OFFICE OF THE STATE CORONER

FINDING OF INQUEST

CITATION:	**Inquest into the death of Sparka Isarva HUNTINGTON aka James Philip Huntington**
TITLE OF COURT:	**Coroner's Court**
JURISDICTION:	Brisbane
FILE NO(s):	COR/03 2193
DELIVERED ON:	01 June 2007
DELIVERED AT:	Brisbane
HEARING DATE(s):	26 May 2006, 17-21 July 2006, 31 July 2006 & 01 September 2006
FINDINGS OF:	Mr Michael Barnes, State Coroner
CATCHWORDS:	**CORONERS: Inquest, restraint of mental health patients.**

REPRESENTATION:

Counsel Assisting:	Ms Jennifer Rosengren
Next of Kin:	Ms Catherine Morgan (instructed by Legal Aid)
Queensland Health:	Mr James McDougall (instructed by TressCox Lawyers)
Senior Constable	Kylie Bruce,
Senior Constable	Nathan Wright,
Constable	Michael Joseph Augustine,
Sergeant	John Charles
Bateson & Constable	Ken Olsen
Mr Glen Cranny	(Gilshenan & Luton Lawyers)
Commissioner of Police QLD:	Mr Liam Burrow (QPS Solicitors)
Office of Public Advocate:	Ms Kathleen Dare (Public Advocate)
Registered Nurse	Antoinette Pereira,
Registered Nurse	Peter Lopes &
Registered Nurse	Christopher Scibisz:
Mr John Allen	(instructed by Roberts & Kane Solicitors)
Dr Purse Tucker	
Ms Stephanie Gallagher	(instructed by Minter Ellison Lawyers)

Findings of the Inquest into the death of Sparka Isarva Huntington

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The *Coroners Act 2003* provides in s45 that when an inquest is held into a death in custody, the coroner's written findings must be given to the family of the person who died, each of the persons or organizations granted leave to appear at the inquest and to various specified officials with responsibility for the justice system including the Attorney-General and the Minister for Corrective Services. These are my finding in relation to the death of Sparka Isarva Huntington. They will be distributed in accordance with the requirements of the Act.

Introduction

On 14 December 2003, Mr Huntington was an involuntary patient in the mental health unit of the Logan Hospital. As a result of his being perceived to be a threat to the safety of staff and other patients it was decided to place him in a "seclusion room" until the medication that was to be administered sufficiently sedated him. Mr Huntington resisted efforts to move him and a violent struggle with hospital security officers and nurses ensued. Police were called to assist. Soon after one of the officers handcuffed Mr Huntington, it became apparent that he was unconscious. Efforts to revive him failed and Mr Huntington died.

These findings explain how that occurred and consider whether the actions of hospital staff caused or contributed to the death and whether changes to hospital policies or procedures could reduce the likelihood of similar deaths occurring in future.

The Coroner's jurisdiction

Before turning to the evidence, I will say something about the nature of the coronial jurisdiction.

The basis of the jurisdiction

In some cases, immediately after a death occurs, it can be difficult to determine which category of "reportable death" it may fall into. Obviously if there is any doubt, a death should be reported to a coroner so that inquiries can be made to settle that issue. Mr Huntington's death was reportable to a coroner on a number of bases; it was an unnatural death that happened in suspicious circumstances; as he was an involuntary patient under the *Mental Health Act 2000* it was a death in care and because he was handcuffed by police around the time of his death it may have been a death in custody.[1]

An inquest must be held into a death in custody[2] and a death in care if the circumstances raise issues about the deceased person's care.[3] An inquest may be held at the discretion of the investigating coroner in the case of any other reportable death.[4]

[1] See s8, s9 and s10
[2] s27(1)(a)(i)
[3] s27(1)(a)(ii)
[4] s28

The scope of the Coroner's inquiry and findings

A coroner has jurisdiction to inquire into the cause and the circumstances of a reportable death. If possible he/she is required to find:-

- whether a death in fact happened;
- the identity of the deceased;
- when, where and how the death occurred; and
- what caused the person to die.

There has been considerable litigation concerning the extent of a coroner's jurisdiction to inquire into the circumstances of a death. The authorities clearly establish that the scope of an inquest goes beyond merely establishing the medical cause of death but as there is no contention around that issue in this case I need not examine those authorities here with a view to settling that question. I will say something about the general nature of inquests however.

An inquest is not a trial between opposing parties but an inquiry into the death. In a leading English case it was described in this way:-

> *It is an inquisitorial process, a process of investigation quite unlike a criminal trial where the prosecutor accuses and the accused defends… The function of an inquest is to seek out and record as many of the facts concerning the death as the public interest requires.* [5]

The focus is on discovering what happened, not on ascribing guilt, attributing blame or apportioning 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. As a result, the Act authorises a coroner to make preventive recommendations concerning public health or safety, the administration of justice or ways to prevent deaths from happening in similar circumstances in future.[6] However, a coroner must not include in the findings or any comments or recommendations statements that a person is or maybe guilty of an offence or is or may be civilly liable for something.[7]

The admissibility of evidence and the standard of proof

Proceedings in a coroner's court are not bound by the rules of evidence because s37 of the Act provides that the court "*may inform itself in any way it considers appropriate."* That doesn't mean that any and every piece of information, however unreliable, will be admitted into evidence and acted upon. However, it does give a coroner greater scope to receive information that may not be admissible in other proceedings and to have regard to its provenance when determining what weight should be given to the information.

This flexibility has been explained as a consequence of an inquest being a fact-finding exercise rather than a means of apportioning guilt: an inquiry rather than a trial.[8]

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[5] *R v South London Coroner; ex parte Thompson* (1982) 126 S.J. 625
[6] s46
[7] s45(5) and 46(3)
[8] *R v South London Coroner; ex parte Thompson* per Lord Lane CJ, (1982) 126 S.J. 625

A coroner should apply the civil standard of proof, namely the balance of probabilities, but the approach referred to as the *Briginshaw* sliding scale is applicable.[9] This means that the more significant the issue to be determined, the more serious an allegation or the more inherently unlikely an occurrence, the clearer and more persuasive the evidence needed for the trier of fact to be sufficiently satisfied that it has been proven to the civil standard.[10]

It is also clear that a coroner is obliged to comply with the rules of natural justice and to act judicially.[11]This means that no findings adverse to the interest of any party may be made without that party first being given a right to be heard in opposition to that finding. As *Annetts v McCann*[12] makes clear that includes being given an opportunity to make submissions against findings that might be damaging to the reputation of any individual or organisation.

The investigation

The police officers who were present at the time of the death immediately secured the scene and separated the potential witnesses by asking them to remain in separate interview rooms until they could be spoken to.

Detectives, scenes of crime officers and a police photographer attended, as did the director of the forensic medicine unit.

