented a significant, dangerous and unacceptable departure from the manner in which the physical restraint of Mr Rangi should have been undertaken.

165. With respect to the second phase of the restraint, I note there was no effective discontinuance of the restraint from phase one to phase two. There were two particularly concerning aspects of the second phase of the restraint. First was the fact that Mr Rangi came to be placed in an essentially prone position, somewhat more on the left side of his body due to his large size. The second far more serious aspect was the application by HSO1of a neck restraint.

166. With respect to the first matter, it was known to all members of the team from their OVP training, as well as from the limited briefing discussion by CN Collier, that given Mr Rangi's body habitus there were risks with him being placed in a prone position. In fact they expressed such to Mr Rangi at the outset of the physical intervention. The prone position had been avoided in the first phase of the restraint. There is no particular reason to think that it could not have been avoided in the second phase of the restraint had the team sought to do so.

167. The time during which Mr Rangi was in the prone position during the second phase of the restraint was less than the two minutes discussed in the relevant procedures, i.e. the Chief Psychiatrist's physical restraint policy but plainly that time frame is a guideline and not prescriptive and where a prone position could be avoided at all, it should be, given the risks of injury.

168. The time limits contained within the Chief Psychiatrists guidelines do not presume the application of a simultaneous neck restraint.

[91] T3-91.
[92] Ex B1 (page 7 of 26).

169. The neck restraint applied by HSO1 was not authorised by the Hospital's OVP training. HSO1 knew that to be the case.[93] Furthermore, HSO1 knew from his training not to apply direct pressure to a patient's neck, chest or back during the course of a physical restraint.[94] In addition, despite having undergone some previous training to obtain qualifications as a security guard, HSO1 had never undergone any specific training as to how to safely apply a neck restraint, i.e. a lateral vascular neck restraint ("LVNR").[95] His previous experience in applying a neck restraint, was the instance where the patient had bitten his little finger.

170. Counsel Assisting submits that as to the neck restraint that was applied, I should find, having regard to the evidence of Mr Hayworth and Senior Sergeant Hayden, that while HSO1 initially applied an LVNR it subsequently became a respiratory neck restraint or, as it is commonly known, a chokehold.[96] I accept that submission and find that the lateral vascular neck restraint applied by HSO1 by virtue of incorrect application became a became a chokehold (or respiratory neck restraint).

171. HSO1 had no training or experience in applying a correct LVNR and thus I accept he must have been at real risk of doing so incorrectly. The application of a chokehold was clearly dangerous. It is not a technique that QPS officers are taught to deploy in restraints.[97]

172. Notwithstanding HSO1's complete lack of training and experience in applying a neck restraint, and his knowledge that it was not an authorised restraint technique, he proceeded to do so and maintained that restraint for a period of approximately almost 60 seconds. Again HSO1's evidence was that he applied the neck restraint in an attempt to control Mr Rangi's head, because of a concern of being bitten. His primary concern was not Mr Rangi's safety at that particular point in time, but his own.[98]

173. HSO1 knew the reason why he was not permitted to apply direct pressure to a patient's neck was because of the risk of harm to patients. He knew the risk of harm during any restraint, including potentially death, would be increased if direct pressure was applied to an area such as the neck.[99] Thus with no training or instruction and no real previous experience in applying a neck restraint, HSO1 made a decision to do something he knew could potentially cause Mr Rangi harm. Furthermore, he accepted that he could not possibly have satisfied himself that such a restraint was going to be safe

[93] T5-127.
[94] T5-131 to 5-132.
[95] T5-125.
[96] Ex B1 (page 9 to 14 of 26) and T7-11.
[97] T7-12.
[98] T6-24.
[99] T6-20.

for Mr Rangi, because he had no idea how to apply the neck restraint technique correctly.[100]

174. I accept the submissions of Counsel Assisting that in all the circumstances the application of that unauthorised neck restraint by HSO1 was reckless and entirely unacceptable. It represented an absolute prioritisation by HSO1 of himself over Mr Rangi's safety, because of an apparent fear of the prospect of being bitten. There were techniques available to HSO1 that he could have used to control the head and avoid being bitten. This represented a fundamental and serious departure from the manner in which the physical restraint of Mr Rangi ought to have been performed and was contrary to the Hospital's OVP training and the relevant policies and procedures.

175. The other issue for consideration in relation to the performance of the physical restraint concerns the lack of intercession or action by any of the other team members in respect of the application of the unauthorised restraint techniques by HSO1.

176. With respect to the knee pin, Counsel Assisting urges a finding that both HSO Beltramelli and HSO Fitzgerald were in a position to observe that technique being applied and did so. It is plain from the combined body worn and CCTV footage evidence they were in a position to do so. Neither said anything to HSO1 about the fact that what he was doing was unauthorised something they both knew.

177. Notwithstanding the submissions of Counsel on behalf of HSO Beltramelli and Fitzgerald to the contrary, I am comfortably satisfied that each of those HSO's saw HSO1 apply the knee pin to Mr Rangi's head.

