QUEENSLAND COURTS

CORONERS COURT OF QUEENSLAND

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Warren Andrew Osborne**
TITLE OF COURT:	Coroners Court
JURISDICTION:	Brisbane
FILE NO(s):	2015/3183
DELIVERED ON:	29 January 2018
DELIVERED AT:	BRISBANE
HEARING DATE(s):	4-7 December 2017
FINDINGS OF:	Terry Ryan, State Coroner
CATCHWORDS:	Coroners: inquest, restraint in a hospital setting, amphetamine use, restraint asphyxia.
REPRESENTATION:	
Counsel Assisting:	Daniel Bartlett
Metro North HHS and employees:	John Allen QC instructed by MNHHS Legal Unit
Snr Constable Kirby and Constable Gray:	Troy Schmidt
Commissioner of Police and Snr Sgt Hayden:	Belinda Wadley, QPS Legal Group

Contents

Introduction

1. Warren Osborne was aged 45 years at the time of his death on 17 August 2015. He had been released from the Woodford Correctional Centre three days earlier after completing a three-month term of imprisonment for unlawful use of a motor vehicle, dangerous conduct with a shotgun and drug offences.

2. On the morning of his death, officers from the Queensland Police Service were called to a disturbance at a home at Bribie Island occupied by Mr Osborne's friends. Mr Osborne had refused to leave his friends' property, and told them he was frightened to do so. The QPS officers subsequently drove Mr Osborne to the Caboolture Hospital after he reported that he was suffering a drug induced psychosis. After being triaged at the hospital he became anxious and did not want to wait in in the Emergency Department.

3. Mr Osborne left the Emergency Department and tried unsuccessfully to gain access to the Mental Health Unit (MHU). As security doors were faulty, he then proceeded to wander around other hospital wards that he should not have been able to access.

4. Subsequently, nursing and security staff tried unsuccessfully to persuade Mr Osborne to return to the Emergency Department from Ward 2A, a ward where patients were recovering from surgery. He refused to do so, and a struggle ensued with security officers. Mr Osborne was then restrained on the floor for over ten minutes, and the QPS was called to remove him from the hospital.

5. When QPS officers arrived at Ward 2A Mr Osborne was handcuffed, and it soon became apparent that he was unresponsive. Attempts to resuscitate Mr Osborne were unsuccessful.

6. These findings confirm the identity of the deceased person, when, where and how he died and what caused his death. They also consider the following issues that were determined to be within the scope of the inquest:

    - The adequacy and appropriateness of the decision to request for the deceased to be restrained in the lead up to his death;

    - The adequacy and appropriateness of the manner by which the deceased was restrained in the lead up to his death;

    - The adequacy and appropriateness of the manner by which the deceased's vital signs were checked during the restraint;

- The adequacy and appropriateness of the training provided to employees of the Caboolture Hospital with respect to physically restraining a person;

- Whether any further recommendations can be made to prevent a death in similar circumstances from happening in the future.

The investigation

7. An investigation into Mr Osborne's death was conducted by the QPS Ethical Standards Command (ESC) and a very detailed report was prepared by Detective Senior Sergeant Peter Ryan.

8. Senior Sgt Ryan attended the scene on 17 August 2015 with other ESC officers. A forensic examination of the scene was undertaken and a detailed set of photographs taken. Senior Sgt Ryan oversaw investigations into Mr Osborne's background and relevant aspects of QPS training and policy.

9. Interviews were conducted with the attending police officers and hospital staff who interacted with Mr Osborne on the day of his death. Four hospital staff provided statements through their legal representatives. Relevant CCTV records and files from the Caboolture Hospital and Queensland Corrective Services were obtained, together with body worn camera footage from the attending QPS officers.

10. Advice was obtained from a government medical officer in relation to the effects of methylamphetamine in Mr Osborne's system at the time of his death.

11. A post mortem examination was conducted on Mr Osborne's body at Queensland Health Forensic and Scientific Services on 19 August 2015. Blood, urine, stomach contents and vitreous humour samples were subject to further toxicological testing.

12. I am satisfied this matter has been thoroughly and professionally investigated and all sources of relevant information have been accessed and analysed.