On the evening of the death, after giving very brief versions of what transpired, hospital staff declined to be interviewed. Subsequently, the investigating officers were advised that a firm of solicitors retained by the hospital would provide statements. These were not finalised until August 2004. In the case of one of those statements I am concerned that relevant information was intentionally omitted. This is yet another example of hospital staff failing to adequately co-operate with the investigation of a hospital death as a result of interference by their union or hospital lawyers. Henceforth, I intend exercising the powers contained in the *Coroners Act 2003* to ensure that these investigations are not obstructed.

An investigation report was prepared by Detective Sergeant Thiesfield. It was of a high standard and I have relied on it significantly when summarising the evidence for the purpose of these findings.

The inquest

A pre-hearing conference was held in Brisbane on 26 May 2006. Ms Rosengren was appointed Counsel Assisting. Leave to appear was granted to Mr Huntington's mother, Queensland Health, the Commissioner of the Queensland Police Service, the police officers involved in restraining Mr

[9] *Anderson v Blashki* [1993] 2 VR 89 at 96 per Gobbo J
[10] Briginshaw v Briginshaw (1938) 60 CLR 336 at 361 per Sir Owen Dixon J
[11] *Harmsworth v State Coroner* [1989] VR 989 at 994 and see a useful discussion of the issue in Freckelton I., "Inquest Law" in *The inquest handbook*, Selby H., Federation Press, 1998 at 13
[12] (1990) 65 ALJR 167 at 168

Huntington and the Public Advocate. A list of witnesses was settled and the issues to be examined during the inquest was agreed upon.

The oral evidence was heard over seven days on 17 to 21 July, 31 July and 1 September 2006. Victim impact statements of Mr Huntington's sister and de facto partner were tendered along with 129 other exhibits. Twenty one witnesses were called to give evidence. Mr Huntington's mother, two sisters and de facto partner were present in court for the duration of the hearing.

The evidence

I turn now to the evidence. Of course I cannot even summarise all of the information contained in the exhibits and transcript but I consider it appropriate to record in these reasons the evidence I believe is necessary to understand the findings I have made.[13]

Background

Family history

Sparka Huntington was born on 9 July 1972 at Port Moresby, Papua New Guinea. He was the youngest of the three children of Kaia Makao and Gabriel Aisi Tou. Prior to the birth of the deceased, Mr Tou left the family home and had nothing to do with the raising of the family.

In 1974, Kaia met and married Raymond Huntington. Approximately three months after the marriage, Mr and Mrs Huntington and one of Sparka's sisters, Tonni Frood moved to Australia. The deceased remained in Papua New Guinea where he was cared for by his mother's older brother until 1975 when he moved to Australia and lived with his sister Tonni, his mother and her husband. In 1982, the family moved to Morwell, Victoria. In 1983, Sparka's other sister, Karen, came to live with the family.

In 1988, Mr and Mrs Huntington separated and she moved to Brisbane. For a time, the three children continued to living with their strep father in Morwell.

Sparka was 16 years old at the time and working at the local abattoir. His sister Tonni says Sparka seemed to be coping well; he had friends from school and from his work. When Tonni rented a flat in Morwell, Sparka moved in with her.

Around 1990, the deceased moved to Brisbane to live with his mother in Woodridge. He worked for a time at the Dinmore meat works but the mental health problems detailed below made this employment only sporadic.

Sparka Huntington had two children; a daughter Moale (now 12 years old) and a son, Joshua (now 9 years old).

[13] I readily acknowledge that in drafting these findings I have relied heavily on the investigation report of Detective Sergeant Thiesfield which I found to be of a high quality and of great assistance.

He was in a de facto relationship with Melody Unmeopa at the time of his death.

According to his sister Tonni, Sparka had loving and supportive relationships with his extended family. Ms Frood says that her brother was very gentle and that she had never seen him act violently towards anyone. She referred to him as a joker and very generous soul. It must be said that Mr Huntington's criminal history, which includes numerous convictions for violent crimes, is not consistent with this assessment.

Sparka did not like his Papuan name and frequently called himself James Phillip Huntington or combinations of those names.

Medical history[14]

In early 1988, when he was 16, Mr Huntington first exhibited signs of mental illness. Ms Frood recalls that he was drinking heavily at a party and deliberately cut his throat with a knife. He was admitted to the Hobson Park Psychiatric Hospital for about 2 weeks. Mr Huntington was assessed as suffering from paranoid schizophrenia. He was obviously very ill; while in hospital he tried to gouge out one of his eyes with a spoon. He had approximately 20 admissions in the years following this initial episode.

In 1990 he came to Brisbane to live with his mother but was soon after admitted to the John Oxley Memorial Hospital and then the Wolston Park Hospital following the commission of various offences. He was there assessed as suffering from hebephrenic schizophrenia.

Mr Huntington committed more offences in 1993; on each occasion he was assessed by the Mental Health Tribunal as being unfit to stand trial and was detained on a forensic order.

His condition was variously described as "*schizoaffective disorder, manic type"* and "*disorganised schizophrenia*." A Dr Young reported in 1998 that Mr Huntington's illness was longstanding with acute exacerbations especially after drug use and it was characterised by elevated mood, impulsivity, confusion, and delusions and hallucinations. In the same year, a Doctor Brown, reported that the deceased had suffered from a manic depressive psychosis for the past nine years.

Criminal/forensic mental health history

A criminal history dating back to 1990 documents that the deceased had been charged with numerous offences that include, indecent assault on an adult, indecent behaviour, resist arrest, indecent treatment of child, ill treatment of children, aggravated assault, stealing, wilful damage, unlawful on premises/trespass, possession of drugs, shop stealing, fare evasion, drink driving, unlicensed driving, disorderly conduct and resist arrest. It seems that

[14] This summary is almost certainly far from accurate as it relies on Queensland Health records which are apparently incomplete, not kept in a logical order and are, in some parts, illegible.

despite this lengthy history, Mr Huntington was never imprisoned as when he was charged with serious offences he was assessed by the Mental Health Tribunal (MHT) as being unfit to stand trail. For more minor matters he was fined or undertook community service.

In 1993 he became subject to a forensic order when the MHT found him to be of unsound mind in relation to a number of offences. He was ordered to be detained in the John Oxley Memorial Hospital. In July 1994 he first presented at the Logan Hospital for a short admission. His whereabouts thereafter became unknown for a long period of time but it was later reported that he spent five months in John Oxley Memorial Hospital.

In October of 1994 the Patient Review Tribunal (PRT) granted him leave at the discretion of his treating psychiatrist and the Director of Mental Health ordered the transfer of his care to the Logan Mental Health Service.

In February 1998 Mr Huntington became the subject to another forensic order when the MHT found him to be of unsound mind in relation to further criminal charges. The order again required him to be detained at the John Oxley Memorial Hospital.

A month later, the PRT granted Mr Huntington leave on the usual conditions, namely that his accommodation circumstances be approve by his case manager, that he attend appointments as directed and that he accept medication as prescribed. Subsequently, at six monthly intervals his forensic order was confirmed and he was allowed leave on the standard limited community treatment conditions.