178. Taking into account all the evidence including the footage and submissions of parties I am unable to form as view as to whether HSO Beltramelli either saw, or became aware during the restraint, that HSO1 applied a neck restraint.

179. However, HSO Fitzgerald accepted he did observe HSO1 applying that technique. Notwithstanding that, he did not say anything to HSO1 about the application of that unauthorised technique. He knew the technique was unauthorised. Like HSO1he prioritised his own situation and safety over that of Mr Rangi.[101]

180. Furthermore, HSO Fitzgerald was in a position to observe and did observe Mr Rangi's face while he was being restrained around the neck by HSO1. He could hear gasping and gurgling and observed Mr Rangi's face to go

[100] T6-20.
[101] T5-101 to 5-103.

"deep red", signs which he knew indicated Mr Rangi was in distress. Despite that HSO Fitzgerald did not say anything to HSO1 to stop the restraint around the neck. His primary reason for not saying anything was that RN Shiju was at Mr Rangi's head observing him and thus he seemingly left it to her to raise any issue about Mr Rangi being in distress.[102]

181. Even taking into account the dynamic situation unfolding, it is submitted that HSO Fitzgerald should have raised the fact that Mr Rangi was in distress and that an unauthorised neck restraint was being applied to him with a view to ceasing the restraint at an earlier time. It was a concerning feature of the restraint that no one who was capable of and likely did see the knee pin and neck restraint being applied by HSO1, said anything about it at the time or sought to stop such techniques being imposed.

***(iii) the monitoring of the deceased during the physical restraint and immediately after;***

182. Two issues arise for consideration. First, the monitoring of Mr Rangi during the course of the physical restraint. Secondly, the monitoring of him when the restraint concluded.

183. With respect to the first matter, as discussed above, the absence of a designated response team leader meant that at least during the first phase of the restraint there was no person fulfilling the specific responsibility of protecting Mr Rangi's head and airway and monitoring his physical observations. That was, as noted above, contrary to the duress response procedure and the Hospital's OVP training.

184. After RN Shiju administered the injection she then by necessity, in the absence of a designated response team leader, assumed the role of monitoring Mr Rangi's airway, breathing, consciousness and body alignment.[103] Having assumed that role it is clear from the video evidence that RN Shiju spent the majority of the second phase of the restraint, which lasted approximately 60 seconds, at the head of Mr Rangi's body where she could observe his face and head. During that time she repeatedly told Mr Rangi to "relax" and "chill out" or words to that effect.[104]

185. It must have been obvious to RN Shiju given her lengthy experience as a Registered Nurse that he was physically distressed. The body-camera footage, which demonstrates what RN Shiju must have observed, shows clear signs of physical distress including gasping and gurgling by Mr Rangi. At no time did RN Shiju take steps to cease the second phase of the physical restraint. Likewise, she did not take any steps to attempt to direct HSO1 to

[102] T5-103 to 5-104.
[103] Exhibit C12.1 bottom of page 138 to the top of page 139 of 231.
[104] Ex B3.1 and the aide memoire transcript.

desist with the neck restraint of Mr Rangi a technique she must also have known was unauthorised pursuant to her OVP training.

186. I reject RN Shiju's assertion that she did not appreciate Mr Rangi's distress. I agree with Counsel Assisting that it is implausible that an experienced Registered Nurse of more than ten years in general nursing and 18 months as a mental health nurse would not have appreciated the physical distress Mr Rangi was plainly suffering. Likewise, I reject her evidence that when she did see discolouration happen in Mr Rangi's face she asked for the restraint to cease. She is not heard to raise any issue with the team members about Mr Rangi being in physical distress and the restraint needing to cease in the body-camera video evidence. Rather, it seems from the CCTV / bodyworn evidence that the decision to cease the restraint occurred because by that time Mr Rangi had been subdued.[105] By then Mr Rangi is plainly non-responsive.

187. The fact that RN Shiju did not properly monitor Mr Rangi during the second phase of the restraint, including her failure to identify the use of an unauthorised neck restraint, and to call for the restraint to be ceased earlier represented serious failings on her part. Nurse Shinju should never ever have been in that position in the first place, but at no time did she question RN Collier's absence or put a halt or pause proceedings. I am unware of what dynamics existed such that Nurse Shinju's was unable to question her predicament, and / or later Mr Rangi's predicament.

188. The second issue concerns the monitoring of Mr Rangi after the second phase of the physical restraint ceased.

189. The team withdrew The CCTV footage bears out (at 8.30.05) HSO1 leaning in for one last application of pressure to Mr Rangi by HSO1. He appears to lean in and apply body weight before releasing Mr Rangi.

190. Mr Rangi was left in a prone position with his left arm under his chin and his legs crossed at the ankles up against a fixed chair in the lounge area. That position was not a typical recovery position. As Dr Rothwell noted it would have made it hard for Mr Rangi to breathe properly. It was known to the staff involved in the restraint that Mr Rangi was obese and therefore the prone position in which he was left put him at additional risk.