The inquest

13. Following a pre-inquest conference 27 October 2017, the inquest was held at Brisbane from 4-7 December 2017. Seventeen persons were called to give oral evidence at the inquest:

- Detective Senior Sergeant Peter Ryan – ESC Investigator
- Melanie Ponton – Registered Nurse
- Clare Sonter – Registered Nurse
- Lina Clifton – Registered Nurse
- Leif Laakso – Security Officer
- Richard Duke – Security Officer
- Kirrily Halliday – Registered Nurse
- Alison Kelman – Nursing Hospital Co-ordinator
- Paul Csepreghy – Mental Health Hospital Co-ordinator
- Peter Jones – Operational Support Officer
- Anthony Wiles – Operational Support Officer
- Stephen Kirby – Snr Constable
- Michaela Gray - Constable
- Scott Trudgett – Occupational Violence Prevention Co-ordinator
- Snr Sgt Damien Hayden – Use of Force expert
- Dr Lance Le Ray – Director of Medical Services, Executive Director Caboolture-Kilcoy Hospitals
- Dr Rohan Samarasinghe – Forensic Pathologist

The evidence

Social History

14. Mr Osborne is survived by his parents, his older brother, and his daughter. His parents separated when he was aged one, and Mr Osborne was cared for by his father from age three. Mr Osborne left school after year 10 and commenced a carpentry apprenticeship. His father described him as an excellent carpenter.[1] He was also described as having a heart 'as big as Phar Lap' but was sensitive and emotionally insecure. I extend my condolences to his family.

15. Mr Osborne was in a long-term relationship for approximately 18 years until approximately 2009. He has one child aged 24 years.

16. Mr Osborne had commenced using drugs in his late teens and appeared in court on a range of good order and *Bail Act* related offences. In 1996, he was charged with supplying dangerous drugs and was sentenced to a suspended prison sentence of 18 months. He subsequently appeared in court on many occasions.

17. In 1994, Mr Osborne suffered a serious injury to his foot which needed orthopaedic surgery. He subsequently developed an addiction to pain medication which continued until his death. In the three years leading up to

[1] Exhibit A12

his death he had been prescribed methadone, oxycodone and amitriptyline on 15 separate occasions.

18. Mr Osborne was also injured in a workplace accident in the early 1990s when he fell from a roof. He subsequently received ongoing income protection insurance payments of around $3700 per month. It appears that Mr Osborne used a significant amount of his compensation payments to purchase drugs.

Events leading up to the death

19. At around 3:00am on the day of his death the Queensland Police Service were called to the home of Mr Osborne's friends at Jabiru St, Bribie Island. He had caused a disturbance there, and while he appeared to be agitated and anxious, he was not acting aggressively. He was refusing to leave the property and told his friends he was frightened to do so.

20. Two police officers, Sgt Driver and Constable Golinski, attended the house and spoke to Mr Osborne. Mr Osborne co-operated with the police and told them he was under the influence of 'speed', and that he had been released from custody the previous Friday.

21. Mr Osborne agreed to be driven by the police officers to his grandmother's home at Sandstone Point, where he was staying temporarily. However, after arriving there he asked to be taken to hospital as he was suffering drug psychosis and severe anxiety.

22. The police officers then drove Mr Osborne to the Caboolture Hospital where they arrived at 4:06am. Mr Osborne entered the Caboolture Hospital voluntarily. He had not been arrested by the police officers, nor was he the subject of an emergency examination order under the *Mental Health Act*. There was evidence of an informal practice which saw QPS officers take patients via the ambulance bays at the Emergency Department. That practice was not adopted on this occasion.

23. Mr Osborne was triaged at the Emergency Department as presenting with high levels of anxiety and being affected by the use of amphetamines. He was assessed as a level 4 category patient. This meant he should be seen by medical practitioners within one hour. Mr Osborne was offered two Valium tablets for sedation but he spat those out. An attending nurse rated Mr Osborne's drug intoxication level as being 5 out of 10.

24. Mr Osborne waited in the Emergency Department with other patients. There were 15 patients waiting to be seen, and some had been waiting for up to five hours. Closed circuit television showed that Mr Osborne was apparently agitated but he was not acting aggressively. A security officer

checked on Mr Osborne in the waiting room at 4:09am and 4:22am, but did not have cause to remove him from that area, where elderly persons and children were also present.

25. At 4:29am Mr Osborne started to walk around the hospital unimpeded. He had gained access to the main part of the hospital through two unsecured security doors, which had been malfunctioning since at least 14 August 2015.

26. Mr Osborne initially tried to enter the MHU. He banged loudly on the door to the MHU and then proceeded back to the main part of the hospital. Hospital security personnel were then made aware of Mr Osborne's entry into the main part of the hospital and began to search for him.