In the years following Mr Huntington would generally comply with the conditions of his order for a time and then relapse due to illicit drug use and the failure to regularly use his prescribed medication. His community leave would then be revoked and he would become an inpatient for as long as it took for Mr Huntington's condition to stabilise.

This sequence of events was repeated in the months prior to his death. Mr Huntington's limited community treatment order was revoked on 18 September 2003 when Mr Huntington failed to attend his 6 monthly review. It was also revoked because he was not always living at his given address and it was thought he was probably using illicit drugs and was a danger to the community. At the time Dr Leivesley was his treating psychiatrist and in a report to the Tribunal he expressed the view that Mr Huntington's "*dangerousness remained moderately high and that he had not been attending appointments."*

The effect of the revocation of the community treatment order was that Mr Huntington was required to return and remain in the nominated authorised mental health service, namely the Logan Hospital. Staff at the hospital sent the necessary documentation to the local police on 29 September and Mr Huntington was brought to the hospital where he was assessed as being of high risk of violence and of absconding. Despite the assessment Mr

Huntington was not placed in a locked ward and he absconded from the hospital the next day.

Hospital staff again prepared the necessary documentation to authorise police to locate Mr Huntington and return him to the custody of the mental health service. It was faxed to the Beenleigh Police Station. I have no evidence of what action was taken in relation to this notice but it is apparent that it was not given effect to.

The events leading up to the death

Mr Huntington returns to the Logan Hospital

On 6 December 2003, Clinical Nurse Antoinette Pereira was rostered night shift in Ward 2C. At about 10 o'clock Mr Huntington presented himself at the mental health unit and advised that his community leave had been revoked and that his forensic order therefore required that he be admitted.

Clinical Nurse Pereira knew Mr Huntington from previous admissions and considered that he was not displaying overt symptoms of psychosis; he admitted to the use of ecstasy and intravenous amphetamines and in accordance with standard practice she arranged for the on call psychiatric registrar, Doctor Barkley, to assess him. Accordingly, Mr Huntington was admitted to an open ward at approximately 11.30pm.

Dr Barkley spoke with Mr Huntington at about midnight and ordered that he be given 40mg of Zuclopenthixol intramuscularly and 10mg of Diazepam orally. Dr Barkley apparently had very limited experience in caring for psychiatric patients. It seems he ordered the drugs and doses as a result of being told by the patient that these were his usual medications because Mr Huntington's current records were held by the Logan Community Mental Health Unit and they were not accessible to the hospital doctors out of business hours.

Clinical Nurse Pereira reviewed the medical chart in preparation for giving the drugs ordered and noticed that the Zuclopenthixol was far less than the usual dose of between 200-400mg. She queried Dr Barkely about this. He accepted her advice that it was an inappropriate dose and requested that the Zuclopenthixol not be given pending reconsideration of the medication needs of Mr Huntington the following day when his community mental health records could be accessed.

Nurse Pereira administered 10mg of Diazepam. During this time Mr Huntington was demanding and somewhat intimidating but he settled after being give the Diazepam. He then had some food and went to bed without further incident.

Mr Huntington absconds

The next day at about 3.15 in the afternoon, a female mental health patient alleged that the deceased had demanded sex from her. It later transpired that he had allegedly seriously sexually assaulted the woman. Because of this allegation, Mr Huntington was told that he could not enter Ward 2B where the

victim was staying. At this he became extremely hostile and aggressive and threw a basketball at a nurse. Security was notified but before any action could be taken Mr Huntington left the hospital.

Police bring him back

A warrant was issued and at approximately 10:00am on 8 December, police located the deceased and he was returned to Ward 2C.

Dr Davies, the director of the mental health service, says that as a result of being told of the revocation of the community treatment order and the allegation of sexual assault he determined that if Mr Huntington was to return to the hospital he was to be kept in the medium secure Acute Observation Area (the AOA) while efforts were made to find a bed for him in a more secure facility. It was also decided that he would be "*specialled*"; that is two nurses would take turns in exclusively monitoring Mr Huntington.

Mr Huntington absconds (again)

However, at the time Dr Davies and the treating team made this decision, Mr Huntington had already been brought back to the hospital and he was not taken to the AOA because there were no beds available there. He therefore remained in 2C and as this is an open ward, at approximately 3:00pm, approximately five hours after police had brought him back to the hospital, Mr Huntington again absconded by simply walking away.

Dr Davies also says that in the following days he discussed with the Acting Director of Mental Health Services and the Director of the Park medium secure mental health facility, the need for Mr Huntington to be detained in such a facility in preference to the mental health unit at the Logan Hospital. He was told that there were no beds available at the Park.

Mr Huntington returns (again)

On 14 December 2003, Pereira was rostered to work an afternoon shift in Ward 2C and was assigned to be in charge of the AOA. During the handover with morning staff, Pereria was advised that the deceased had returned to the hospital of his own volition at about 1.00pm. In accordance with the care plan referred to earlier, he was taken to the AOA. Registered Nurse Christopher Scibisz and Enrolled Nurse Keith Staite were assigned the duty to look after the deceased in the AOA on an hourly rotating basis.

At approximately 2.45pm, Doctor Anthony Tie, the junior on call psychiatric registrar arrived at the mental health unit. Dr Tie says he spoke to nursing staff about the deceased and was informed that there were no immediate concerns about him, but they did have concerns about the treatment of two other patients in ward 2C. Dr Tie therefore attended to those patients.

As he was completing that work, one of the nurses informed him that Mr Huntington was '*getting toey'*. Dr Tie therefore went into the living/lounge area of the AOA and sat with Mr Huntington on a sofa to undertake a mental state assessment. Dr Tie says that from the outset Mr Huntington did not seem to want to co-operate with the process and simply kept demanding that

he be given 40mg of his depot medication Zuclopenthixol. Mr Huntington became increasing verbally aggressive and intimidated Dr Tie. A number of the nurses witnessed this conflict. Nurse Pereira says she heard Mr Huntington say that if he wasn't given the medication he was demanding he would kill Dr Tie.

Dr Tie says that due to the deceased's lack of cooperation he abandoned the review and walked towards the nurses' station. Mr Huntington followed him and despite being told by a nurse that he was not allowed to enter the office he pushed past and went in, sat down, refused repeated requests to leave and continued to demand the medication. Nurse Pereira and the other nurse present in the office support Dr Tie's account. They also agree that it was decided to give Mr Huntington only 40 mg of his depot medication even though his usual was dose was 200mg in an effort to de-escalate the situation.

After the administration of the 40mg of Zuclopenthixol Mr Huntington demanded he also be given his usual sedative Valium. Dr Tie gave evidence that even though he felt that the situation was dangerous and that Mr Huntington was a risk to those present he was not prepared to give him the sedatives as that might reinforce the inappropriate behaviour Mr Huntington was exhibiting. This approach to the dangerous situation is rather strange and a vastly more experienced psychiatrist gave evidence that she would have given the drug - that its sedating effects could have helped. However, it can not be demonstrated that had Mr Huntington been given the sedatives he was demanding, the violence that followed would have been avoided.