191. When the team withdrew, no one remained directly with Mr Rangi to closely monitor his vital signs. The absence of someone assuming that role was contrary to the Chief Psychiatrist's physical restraint practice guidelines and physical restraint policy. The person who should have assumed that role as a continuation of having assumed the role (by – defacto) of monitoring Mr

[105] Ex B3.1 and the aide memoire transcript.

Rangi's vital signs and observations during the second phase of the restraint was RN Shiju.

***(iv) the training provided to those persons who performed, or were involved in, the physical restraint;***

192. The Hospital's OVP procedure required that all staff members employed by the Mental Health Service Group were required to have current OVP training. The staff members who worked in extreme risk areas such as the Mental Health Service Group were required to undergo an initial five core modules of training.[106] Thereafter staff members working in those extreme risk areas would undertake refresher training every 12 months. It was specifically modules 4 and 5 of that initial core training that dealt with team restrictive practices, i.e. the undertaking of a physical restraint of a patient.

193. All of the relevant staff members involved in Mr Rangi's restraint had undergone the initial core five modules of training. Save for CN Collier they were all otherwise current in relation to their OVP training having undertaken annual refresher training. Evidently CN Collier had not undertaken her annual refresher training because of the medical condition she suffered that meant she was on sick leave from February to May 2018. She was due to undertake her refresher training in May 2018.

194. While strictly speaking CN Collier was not OVP current, she did not suggest in her evidence that that was relevant, at least from her perspective, to any issues that arose in respect of the care of Mr Rangi. The currency of her OVP training is not likely to be relevant to the critical decision to acutely sedate Mr Rangi. It is not possible to say whether had she undertaken her annual refresher training in May 2018 that would have made any difference to the manner in which she undertook the briefing of the restraint team or her decision not to attend the restraint as the response team leader.

195. Save then for that issue, the persons involved in the physical restraint of Mr Rangi had received the appropriate training. Notwithstanding that fact, evidently, there were serious deficiencies in the manner in which the physical restraint was performed as identified above.

196. It is noted that the OVP training was in place as at the time of Mr Rangi's death has now been superseded. That matter is dealt with further below.

***(v) whether the restraint was performed in accordance with relevant policy and practice guidelines of the Chief Psychiatrist, Queensland***

[106] T3-85.

***Health and the Health Service's applicable policies, procedures and OVP training.***

197. For the reasons discussed above, the physical restraint of Mr Rangi was not performed in accordance with the relevant procedures of the Hospital, the policies of the Chief Psychiatrist or the Hospital's OVP training.

198. The critically fundamental aspects of non-compliance were:-
- The inadequate manner in which the briefing for the planned physical restraint occurred;
- The absence of a designated team response leader to monitor Mr Rangi during the course of the first phase of the physical restraint;
- The application of unauthorised restraint techniques including the application of direct pressure to Mr Rangi's head and neck;
- The restraint of Mr Rangi in the prone position during the second phase of the restraint;
- The failure to observe the indications of physical distress demonstrated by Mr Rangi and to escalate those concerns by way of ceasing the second phase of the restraint at an earlier time; and
- The absence of any direct monitoring of Mr Rangi's airway, breathing and consciousness immediately following the restraint.

***Coronial Issue 4 – Circumstances of Death: Adequacy of Post-Restraint Medical Treatment***

*In relation to the circumstances of the deceased's death, investigation and consideration of: -*

*(c) the adequacy and appropriateness of the medical treatment provided to the deceased after the physical restraint ceased, including:-*

*(i) the time taken to instigate such treatment;*

199. The opinion of Dr Rothwell, which should be accepted, is that the time taken to instigate Mr Rangi's resuscitation was adequate.[107] The time taken to instigate Mr Rangi's resuscitation is a different matter to the way in which he was left following the cessation of the second phase of the restraint and the absence of any direct clinical monitoring of him. Notwithstanding those matters though, there should be a finding that the instigation of the resuscitation was within an adequate time.

***(ii) the manner in which that treatment was carried out;***

200. Again, having regard to the evidence of Dr Rothwell, there should be a finding that the manner in which the attempted resuscitation of Mr Rangi was carried out was reasonable and appropriate. Those efforts involved a large

[107] Ex A6 page 5 and T6-46.

number of people. Dr Rothwell commended one of the leaders of that effort, Dr Segaran for his calm and supportive approach to a team who was mostly unknown to him.[108]

201. The resuscitative efforts were applied for approximately 32 minutes before being ceased when it was apparent that continued efforts would be futile. During the course of the resuscitation Mr Rangi's heart rhythm was always in asystole. In other words, his heart was never in a shockable rhythm such as to deploy the defibrillator. Given that fact, there was little prospect of the resuscitation efforts ever being successful. Regardless of that the team who attempted to resuscitate Mr Rangi did all they reasonably could and made every possible effort to save his life.

***(iii) whether there were any deficiencies in respect of the treatment carried out.***

202. Dr Rothwell did not identify any deficiencies in respect of the resuscitative efforts carried out. He noted in his report some areas for improvement, none of which, in his view, had any bearing on the outcome for Mr Rangi.