27. At 4:33am Mr Osborne took a lift to the second floor of the hospital. After he entered the maternity ward he made his way to Ward 2A, which was a surgical ward predominantly caring for post-operative patients. Also located on level 2 were the birthing suite, special care nursery and the critical care unit. Although closed circuit television captured Mr Osborne's passage through the ground floor, it did not record the events on level 2.

Circumstances of the death

28. At around 4:45am nurses working on Ward 2A became aware of Mr Osborne's presence in the ward. The beds in the ward were occupied by around 30 patients and the lighting was dimmed to facilitate sleep. There were three nurses on duty, together with a mental health nurse, who provided direct care to a mental health patient.

29. The evidence of the two nursing staff present on the ward at the time was that they were disconcerted and felt uncomfortable as a result of Mr Osborne's presence. He was a stranger and posed an unknown threat to staff and patients.

30. RN Melanie Ponton told the inquest that she was sitting at the nurse station with RN Clare Sonter when she first saw Mr Osborne. He was near a linen trolley 2 to 3 metres away. Mr Osborne was showing signs of agitation and was pacing backwards and forwards, wringing his hands and rubbing his head. RN Ponton asked Mr Osborne why he was on the ward. Mr Osborne said that he wanted to speak to a mental health doctor. RN Ponton advised Mr Osborne that he needed to go to the Emergency Department who would contact a mental health professional on his behalf. RN Sonter's evidence was that Mr Osborne said that he did not want to wait to see a doctor.

31. Nurses Ponton and Sonter tried to placate Mr Osborne by talking to him and providing him with a cup of tea. While he was coherent, he was clearly agitated. RN Sonter said that Mr Osborne was refusing to leave, scratching himself and spilling his tea. RN Kirrily Halliday called security and, in response, Mr Richard Duke attended Ward 2A at 4:44am.

32. Mr Duke's evidence was that he calmly tried to persuade Mr Osborne to return to the Emergency Department. Mr Osborne was responsive but did not leave Ward 2A. While Mr Duke was talking to him, Mr Osborne was standing in the doorway of a room full of sleeping patients, some of whom were starting to wake up as a result of the disturbance.

33. As he was unable to persuade Mr Osborne to leave the ward, Mr Duke called a Code Black which alerted hospital personnel to imminent or actual violence and called for assistance.

34. By 4:50am the Code Black Team consisting of a security officer, Leif Laakso, operational support officer, Peter Jones, Nursing hospital co-ordinator, Alison Kelman and Mental Health hospital coordinator, Paul Csepreghy, was present in Ward 2A.

35. Ms Kelman had become aware of Mr Osborne's presence in the hospital after she was informed by staff in the maternity ward that Mr Osborne had been asked to leave that ward. Ms Kelman was in the maternity ward when she received a Code Black call to attend Ward 2A at around 4:50am.

36. After arriving at Ward 2A, Richard Duke, Alison Kelman and Paul Csepreghy again tried to persuade Mr Osborne to leave Ward 2A and return to the Emergency Department. Mr Osborne was raising his voice, and continued to demand that he be taken directly to the MHU.

37. Mr Csepreghy's evidence was that he assessed that Mr Osborne was significantly affected by drugs. He rated his level of intoxication as 8/10 compared to the 5/10 rating given in the Emergency Department. He said that there was "no chance" that Mr Osborne could be seen directly in the MHU because he had to be assessed by the acute care team in the Emergency Department before transfer to the MHU.

38. At some time between 4:50am and 4:57am the decision was made to physically escort Mr Osborne from Ward 2A due to the threat he posed to staff and sleeping patients. Ms Kelman's evidence was that she made the decision to restrain Mr Osborne because he had been given approximately 10 minutes to voluntarily leave the ward and was becoming louder and more disruptive. Mr Csepreghy's evidence was that he had also formed the view that Mr Osborne had to be escorted from the ward.

39. As Mr Duke and Mr Laakso tried to take hold of Mr Osborne, he broke free and ran a short distance behind the nurses' station in the centre of Ward 2A, where RN Ponton was standing with another nurse. Up until this point Mr Osborne had not acted aggressively or with violence. RN Ponton's evidence was that as security officers took hold of Mr Osborne's arms he was fighting and resisting. While he did not seem to be lashing out at them he kept getting free and was yelling.

40. Having regard to the dynamic nature of the initial scuffle and restraint, it is not surprising there was some dispute as to exactly how Mr Osborne was initially restrained. However, it is clear that within a short time Mr Osborne was restrained on the ground in a prone position.