As it was, the deceased remained in an angry and aggressive mood and continued to direct threatening comments towards Dr Tie. Nurse Scibisz recalled the deceased saying *"I am going to get you, watch your back."*

At some stage during this interaction, Nurse Pereria surreptitiously pushed the duress alarm. This alarm was audible throughout the mental health unit and the security officers' station. It caused many of the nurses working in the other two mental health wards to rush to the doorway of the AOA. Nurse Pereira seems to think this happened after Mr Huntington had been given the Zuclopenthixol but as some of the nurses report seeing the injection being given this is obviously incorrect.

In any event, it is obvious that Nurse Pereira determined that the emergency did not remain acute as when the nurses responded to the alarm she signalled for them to stay out of the AOA, at that stage. Clinical Nurse Margaret Bhimbhai, Enrolled Nurse Wayne Kent, Registered Nurse Peter Lopes, Clinical Nurse Sheryl Langford and Enrolled Nurse Anna Ehman had rushed to AOA and stopped at the glass partition that separates it from the other wards. When it was obvious that they were not immediately needed, most returned to their wards. Mr Huntington had also heard the alarm and soon after it sounded and he had been given a small dose of Zuclopenthixol but denied any Diazepam, he walked out of the nurses' station.

Upon leaving the nurses' station, the deceased approached Nurse Staite in the lounge area. He was one of the nurses allocated to "*special"* the deceased and he had spoken briefly to Mr Huntington before Dr Tie's unsuccessful attempt to undertake a mental state assessment. He says that after a short conversation, Mr Huntington walked into the adjacent courtyard. This witness recalls that it was the arrival of two security officers that prompted Mr Huntington to go outside while other witnesses are of the view that Mr Huntington was outside for some time before the protective security officers (PSOs) came to the AOA.

Access to the courtyard is via a hinged glass door from the lounge area. The perimeter of the courtyard is surrounded with a high security fence. There is a locked gate at the very north-eastern corner of it and the courtyard consists of a concrete area, a paved area, a relatively large grass area and two garden areas.

Violence erupts

The versions of the numerous witnesses who participated in or observed what happened next varies significantly. They agree only on the following; two security guards came into the court yard; they attempted to put Mr Huntington on the ground so that they could restrain him and move him into a seclusion room where he could be given more medication; a violent and protracted struggle ensured during which five or six people were actively involved in trying to restrain Mr Huntington; numerous calls were made for police assistance, Mr Huntington was given two injections; police came and handcuffed Mr Huntington; it was then immediately apparent that he was in urgent need of resuscitation; that was attempted but was unsuccessful and Mr Huntington died at the scene of the struggle.

Because the differences in the accounts of the various witnesses are significant, and because a critique of the performance of those involved in attempting to restrain Mr Huntington requires it, I shall identify the conflicts in the evidence and where possible resolve them.

Nurse Staite says he followed Mr Huntington into the court yard sought to reassure and calm him. Nurse Scibisz says that he was concerned for the safety of other patients in the area and also followed the deceased into the courtyard with the hope of establishing some rapport with him in an endeavour to calm him down. Mr Scibisz stated that he observed another patient offer the deceased a cigarette and was immediately told to '*fuck off*'. Mr Scibisz attempted to engage in conversation with the deceased, but was told to go away.

It seems clear that within a few minutes of Mr Huntington going into the courtyard he was joined there by the PSO's, Perry David McIllreavy and Michael Francis McLachlan. They had responded to the alarm that Nurse Pereira had activated and they first discussed the situation with her. She outlined to Messrs McIllreavy and McLachlan that the deceased was Hepatitis C positive and that he had made threats towards staff. Nurse Pereira instructed Messrs McIllreavy and McLachlan that the deceased needed to be

taken to the seclusion room. This room can be locked and contains a window and a soft bed. It was hoped that the containment area would allow the deceased to calm down in a controlled environment. It seems that the PSOs arrived at the AOA at about 3.15pm.

Nurse Lopes remained near the glass wall at the entrance to the AOA and observed Messrs McIllreavy, McLachlan, Scibisz and Staite in the courtyard. Initially, Dr Tie walked with the security officers towards the courtyard, but as he believed he had been the focus of the anger being displayed by the deceased and did not wish to exacerbate the situation, he did not go outside with them. He says he monitored the situation from a distance.

Two of the witnesses say that when Messrs McIllreavy and McLachlan entered the courtyard, Mr Huntington approached them. However the PSO's say that they approached the deceased in the courtyard and requested that he accompany them to the seclusion room. All of the witnesses except EN Staite say that as the PSO's and Mr Huntington came together Mr Huntington attacked Mr McLachlan, throwing punches at his head and grabbing him in a headlock. Nurse Staite recalls that as the PSOs approached Mr Huntington, PSO McIllreavy used some sort of kicking motion to Mr Huntington's groin and lower body. No one else recalls seeing this and I find that he is mistaken and that it was Mr Huntington who became aggressive when confronted by the PSOs

Nurse Scibisz, Dr Tie and Nurse Lopes say that when the PSOs approached Mr Huntington, he adopted a fighting stance with his fists raised in front of his body. Mr McLachlan then approached the deceased with the intention of bringing the deceased to the ground. As Mr McLachlan bent down, the deceased grabbed him around the head and Nurse Scibisz observed the deceased to continuously punch Mr McLachlan in the head and face. This version is corroborated by Dr Tie who stated that he observed the deceased punch one of the PSO's with a closed fist to the head. Nurse Lopes stated that he observed Mr McLachlan getting punched and ran out to assist.

Mr McLachlan and Mr Huntington then fell to the ground with the weight of the deceased landing on Mr McLachlan's head. In this position, the deceased was able to hit Mr McLachlan several times more. Mr McIllreavy then attempted to place the deceased in a restraint hold by taking hold of his arm in order to prevent further assaults on him. Upon seeing the deceased punching and kicking McIllreavy and McLachlan, Nurse Pereira instructed Nurse Kent to enter the AOA and assist the PSOs with the restraint of the deceased.

Messrs Scibisz and Kent assisted the PSOs by grabbing the legs of the deceased. Nurse Lopes says he also assisted by holding the right arm of the deceased and Nurse Staite restrained his hips. Mr McLachlan says he was then able to take hold of the deceased's left arm and apply a restraint at the point of the shoulder blade. Mr McIllreavy says he was positioned on the right side of the deceased and that he placed the deceased's arm under his chin to protect his airway. It is clear form the evidence of others that if this occurred at

all, Mr Huntington's arm did not remain in this position for very long. Nurse Scibisz says that the deceased was lying on his stomach, continuing to struggle vigorously, and stating that he was going to kill everyone. The deceased was not wearing a shirt and due to the rain made his skin wet and difficult to restrain.