203. The only substantive issue that was raised concerned that of the position of the ETT. Dr Rothwell noted that by the time of autopsy the ETT was in the oesophagus rather than the trachea. The factual issue for determination is whether or not Dr Segaran inadvertently intubated the oesophagus as opposed to the trachea during the resuscitation.

204. Even if that had been the case, Dr Rothwell would not have been critical of Dr Segaran, because having inserted the ETT, he quite appropriately then took all reasonable steps to satisfy himself that it was correctly located.[109] Those steps included observing fogging of the ETT; the presence of breath sounds on auscultation of both sides of Mr Rangi's chest (a matter confirmed independently by another colleague) and the use of a portable capnometer to demonstrate the presence of carbon dioxide in expired breath.

205. Dr Rothwell noted in his evidence that those mechanisms by which the correct placement of an ETT in an emergency situation is checked can produce false positives. Thus, his view, that even if Dr Segaran had inadvertently intubated the oesophagus, having done what he did there was nothing further he reasonably could or should have done to check the placement. The only other means to check placement would be to carry out an x-ray which was not an option.

206. Furthermore, even if there had been inadvertent intubation of the oesophagus, that would not likely have made any difference to Mr Rangi's

[108] Ex A6 page 5.
[109] T6-50.

outcome given the fact that he was never in a shockable rhythm, i.e. he was always in asystole.[110]

207. Putting those matters aside though, the factual issue is whether Dr Segaran did inadvertently intubate the oesophagus during the resuscitation. Having regard to all the evidence I accept the submissions of Counsel Assisting and Counsel for the THHS that Dr Sagaran did **not** inadvertently intubate Mr Rangi's oesophagus during the resuscitation. All of the checks Dr Segaran performed to confirm the ETT was in the correct location were positive indicating correct placement in the trachea. Second, the ETT was not secured in place during the course of Mr Rangi's resuscitation by way of tie or tape. Rather it was held in place by a staff member. That was appropriate for the purposes of the resuscitation. It was not then secured after the resuscitation ceased. Thus it was entirely plausible that the unsecured ETT might migrate out of the trachea into the oesophagus during the course of the care and transport of Mr Rangi following his death.[111] Third, in the immediate aftermath of the cessation of the resuscitation, Dr Segaran looked again through the laryngoscope to satisfy himself that the ETT was in the correct position, which he says it was. Fourth, Dr Segaran presented as a careful, calm and highly competent medical practitioner which also well favours the likelihood that he did correctly place the ETT in the trachea.

208. I am comfortably satisfied that Dr Segaran correctly inserted the ETT into the trachea and that it subsequently migrated into the oesophagus after Mr Rangi's death.

209. I find that migration of the tube occurred after resuscitative efforts were concluded.

***Coronial Issue 5 – Deficiencies in Policies and Procedures***

*In relation to the circumstances of the deceased's death, investigation and consideration of:-*

*(d) whether there existed at the time any deficiencies in the Health Service's policies and procedures in respect of the physical restraint of patients.*

210. Having regard to the evidence as a whole, at the relevant time there were no specific deficiencies in the Health Service's policies and procedures in respect of the physical restraint of patients.

[110] T6-50 L25.
[111] T6-50 L30-40.

211. The deficiencies that arose were in the application of those policies and procedures, i.e. the lack of compliance (and in the case of the attempted figure 4 leglock, a lack of understanding) with them.

***Coronial Issue 6 – Recommendations***

> *In relation to the circumstances of the deceased's death, investigation and consideration of:-*
>
> *(e) whether any recommendations can be made to prevent a death in similar circumstances from happening in the future.*

212. Following Mr Rangi's death, the Health Service immediately engaged an external expert, Lisa Fawcett, to review the restraint policies, protocols, procedures and practices within the AAMHIU. Ms Fawcett did so and delivered a report on 31 July 2018.[112] The Fawcett Report identified the protocols and procedures of the Health Service were not outliers across the State, but there was inconsistent practice compliance with them; the importance of implementing the SafeWards model; there was a need for a review of restrictive practices and access to OVP training and management of the relationship between clinical and security staff. The Health Service considered the Fawcett Report recommendations and developed an action plan and progress report.[113]

213. Furthermore, on 7 September 2018, the Health Service approved a three stage investigation pursuant to Part 9 of the *Hospital and Health Boards Act* 2011 (Qld). That three stage investigation was completed by the time of the inquest. Stage one was the "Investigation into the Death of Mr Taare Rangi" the Stedman Report; stage two was the "Townsville Acute Adult Mental Health Service - Governance Report" the Lakra Report and stage three was the "Operational Management and Accountability Report" the Reid Report – in each case the reports named after the respective authors.[114]

214. Across the three reports a total of 45 recommendations were made all of which have been accepted by the Health Service.

215. It is clear for this that following Mr Rangi's death the Health Service has taken significant steps to investigate the circumstances and to seek out ways in which the risk of future deaths of a similar kind might be prevented, both at the level of the "coalface" as well as at a corporate governance level. The depth and breadth of the changes are described in the statement of Sharon Kelly, Executive Director of Corporate and Strategic Governance of the Health Service.[115] She also gave evidence and spoke to the changes. I am

[112] Ex C6.
[113] Ex C12.
[114] Ex C12 Annexure 8, C14 and C13.
[115] Ex D19.

satisfied that the changes address the issues identified by the various reviews.

216. The fact that the Fawcett Report together with the Stedman, Lakra and Reid Reports identified the need for a significant number of recommendations for change and improvement is, of itself, notable.

217. The comprehensive nature of the Health Service's investigations and external reports mean that there are a limited number of further recommendations that might be considered at the conclusion of Inquest.

218. Counsel Assisting submits that further considerations might include:

I. investigation / implementation of MAYBO training;
II. staff debriefing and ensuring police access to witnesses after relevant critical events;
III. completion of incident reports by staff and relevant witnesses (not supervisors who were not present at the event);
IV. incident reporting to describe restraints and use of force used;
V. use of force techniques to be documented restraint techniques not to include figure 4 leg-lock (or similar)

219. The THHS replaced previous OVP training program with the Management of Actual and Potential Aggression ("MAPA") program. The MAPA training program adopted by the Health Service since Mr Rangi's death is different to what it is understood is now being implemented in other Health Services in Queensland. According to the manager of the Queensland Occupational Violence Strategy Unit ("QOVSU") of Queensland Health it identified a training program known as MAYBO to be the standardised accredited OVP training across Queensland's public Hospital and Health Services.[116] The THHS took the view that the MAPA training was better than the MAYBO training.[117] It appears from the statement of Ms Griffiths that the intent of the QOVSU was to identify a standardised OVP training for implementation across all Queensland public Hospital and Health Services.[118] The rationale for standardised training is obvious.

220. I note that the QOVSU recommendations were made after implementation of MAPA and that Counsel for the THHS indicates in submissions that the THHS is willing to engage further in relation to adopting the most appropriate standard.

221. It may be appropriate for the Health Service to consider, in conjunction with the QOVSU, the continued application of the MAPA training program as opposed to the MAYBO program. At the very least, the QOVSU may wish

[116] Ex D18 para 13-18.
[117] T6-18 L45.
[118] Ex D18.

to consult with the Health Service and consider its reasons for preferring the MAPA training.

222. I am satisfied that the THHS is willing to consider any and all improvements in occupational violence training and development for staff and remain open to working with key stakeholders to ensure best practice. I do not intend to formalise a recommendation.

223. Second, concerns the Health Service's procedure deployed in circumstances of an unexpected death of a patient in the Mental Health Service Group – procedure THHSCLI100522v5 "Management of an Unexpected Death of a Consumer Mental Health Service Group (MHSG)".[119]

224. Debriefings for the purpose of ensuring staff wellbeing at the time / soon after a critical event are largely uncontroversial and an essential part of ensuring staff health and welfare, and discharging a duty of care to employees. In some cases the critical event may also potentially give rise to a police investigation. In this case by the time QPS were informed and arrived at the HDU all key witnesses had been sent home because the conclusion of the event also coincided with the end of the rostered shift.

225. There is value in forming a working group to develop guidelines that will ensure that staff briefings do not impact on a potential police investigation. It is essential that all understand their role and responsibility for preserving (potential) crime scenes and their rights insofar as assisting police, and to prevent the perception of any collusion between relevant witnesses or participants or stakeholders. [That is and was not the case in this matter].

226. I am not aware of such guidelines within a hospital and health setting. I will ensure that these findings are provided to Queensland Health to advise them of this potential gap in procedure. I do not intend to formalise a recommendation. I am confident such guidance by the relevant government department will be well received within a hospital and health setting.

227. The Health Service's practice of having incident reports initially prepared by persons who had only a peripheral involvement in an event. In this case, the evidence demonstrates that the initial draft of the incident report was prepared by the HSO Supervisor, Mr Pridmore.[120] Subsequently, it is understood that HSO Fitzgerald and HSO Beltramelli had input into the contents of that document. However, the practice of a person who was not intimately involved in the critical event, i.e. in this case the actual physical restraint of Mr Rangi, preparing an important document should be discouraged. It would be far better if the relevant critical personnel such as the HSO's prepared the incident report without any prior draft being prepared

[119] Ex D20 page 17 of 26.
[120] Ex C7.3 being Version 1 of the Incident Report said to have been prepared by Mr Pridmore.

by others. Best practice would also require contemporaneous reporting of critical incidents by witnesses, or participants to the event. I do not intend to formalise a recommendation.

228. As recommended by Senior Sergeant Hayden incident reporting documentation should be reviewed with a view to including fields within that documentation to record what use of force technique or tactic was attempted/applied. This may assist in more accurate statistical data being collected and allow an opportunity to analyse the frequency of use or effectiveness of certain use of force techniques or tactics.[121] Such a practice would also inform any internal and / or external reviews.