During the restraint, Nurse Kent and Nurse Lopes say the deceased was struggling very vigorously, yelling abuse and refusing to comply with repeated requests to calm down.

Nurse Ehman says that she approached the deceased and had a brief conversation with him. She says that Mr Huntington asked her to "*tell them to get off me*." Ms Ehman says she responded by telling him that "*I can't do that Sparka. You have to calm down first*." There is a deal of uncertainty and some inconsistency about what else Nurse Ehman said at the time. In her statement she simply says that after this conversation she left the courtyard.

However when she gave evidence she said that she had noticed blood and mucus coming from Mr Huntington's mouth and nose and that when she left the courtyard she told Dr Tie of this. Naturally, she was cross examined as to why this very relevant information was not in her statement and Nurse Ehman said that she had told this to the solicitor who had interviewed her but it had not been included in her statement. She also said that she had tried on a number of occasions to have her statement changed to reflect her evidence this regard without success.

As a result of this evidence the notes of the solicitor who interviewed Ms Ehman were called for. Those notes corroborate Ms Ehman's claim that she told the solicitor that she had told Dr Tie about the blood coming from Mr Huntington. They also record that she told PSO McIllreavy about the blood and that Mr Huntington was having trouble breathing. It is difficult to assess the reliability of this evidence as Dr Tie and Mr McIllreavy deny that they were told what Ms Ehman alleges and she gave inconsistent and conflicting evidence about how her statement was taken and what efforts she made to have it corrected. It is clear that Ms Ehman made a minor change to her statement and it is difficult to understand in those circumstances why she did not insert this more relevant information at that time. Having regard to all of the circumstances I have come to the conclusion that it would be unsafe of me to find the allegations Ms Ehman made proven in view of the absence of supporting evidence.

It is also clear however, that the solicitor retained to take statements from hospital staff failed to include information which was critical of the actions of other hospital staff but clearly relevant to an understanding of the circumstances of Mr Huntington's death.

Nurse Kent says that he positioned himself near the head of the deceased to assess the situation and was of the opinion that the restraint was appropriate with no force being applied to either the neck or torso. Nurse Kent also says that he did not see anything out of the ordinary with the restraint and assisted

Messrs Scibisz, McIllreavy, McLachlan and Lopes with the restraint by holding the right leg of the deceased.

Clinical Nurse Sheryl Langford who came briefly into the courtyard during the struggle says that she heard people repeatedly asking Mr Huntington to calm down. Ms Langford observed that both fists of the deceased were clenched and he was yelling abuse and appeared extremely angry. She says that she was very concerned about what would occur if Mr Huntington was not restrained and broke free. Nurse Lopes stated that he was also extremely concerned that if the deceased was not restrained he would injure persons or himself. Nurse Lopes was of the opinion that Mr Huntington was showing no signs of abating his aggressive behaviour. He went into the nurses station and spoke with Nurse Pereira and Dr Tie and informed them that he believed Mr Huntington was homicidal. When he returned to the courtyard, Mr Huntington was still struggling.

In consultation with Nurse Pereira, Dr Tie concluded that Mr Huntington needed to be sedated. Accordingly, he ordered an intramuscular injection of 150mg of Acuphase.

Nurse Pereira says that she then approached the deceased and advised him that she was going to administer the drug and injected it into his right buttock. During the administration of the drug, Mr Huntington continued to violently resist Messrs McIllreavy and McLachlan and the nurses who were assisting them.

Nurse Pereira then returned to the nursing station and spoke with Dr Tie about seeking advice from the on-call consultant. Dr Tie attempted to contact Doctor Tucker via his mobile phone, but received no reply. Nurse Pereira then suggested that Dr Tie attempt to contact the second on-call consultant. She also suggested that police assistance be sought. Dr Tie accepted this advice and attempted to contact Doctor Davies, the district director of mental heath and the area manager Dr Tucker.

At 15:35 hours, Beenleigh Communications Centre received the first contact from Dr Tie who identified himself as a registrar at Logan Hospital. Dr Tie outlined that security and nursing staff were unable to restrain a mental health patient and in his opinion the matter was getting out of hand and required immediate police assistance. Beenleigh Communications Centre CAD system indicates that Dr Tie's request for police assistance was allocated job number 1093.

At 15:40 hours, Beenleigh Communications Centre detailed the job to Logan unit 355 containing Senior Constable Bruce, Senior Constable Nathan Wright and Constable Olsen. They were instructed to proceed to the job in accordance a priority code 3 which is designated for routine matters rather than code 2 which is used when the job is considered urgent or code 1 which is used when it is assessed that there is an imminent threat to life. As a result of this low priority code, the officers detailed the job considered it appropriate to conduct a traffic stop en route to the hospital while they sought clarification

as to whether hospital security could attend to the incident. When it was confirmed that their attendance was required they proceed to the hospital and arrived there at 15.50.

In the circumstances, I consider that the police communications room operator failed to seek enough information from the hospital staff who called for assistance and failed to give the job appropriate priority. However, I do not consider that had the job been allocated a code 2, as it clearly warranted, the outcome would have been any different.

While awaiting police attendance, Nurse Pereira advised Dr Tie that in her opinion Mr Huntington required more quick acting sedation as Acuphase takes 3 – 4 hours to take effect. Dr Tie agreed and ordered the intramuscular injection of 10mg of Midazolam. At this time, Dr Tie was on the phone again seeking assistance from the on-call consultant, while Nurse Pereira drew up the Midazolam. While doing this, Nurse Pereira outlined to Dr Tie that given the fact that police had been called to deal with the situation, it was most probable that the deceased would be removed from the hospital. Therefore, it was not advisable to give 10mg of Midazolam because the respiratory rate of the deceased would need to be closely monitored for a period of time after the administration, attention he was unlikely to receive if he was in the watch house. Nurse Pereira suggested that Mr Huntington instead be given 5mg of Midazolam and 10 mg of Droperidol.

In the circumstances, Dr Tie concluded that Midazolam should be avoided completely and requested that Mr Huntington be given 10mg of Droperidol. Nurse Pereria drew up and checked the 10mg of Droperidol and again approached Mr Huntington in the courtyard. She told him that she was going to administer the 10mg of Droperidol which she then did by injecting it in his left buttock. Nurse Pereria stated that after she did this, the deceased yelled out '*I am going to fucking kill you'.*

At this time, Nurse Pereira observed the head of the deceased and stated that he was able to move about in all directions as he tried to free himself from the restraint. Nurse Pereira says that she did not see anybody holding the deceased in a headlock or applying pressure to his neck, although the evidence of the security officers and other makes clear that the PSO's had their knees on Mr Huntington's shoulder blades at various times while the nurses were sitting on his buttocks and legs.