229. I strongly suggest that the Townsville Hospital ensure that any use of force tactics attempted or applied during restraint and acute sedation procedures be clearly documented within incident reports, and meaningfully described in such a way that the event can be clearly understood upon review. Accordingly I will advise Queensland Health of the identified gap, it may a common issue amongst health services and perhaps remedied by updates to incident reporting software.

230. In relation to the 'figure 4 leglock': The Health Service should ensure that whatever technique has replaced the "figure 4 leg lock" should not bring with it similar risks of injuries to patients or any unnecessary risk that can otherwise be avoided. I do not intend to make a formal recommendation noting the ongoing reviews in respect of occupation violence techniques undertaken by The Townsville Hospital I am satisfied such considerations have been undertaken.

## Further considerations (Referrals)

231. The final matter for consideration is the referral requirements provided for in s.48 of the Act, which states:-

> ***48 Reporting offences, corrupt conduct or police misconduct***
>
> *(1) A reference in this section to information does not include information obtained under section 39(2).*
>
> *(2) If, from information obtained while investigating a death, a coroner reasonably suspects a person has committed an offence, the coroner must give the information to—*
>
> *(a) for an indictable offence—the director of public prosecutions; or*

[121] Ex B1 page 22 of 26.

*(b) for any other offence—the chief executive of the department in which the legislation creating the offence is administered.*

*(3) A coroner may give information about corrupt conduct or police misconduct under the Crime and Corruption Act 2001 to the Crime and Corruption Commission.*

*(4) A coroner may give information about a person's conduct in a profession or trade, obtained while investigating a death, to a disciplinary body for the person's profession or trade if the coroner reasonably believes the information might cause the body to inquire into, or take steps in relation to, the conduct.*

*(5) In this section— disciplinary body for a person's profession or trade means a body that—*

*(a) licenses, registers or otherwise approves the carrying on of the profession or trade; or*

*(b) can sanction, or recommend sanctions for, the person's conduct in the profession or trade.*

232. In this case consideration arises in respect of both s.48(2) and s.48(4) of the Act.

233. It should be recalled that pursuant to s.48(1) of the Act the court cannot consider information obtained under s.39(2) of the Act in determining whether a reasonable suspicion or belief exists. That is relevant only so far as the evidence given by HSO1 under compulsion.

234. There are important differences between s.48(2) and s.48(4) of the Act.

235. For the former, the court must give the information obtained while investigating a death to the Director of Public Prosecutions if there is a "reasonable suspicion" a person has committed an offence. The referral requirement is thus mandatory once that threshold of "reasonable suspicion" exists.

236. In the event a referral is made under s.48(2) of the Act it should be emphasised that it is the role of the Director of Public Prosecutions to determine whether charges should be brought and any such referral is **not** a finding against the person in question that they are or may be guilty of an offence or civilly liable for something.[122]

237. In contrast, s.48(4) of the Act provides for a discretionary referral of information obtained, while investigating a death, about the conduct of a person in a profession or trade to their respective disciplinary body if the court "reasonably believes" the information might cause that body to inquire

[122] See s.45(5) of the Act.

into or take steps in relation to the conduct. Thus, there is a discretion that exists in respect of any referral and the threshold for such a referral is one of reasonable belief as opposed to reasonable suspicion.

238. The distinction between reasonable suspicion and reasonable belief is well settled. In each case a factual basis for the suspicion or belief must exist. The facts which can reasonably ground a suspicion may be quite insufficient reasonably to ground a belief, yet some factual basis for the suspicion must be shown.[123] Furthermore, suspicion, has been held in its ordinary meaning to be a state of conjecture or surmise where proof is lacking: "I suspect but I cannot prove".[124]

239. In addition, with respect to the notion of suspicion, in *George v. Rockett* (1990) 170 CLR 104 at 115, in a unanimous joint judgment of the High Court, the following statement by Kitto J in *Queensland Bacon Pty Ltd v. Rees* (1966) 115 CLR 266 at 303 was cited with approval:-

> "*A suspicion that something exists is more than a mere idle wondering whether it exists or not; it is a positive feeling of actual apprehension or mistrust, amounting to 'a slight opinion, but without sufficient evidence', as Chambers's Dictionary expresses it. Consequently, a reason to suspect that a fact exists is more than a reason to consider or look into the possibility of its existence.*"

240. The threshold for reasonable suspicion is a low one.[125] That is perhaps understandable given the provision merely provides for information to be provided to the DPP with the decision whether to charge being made solely and independently by it.

241. With respect to the question of what constitutes reasonable belief as opposed to reasonable suspicion, in *George's Case* the Court said:-

> "*The objective circumstances sufficient to show a reason to believe something need to point more clearly to the subject matter of the belief, but that is not to say that the objective circumstances must establish on the balance of probabilities that the subject matter in fact occurred or exists: the assent of belief is given on more slender evidence than proof. Belief is an inclination of the mind towards assenting to, rather than rejecting, a proposition and the grounds which can reasonably induce that inclination of the mind may, depending on the circumstances, leave something to surmise or conjecture.*"

242. Thus is it can be seen that the threshold for reasonable belief is higher than that of reasonable suspicion, but still relatively low.

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[123] *George v. Rockett* (1990) 170 CLR at 115.
[124] Ibid at 115.
[125] See the State Coroner's Guidelines 2013, Chapter 9 – Section 9.13, page 24.

## Referral to the DPP – s.48(4)

243. Referral under s.48(2) of the Act potentially arises in respect of the conduct of HSO1.

244. I am satisfied that HSO1 should be referred to the ODPP as I have formed a reasonable suspicion that an offence has been committed by virtue of:

    a. the application of a knee pin to the head;
    b. the application of a neck restraint upon Mr Rangi.

245. Having regard to the evidence of Senior Staff Forensic Pathologist Dr Botterill, HSO1's neck restraint of Mr Rangi was a substantial or significant cause of his death.

## Referral to Professional Body – s.48(4)

246. With respect to the potential for referral under s.48(4) of the Act, it is submitted that arises for consideration in respect of the conduct of CN Collier and RN Shiju.

247. In considering that prospect, pursuant to s.160 of the *Health Practitioner Regulation National Law (Qld)* ("the National Law") a National Board may investigate a registered health practitioner in a health profession for which the Board is established, if it decides it is necessary or appropriate, inter alia, because the Board for any reason believes the way the practitioner practices the profession is or may be unsatisfactory or the practitioner's conduct is or may be unsatisfactory.

248. In that regard, "unsatisfactory professional performance" of a registered health practitioner is defined to mean that the knowledge, skill or judgment possessed, or care exercised by, the practitioner in the practice of the health profession in which the practitioner is registered, is below the standard reasonably expected of a health practitioner of an equivalent level of training or experience.[126]

249. With respect to CN Collier, I am satisfied and have formed a reasonable belief that the information obtained while investigating Mr Rangi's death might cause her National Board to inquire into or take steps in relation to her conduct on the basis that it potentially amounted to unsatisfactory professional performance.

250. The specific factual basis for such a reasonable belief to exist is as follows:-

[126] See s.5 of the National Law.

- The decision to acutely sedate Mr Rangi in circumstances where it was not clinically warranted to do so;
- The manner in which the briefing for the planned physical restraint was given by CN Collier as the team leader of the HDU and the person who had organised the team of nurses and HSOs to implement her decision to acutely sedate Mr Rangi;
- The decision by CN Collier not to attend the administration of the intramuscular injection and physical restraint of Mr Rangi, if required, as the response team leader such that there was an independent senior nurse present to monitor Mr Rangi's airway and breathing in the event a restraint was necessary and to otherwise direct and supervise the restraint.

251. With respect to RN Shiju, I am satisfied and have formed a reasonable belief that her National Board might also consider the information obtained while investigating Mr Rangi's death sufficient to inquire into or take steps in relation to her conduct in respect of potential unsatisfactory professional performance.

252. The specific factual basis for such a reasonable belief to exist is as follows:-
- For not independently assessing that the restraint team was compromised by the foreshadowed absence of team leader CN Collier and averting the intended course until the roles and responsibilities had been allocated in accordance with relevant policy and procedure;
- Dismissing Mr Rangi's request to consult with a medical practitioner about the proposed intramuscular injection immediately prior to the physical restraint;
- Not directing the restraint to be ceased, particularly in circumstances where Mr Rangi was being restrained around the neck in the second phase;
- The manner in which Mr Rangi was monitored during the restraint, specifically during the course of the second phase of the restraint, including not recognising that he was physically distressed;
- The absence of close monitoring of Mr Rangi immediately following the cessation of the restraint.

253. While the power to make a referral under s.48(4) of the Act is discretionary, it is submitted that having regard to the nature of the conduct described above and the outcome, it is appropriate for that power to be exercised in respect of both CN Collier and RN Shiju.

254. I take into account the submissions of Ms Robb Counsel for Nurse Collier and Shinju who advocates on their behalf that it is unnecessary to make such a referral when the relevant Board (AHPRA) has already received a referral and is investigating each nurse. Notwithstanding those submissions,

I intend to exercise my discretion to refer. It is a matter for APHRA whether a separate investigation is conducted or whether this referral will form part of the current investigation.

## Findings required by s. 45

**Identity of the deceased** – Taare Tamakehu Rangi

**How he died** – The deceased was admitted to the HDU of the Adult Acute Mental Health Inpatient Unit of the Townsville Hospital late on the evening of 6 July 2018 following a relapse of his previously diagnosed bipolar affective disorder. He was placed on a Treatment Authority under the *Mental Health Act 2016* (Qld). On the evening of 7 July 2018 a decision was made to acutely sedate the deceased primarily because he had declined his regular and PRN prescribed medications. That resulted in a physical restraint of the deceased for the purposes of administering an intramuscular injection, during which he suffered a cardiac arrhythmia and died despite resuscitative efforts.