Nurse Pereira states that she heard repeated urgent requests directed towards the deceased for him to calm down – these requests were ineffective. Nurse Pereira then went briefly back to the nurses' station to discard the sharps and immediately returned to the courtyard. She says that on this occasion she remained in the courtyard for about ten minutes, before returning to the nurses' station to make a second call for police assistance.

Dr Tie was of the opinion that the deceased was showing no signs of cooperating with the repeated requests to calm down and requested Nurse Pereira to telephone 000 and request police to hasten their arrival due to his

increasing concern about the ability of the PSOs to restrain the deceased. At 15:45 hours, Beenleigh Communications Centre received the second call for assistance from the hospital. Nurse Pereira outlined that there was an emergency at the Logan Hospital which needed immediate police assistance. She advised that a patient was being held down by security and couldn't hold him down any more.

Nurse Pereira then returned to the courtyard and was of the opinion that the deceased was showing no signs of tiring, but the security and male nurses were struggling to restrain the deceased and appeared tired. Nurse Pereira observed that the deceased has lifted his head and had a small vomit. Nurse Pereira asked the deceased if he was alright to which he replied that he was. Nurse Pereira outlined to Mr Huntington that the police had been called and urged him to stop fighting. Nurse Pereira then returned to the nurse's station and made a third telephone to police requesting assistance.

This call was received at 15:55 hrs hours by the Beenleigh Communications Centre. Nurse Pereira again outlined that she was calling from Logan Hospital and it was the third call for police assistance which was needed urgently. Nurse Pereira confirmed that the patient was still on the ground and that he was still fighting and staff could not release their grip. The officer who took the call inquired whether sedatives had been used and he was told that they had been but had not been effective.

Soon after making the third call, Senior Constable Kylie Bruce, Senior Constable Nathan Wright and Constable Ken Olsen arrived at Ward 2C. As they came out into the courtyard Nurse Pereira informed the police that the struggle had been on going and that they couldn't control Mr Huntington. She requested that he be handcuffed because he was in a rage. The officers all immediately removed their firearms and secured them in a small storeroom and then entered the courtyard.

Senior Constable Bruce says that as she entered the courtyard she observed six or seven medical and security staff holding the deceased down. Other evidence indicates that these persons were PSOs McIllreavy and McLachlan, and Nurses Scibisz, Kent, Staite and Lopes.

Senior Constable Bruce says that the deceased was lying face down across the garden with his head to her left, and feet to her right. The medical and security staff were positioned on either side of the deceased. In her statement she said she couldn't clearly see what the staff were doing with their hands and how the deceased was being held but when she gave evidence Senior Constable Bruce said that one of the PSOs had his hand on the back of Mr Huntington's head and he was face down in the garden bed. Senior Constable Bruce stated that the deceased's arms were beside his body and he did not appear to be moving or struggling.

Constable Olsen also says that Mr Huntington was face down in the mud and that PSO McIllreavy had hold of the hair on the back of Mr Huntington's head with his left hand.

One of those involved in holding the deceased down motioned and verbally requested that the deceased be handcuffed. Constable Olsen moved towards the patient and placed a handcuff on his left wrist. The PSO's and assisting staff then assisted Constable Olsen by moving Mr Huntington's right arm so the second handcuff could be applied. To do this, Constable Olsen was required to bend the left arm of the deceased so that the handcuff could be applied to the deceased's right wrist. Nurse Pereira says that upon the handcuffs being applied by Constable Olsen, the deceased appeared to relax and stop moving.

Nurse Scibisz says that at thus stage the left leg of the deceased had become limp. Nurse Lopes says that the deceased appeared to relax and then cease all movement. Simultaneously, Nurse Pereira requested the nursing staff to turn the patient on his side and check his breathing; she says that she was reassured by staff that he was breathing. Constable Olsen then stepped away and Nurse Pereira instructed the staff to place the deceased in the recovery position and observe his breathing for one minute.

As Mr Huntington was rolled over, Senior Constable Bruce heard one of the medical staff commented that the deceased wasn't breathing. This drew her attention to the face of the deceased on which she observed vomit and dirt. Senior Constable Bruce was of the opinion that the dirt on Mr Huntington's face was a result of his having his face down in the garden bed and she noticed a dry patch and an indentation in the garden bed which she said coincided with where Mr Huntington's head had been.

Nurse Scibisz observed vomit around the mouth of the deceased at this time and heard Nurse Pereira state that she was going to call a code blue. Nurse Pereira says that she noted the colour of the deceased was beginning to change and requested that the police remove the handcuffs.

Senior Constable Wright then removed the handcuffs. The officers estimate that the handcuffs were on the deceased for between approximately twenty seconds and one minute. Each of them say that they did not see Mr Huntington move nor hear him say anything at any time. I accept the evidence of the police officers that by the time they arrived Mr Huntington had ceased struggling and was being held face down in the garden bed, with a security officers holding each arm and shoulder and a number of hospital staff members sitting on Mr Huntington's hips and legs.

Resuscitation attempts

Immediately after the removal of the handcuffs, resuscitation attempts were commenced with Nurse Lopes administering Cardio Pulmonary Resuscitation (CPR) to the deceased. Nurse Scibisz stated that he then ran to collect oxygen equipment that was located elsewhere in the unit. Upon hearing the alarm, Nurse Bhimbhai stated that she assisted in getting the trolley to the AOA and out into the courtyard. Nurse Bhimbhai stated that upon entering the courtyard she observed the deceased on his side, where Nurse Pereira was suctioning his airway and Nurse Lopes was performing CPR.

Doctor Susan Shiels, Doctor Reza Zahibi Madah, Clinical Nurse Pamela Jane Dipplesman and Ehman also responded to the code blue. Dr Tie stated that he unsuccessfully tried to get an IV cannula into one of the arms of the deceased. Nurse Pereita stated that she observed the air viva being applied and achieve a seal. Nurse Pereira then observed the cheeks of the deceased to inflate, which indicated that the airway of the deceased had been compromised.

It appears that the portable suction unit was not adequate to cope with the vomitus that was blocking Mr Huntington's airway.

After a number of attempts Dr Zahibi Madah inserted a laryngeal mask and was able to ventilate the deceased, but the deceased remained asystolic with no cardiac output. Dr Shiels stated that she then gave instructions to get the crash trolley. Pereira stated that the crash trolley arrived in less than two minutes and Doctor Damien Gilbert put a cannula in the right cubital fossa of the deceased.

Medical notes compiled by Doctor Raveenthiran document that the code blue was called at 15:59 hours. During the CPR, 5 mg of adrenaline and 1 mg of atropine was administered to the deceased. After approximately 25 minutes of resuscitation it was agreed that Mr Huntington was not able to be revived and attempts ceased.

Preservation of crime scene

Immediately after the death of the deceased all witnesses were withdrawn from the scene and a crime scene established and guarded by police. The investigation detailed earlier in these finding was then commenced.

Attendance of specialist services

Sergeant Wayne Rasmussen (Reg No. 9410) of the Logan District Scientific Section attended and conducted a scientific examination of the scene.

Blood and vomitus was observed in the mouth and nose of the deceased. Vomitus was also observed on the ground beside the head of the deceased. Immediately to the north east of the deceased, Rasumussen noted that there was some evidence of disruption to mulch and a shrub in the garden bed.

The director of the clinical forensic medicine unit, Dr Robert Hoskins attended and examined the scene and the body of the deceased. Dr Hoskins noted that rigor mortis was present and the following injuries on the deceased:

Swelling and bruising to the right eye.
Small (8mm) superficial laceration from the outer corner of the right eye.
Minor laceration to the right ear.
Small abrasion to the chin.
Patterned contusions on the chest.
Curvilinear laceration on the front left chin with established scab formation.
Circular abrasion on the left hand ring finger knuckle.

Notification of next of kin

Sergeant Nev Huth of Logan CIB advised Tonni Frood, sister and next of kin of the deceased of the death at about 11.30 pm on 14 December 2003.

Identification of the deceased.

On 16 December, the body of Mr Huntington was identified by Tonni Frood, his sister.

Autopsy results

An autopsy was performed by Doctor Nathan Milne on 16 December 2003.
Of particular significance, he noted that Mr Huntington had 90% blockage of his coronary arteries that would predispose him to a myocardial infarction or an arrhythmia. Neither would leave evidence detectable at autopsy.

Doctor Milne also noted vomitus in the airways down to the lungs, suggesting aspiration. He noted petechial haemorrhages in both eyes although he commented that the haemorrhages were few in number. Also of relevance is the congestion in the eyes and lungs that Dr Milne found. Further there was bruising to the deep tissue or strap muscles of the neck. While such findings are consistent with asphyxiation, in evidence Dr Milne said that, apart from the bruising, they could also result from vomiting, coughing, attempted resuscitation and heart attack. He said that in this case there were not sufficient petechia to convince him that asphyxia was the more likely cause of death although it could not be excluded.

Toxicology tests were ordered in relation to samples taken from the deceased and the certificate documented that the deceased had the presence of the following drugs:

Blood:	
Amphetamine	<0.01 mg/kg
Mythylamphetamine	<0.01 mg/kg
Diazepam	<0.05 mg/kg
Nordiazepam	<0.05 mg/kg
Oxazepam	<0.05 mg/kg
Droperidol	<0.04 mg/kg
Zuclopenthixol	<0.02 mg/kg

Urine:	
Alcohol:	Nil

In Dr Milne's opinion, none of these drugs directly contributed to the death, although there was a potential for the amphetamines to negatively affect Mr Huntington's mood and ability to act rationally. That drug would also place greater demands on his heart which would have already been stressed as result of the violent activity undertaken by Mr Huntington.

In summary, Dr Milne concluded that coronary atherosclerosis leading to arrhythmia were the most likely cause of death. However, Dr Milne noted that

death may have been precipitated or contributed to by the struggle where asphyxia may have been a contributing factor.

Cause of death

The cause of death in this case is difficult to determine because neither of the most likely explanations necessarily cause changes to the body that can be detected at autopsy.

An arrhythmia is a change in the rhythm or rate of the heartbeat. It may occur in otherwise healthy people and may cause no ongoing harm. However it is more likely to occur in people who suffer from atherosclerosis. If it results in death, an arrhythmia does not cause any micro or macro changes to the heart tissue that can be detected at autopsy. In most cases where a finding of death due to an arrhythmia is made, that cause is settled upon because no other cause of death can be identified. It is also relevant that the violent struggle that Mr Huntington was engaged in proximately to his death would greatly increase the likelihood of his compromised cardio-vascular system failing.

Asphyxia refers to a state in which the body becomes deprived of oxygen as a result of an obstruction to interference with respiration. If it causes death there may be tell-tale signs such as pulmonary oedema, congestion of various organs and/or petechial haemorrhages but these effects are not found in all cases and even if they are found they may have other causes.

A finding in relation to either cause of death is therefore dependent upon circumstantial evidence. When Dr Milne wrote his autopsy report his knowledge about the circumstances of death was limited to the information contained on the form 1 and presumably any extra information police were able to pass on to him. That was to the effect that Mr Huntington had been restrained on the ground by security officers and nurses. We now know far more. For example, we now know that the security officers had their knees on Mr Huntington's shoulder blades, were holding the back of his head while his face was in the garden bed and that he inhaled some vomit and had mulch in his mouth. We also know that a nurse was sitting on his hips. In my view, the restraint of Mr Huntington involved force being applied to him over a considerable period of time that could have restricted his breathing.

I also accept however, that an arrhythmia could not be excluded and is also a likely cause of death having regard to the severe atherosclerosis that was found at autopsy and the prolonged violent struggle that preceded the death. Regrettably, I do not believe I can be sufficiently certain as to which of these possible causes was the dominant or operative cause.

Findings required by s45

I am required to find, as far as is possible, who the deceased was, when and where he died, what caused the death and how he came by his death. I have already dealt with this last issue, the manner of the death. As a result of considering all of the material contained in the exhibits and the evidence given

by the witnesses I am able to make the following findings in relation to the other aspects of the death.

Identity of the deceased – The deceased person was Sparka Isarva Huntington

Place of death – He died in the Acute Observation Area of the Mental Health Unit at Logan Hospital, Meadowbrook, Queensland, 4131

Date of death – Mr Huntington died on 14 December 2003

Cause of death – The cause of death is undetermined

Concerns, comments and recommendations

Section 46, insofar as is it relevant to this matter, provides that a coroner may comment on anything connected with a death that relates to public health or safety or ways to prevent deaths from happening in similar circumstances in the future.

The issues of concern that are raised by this matter can be highlighted by a chronological summary of the events in question; naturally, because it is aimed at improving practice, such a summary focuses only on those matters which seem to have been inadequately managed and it could create a false impression that nothing was done correctly. In an attempt to redress that misconstruction I feel it appropriate to acknowledge the good work of the health care professionals employed by the LBHSD, both in the community mental health service and the Logan Hospital. Their dedication and expertise enabled Mr Huntington to live in the community relatively safely for many years despite his serious illness and his chronic drug abuse. It is important that the tragic circumstances of his death do not obliterate recognition of these commendable achievements. It is also important to acknowledge the traumatic effect their involvement in this incident clearly had on the staff members concerned.

In summary, however, I am concerned that an inadequate response to the revocation of Mr Huntington's community treatment order resulted in his repeatedly absconding from the Logan Hospital even though the MHT had adjudged him to be a danger to the community. When he represented himself there was again an inadequate response from a junior doctor who seemed inexperienced in dealing with such patients and who was unable to access professional support when the incident escalated. None of the mental health staff members present was able to prevent violence erupting and the security officers who responded to calls for assistance were untrained for the task given to them. An uncoordinated, chaotic, prolonged struggle only ended when the patient died. It is difficult to think that any of the staff involved could be satisfied with the way this patient was managed. My particular concerns and recommendations are as follows.