I find that it was not necessary to administer either regular or PRN medication to Mr Rangi at the time. Administration of his regular medication was delayed in order to obtain results of blood test and administration that evening would not have taken effect for some days (with regular recommended dose). I find that the administration of PRN medication by way of restraint (acute sedation) at the relevant time was not clinically indicated. Mr Rangi was not agitated, threatening violence, actually violent, or a danger to himself or others. Immediately prior to the restraint Mr Rangi demonstrated an extended period of calm, he was not agitated, he appropriately engaged when approached by two other persons preceding the event, he was not triggered or reactionary in any way. Any escalation in Mr Rangi's behaviour was not an unexpected response to being encircled by six staff members. By doing so staff increased Mr Rangi's suffering and physical distress and created the very situation they say they were trying to de-escalate and manage. Nurse Collier's decision to administer PRN IM medication by way of restraint was a serious

and fundamental error of judgement or her part. I formed a view that Nurse Collier's decision to authorise administration of PRN IM sedation was for convenience and made without her independently assessing the veracity of the claims reported to her about Mr Rangi. It was convenient that Mr Rangi be sedated and settled for the night, lest he cause potential trouble. The sedation was pre-emptive and did not fit within any of the prescribed relevant official guidelines. Nurse Collier's decision to then leave the team she had assembled to do her bidding was also a serious and fundamental error of judgement. The restraint team were left without clear direction, clear purpose, and most importantly a senior nurse appointed solely to monitor the Mr Rangi's airway. The unsound decision to send in Nurse Shinju to both administer the injection and then attend to monitoring the airways without preparing Nurse Shinju was contrary to all best practice and caused confusion amongst the restraint team who were initially unaware of Nurse Colliers absence. Nurse Shinju was ineffectual in her attempts to convince Mr Rangi to comply. Mr Rangi asked to speak to the doctor who authorised the medication and was refused. HSO Beltramelli sensing Nurse Shinju's ineffectiveness stepped in to take over the negotiation, an action that ultimately precipated Mr Rangi's takedown. The restraint procedure was not conducted in a way that complied within OVP training or any of the relevant protocols. Mr Rangi exhibited a number of clinical risk factors for restraint. HSO1 deployed a knee pin to the head of Mr Rangi, followed by a lateral vascular restraint, neither technique was taught or sanctioned by the Townsville Hospital and Health Service. Mr Rangi suffered an arrhythmia as result of the restraint. The compression of Mr Rangi's neck during the restraint, the fear and stress he would have experienced during the restraint, his obesity and enlarged heart were contributory to death.

**Place of death** – The HDU of the Adult Acute Mental Health Inpatient Unit of the Townsville Hospital located at 100 Angus Smith Drive, Townsville in the State of Queensland.

**Date of death** – 7 July 2018

**Cause of death** - Cardiac arrythmia during physical restraint.

## Acknowledgements

255. I take this opportunity to acknowledge and thank Counsel Assisting this inquest Mr Andrew Luchich, Ms Gallagher, Ms Robb, Ms Cooper, Mrs Grant, Ms FitzGerald and Mr Mumford and their instructors for their careful consideration of these difficult matters, for their comprehensive written submissions, for their professionalism and for the sensitive manner in which they have referred to, and dealt with Mr Rangi's family.

256. I acknowledge that the repeated viewing of distressing visual footage of Mr Rangi's last moments, often in slow motion, to ensure all witnesses had an opportunity to respond in evidence, no doubt had an affect on all in the courtroom, and recommend ongoing support deal with any such vicarious trauma if required.

257. I acknowledge where deaths of involuntary patients in mental health units within our hospitals, there is an essential public interest to ensure transparency and rigor when investigating the circumstances.

258. The Townsville Hospital leadership and management team responded promptly and appropriately to Mr Rangi's death. The Executive were not initially accurately informed of Mr Rangi's non aggressive presentation and subsequently delivered preliminary news to Mrs Rangi that her son had been aggressive prior to his death. As the true state of the circumstances were revealed the Executive, under the hand of the CEO wrote to Mrs Rangi after the inquest apologising for their error.

259. I am left in no doubt that that the Townsville Hospital, the Executive and all staff, with particular reference to the restraint team involved, were deeply shocked, distressed and affected by Mr Rangi's death. As much was obvious during the oral evidence of staff at all levels.

260. All Mental Health patients specifically those who are admitted pursuant to an involuntary treatment order are among the most vulnerable persons in society.

261. I trust that the public hearing into the circumstances surrounding Taare Rangi's death both reassures the public and Taare's family that our society places value on all life, the marginalised, the ill and those who at law are not deemed fit to make decisions for themselves and are reliant on the greatest care and respect from our health system.

262. I extend my sincerest condolences to Taare Rangi's family – his mother Mrs Gail Rangi, his father Mr Drage Rujanoski, and all those who cared deeply for Taare. I was left in no doubt that his family will take some

considerable time to integrate the circumstances surrounding his death. We all wish them well in their healing.

263. I close the inquest.

Nerida Wilson
Northern Coroner
CAIRNS
29 June 2020