Access to community mental health service records

Mr Huntington presented himself to the Logan Hospital on 6 December some 10 weeks after his community leave had been revoked and nine weeks after he had absconded from the hospital. He was seen by a psychiatric registrar who was unable to obtain sufficient information about his clinical history to adequately assess what drugs he should be given. The registrar therefore felt obliged to seek this information from the patient who, perhaps not surprisingly, gave wildly inaccurate information.

Mental health patients living in the community can often present or be brought by police or others to hospital mental health services as a result of suffering an acute episode. It is essential that on these occasions the clinicians who have to respond have immediate access to the community mental health records of the patient. Currently these are only available during business hours.

The inquest heard evidence that the LBDHS is developing its own digital data base to enable electronic records from its various health services to be accessed remotely. While such a system would have been of assistance in Mr Huntington's case it would provide no benefit if the patient's usual treating team was in another health district. It also seems unwise for one district to develop its own response to a problem that will obviously occur state wide. I have been advised that the need for 24 hour, state wide access to mental health records has been recognised. Accordingly I can only add my support to the calls for such a system to be implemented as soon as possible.

Recommendation 1 - Adequate access to mental health records

I recommend that as a matter of urgency Queensland Health develop an electronic data base to enable clinicians to instantly access medical records of mental health patients who have been treated at any public health service throughout the state.

Failure to take Mr Huntington into secure custody

Despite Mr Huntington being a forensic patient with an extensive history of serious sex and violence offences whose community treatment order had been revoked, and despite him having absconded when brought to the hospital by police when that revocation occurred, he was again admitted to an open ward when he presented himself on 6 December. The next day it seems he seriously sexually assaulted another patient and again absconded. When Mr Huntington was bought back to the hospital by police on 8 December he was again housed in an open ward because a bed could not be found in a medium secure unit within the health district. No inquiries were made concerning the availability of a bed in a secure unit in another district. Mr Huntington again absconded.

This serious error of judgment seems to have occurred because there was no policy in place to ensure that a patient on a forensic order who absconds is placed in a more secure ward when he is returned to the mental health

service facility responsible for his care. If this is still the case it should be remedied.

Recommendation 2 – Secure custody for forensic order patients

I recommend that the Director of Mental Health mandate a policy that stipulates that patients on forensic orders who abscond are automatically held in high-secure or medium-secure wards when they are returned to the responsible mental health facility until their risk of further flight can be assessed.

Training of protective security officers and mental heath nurses

Dr Groves gave insightful evidence about the desirability of identifying signs or triggers of potential violent behaviour and addressing those before they escalate into actual violence. In his view there needs to be a re-evaluation of the use of seclusion and restraint in mental health services leading to a focus on avoiding violence rather than responding to it. He is obviously best placed to lead change in that regard without any further comment from me.

However, until such an approach is universally implemented, the use of physical force to restrain violent patients will continue to be necessary. It was therefore alarming to learn that the two PSO's involved in the struggle that led to Mr Huntington's death had received no training in how to safely restrain a person. Indeed one of the PSO's had, at the time of Mr Huntington's death, worked at the hospital for four years and during that time he had received only about one hour of training that involved no demonstrations or assessment. It is incongruous that those employees could not at law work as "bouncers" in licensed premises because of the lack of any formal training or certification but were engaged as security officers in a hospital with a large mental health service.

In 2003 Queensland Health developed a training course in aggressive behaviour management. Regrettably, even by the time of this inquest only 50% of mental health nursing staff at the Logan Hospital had undertaken the training. In my view this should be addressed as an urgent priority as it aims to not only educate staff about how to safely restrain violent patients but, perhaps more importantly, seeks to equip them with skills that make violent conduct by patients less likely.

The submission made on behalf of Queensland Health asserts that this short coming is being addressed and that more appropriate courses are being developed.

Recommendation 3 – Aggressive behaviour training and credentialing of PSOs

I recommend that as a matter of priority all mental health nursing staff and any security officers who may be called on to assist them undertake the aggressive behaviour management course or any other more appropriate course the department chooses to develop. I also recommend that the holding

of an appropriate competency based qualification be a pre-condition to employment as a security officer in a hospital.

Use of mechanical restraints

The security guards and mental health nurses who attempted to restrain Mr Huntington and move him to a seclusion room where he would not be at risk of harming himself or others, were unable to do so because they could not overcome his physical resistance other than by holding him on the ground in what I have found was a dangerous manner. He was held face down in a garden bed for in excess of 35 minutes and was only released a few minutes before he died.

These circumstances raise for consideration whether hospital security guards should be equipped with accoutrements that would enable them to more effectively restrain violent patients: handcuffs and batons for example.

Dr Groves expressed abhorrence at the prospect of patients suffering from mental illness being subjected to the use of such equipment in a place where they had come or been brought for treatment. He quoted evidence from the United States hospitals where, by changing the way staffs relate to patients, the need to use seclusion has dropped dramatically.

His attitude is admirable and with respect, entirely consistent with the ethos one would expect from a health care professional. However, I remain concerned that as long as there exists such a gap between the ideal quality of service delivery and the reality as demonstrated by the evidence in this case, adherence to such high principles could endanger the lives of patients.

Mr Huntington was forcibly held on the ground by up to six staff for an extended period of time because they could not prevent him from striking out at them in any other way. The use of soft ties to secure his wrists may have allowed Mr Huntington to be moved to a seclusion room relatively promptly where he could have been appropriately sedated, obviating the risk to himself or others. The longer a physical struggle continued the greater the risk of serious harm to the staff or the patient. I understand soft ties are now being trialled at Logan Hospital

Recommendation 4 – Evaluation of soft restraints

Pending the achievement of a quality of care that enables mental health patients to be managed without resort to physical restraint, I recommend that Queensland Health evaluate the use of soft ties to assist in restraining violent patients.

Support for on call registrars

There was ample evidence that Dr Tie desperately needed advice and assistance from a more senior and experienced psychiatrist and that despite numerous attempts to make contact with such a doctor, no assistance was provided in a timely manner. The on-call consultant claims to have made some contact with him. This is denied by Dr Tie. I am unable to resolve the

conflict in the evidence of these two witnesses and in any event I am persuaded that there is no on-going or systemic short-coming in that regard. I therefore make no further comment in connection with the issue.

The role of the DMH

I received significant evidence about the role of the Director of Mental Health and his capacity or authority to influence clinical practice and the utilisation of resources. I had intended making recommendations about these issues but I am aware from other ongoing inquests that this issue is currently receiving attention from within Queensland Health and the structure of the mental health branch and its responsibilities is being reviewed. I therefore consider it appropriate to refrain from making any comment in relation to that issue at this stage.

I close this inquest.

Michael Barnes
State Coroner
Brisbane
1 June 2007