41. After considering the evidence of the persons who were present and/or involved at the time, I can conclude that Mr Jones and Mr Laakso were each restraining one of Mr Osborne's arms while Mr Duke restrained Mr Osborne's legs. For the large part, if not all, of the restraint of Mr Osborne was held in a prone position with his wrists held behind his back and his knees bent, legs crossed and ankles vertical or pushed towards his buttocks.

42. Mr Csepreghy called the police for assistance at 4:57am. By this time Mr Osborne was restrained on the ground, and can be heard struggling violently in the background in the recording of this telephone call.

43. The evidence as a whole indicates that Mr Osborne resisted with considerable force initially, but soon after displayed little or no resistance. RN Ponton's evidence was that he continued yelling and struggling for a few minutes and then went quiet.

44. At least one oxygen saturation test was carried out on Mr Osborne towards the end of the restraint and a result of no less than 93% was obtained. RN Sonter, whose evidence was that she conducted such a test, said that Mr Osborne was warm to touch and had a pulse rate of 130. She said that she had no difficulty applying the monitor to Mr Osborne's finger and that he was still moving at that time.

45. Ms Kelman's evidence was that she was aware, as a result of her training, of the need to maintain the "window of safety" for the restrained person. This meant that no pressure should be applied to the area between the bottom of the neck to the top of the buttocks. At the inquest she said she had monitored Mr Osborne's condition constantly throughout the restraint.

46. In her witness statement[2] Ms Kelman said she had applied the oxygen saturation monitor to Mr Osborne's finger and a reading of 97% was

[2] Exhibit B19

recorded, with a heart rate of 146. At the inquest she conceded that it may have been 93% but noted that the digital readout refreshes, and both readings were possible. Ms Kelman said that she asked for Mr Osborne's oxygen saturations to be monitored because his colour was a "bit off". She assessed the test results as acceptable.

47. Apart from RN Kirrily Halliday, none of the witnesses at the inquest saw any pressure being applied to Mr Osborne's back. There was evidence that Mr Osborne's breathing became progressively deeper and shallower while he was being restrained. RN Ponton's evidence was that she did not recall Mr Osborne say "I can't breathe" at any stage during the restraint.

48. RN Kirrily Halliday was 'specialling' a mental health patient on Ward 2A. This meant that she was providing one on one care. She was having a meal break in the MHU when Mr Osborne was banging on the door to that unit, and hospital security were subsequently notified. She could see Mr Osborne on the CCTV footage at the MHU and saw him in Ward 2A when she returned from her meal break. She subsequently called the MHU to see if Mr Osborne could be seen there. The Mental Health Co-ordinator, Mr Csepreghy, advised her that Mr Osborne would need to be seen in the Emergency Department.

49. RN Halliday said that during the restraint she saw Mr Jones sitting on top of Mr Osborne who was saying "I can't breathe". However, I do not consider that RN Halliday's evidence about the restraint was particularly cogent. She did not make contemporaneous notes, and her statement was not taken until September 2015, a month after the incident. She also acknowledged at the inquest that her view of events in Ward 2A was obstructed, and she conceded that her recollection was hazy. She also frankly acknowledged that, because her view was obstructed, Mr Jones (who was wearing a white gown) may have been leaning on Mr Osborne rather than sitting on him.

50. Each of the security officers gave evidence that, though Mr Osborne had stopped resisting the restraint after about five minutes, he continued to be held in the prone position as they were concerned he was "playing possum". They were concerned that he was pretending to stop resisting and would possibly assault them if they stopped restraining him. Those restraining Mr Osborne also said that they only applied the pressure necessary to hold him in place. I accept that evidence.

51. Mr Laakso's evidence was that Mr Osborne was breathing throughout the restraint. Mr Laakso and Mr Duke both derived comfort from the fact that Mr Osborne's oxygen and pulse were being monitored by medical staff, and they were following the instructions of the Hospital Manager. Mr Laakso said that following the introduction of handcuffs at the Caboolture

hospital it was much simpler to restrain individuals. The evidence of Mr Duke and Mr Jones suggested a lack of awareness about the physiological risks of laying a person in the prone position.

52. Paul Csepreghy's evidence was that, at around 5:05am, when he left Ward 2A to meet the police Mr Osborne was still moving. The police attended Ward 2A at 5:09am.

53. The evidence of Senior Constable Kirby and Constable Gray was that, upon arriving at the scene, they immediately noticed that Mr Osborne was in poor health due to his unnatural skin colour. Mr Osborne was not making any sounds or resisting the restraint.

54. Constable Gray said that she said to those restraining Mr Osborne, "you need to get off". Senior Constable Kirby said that he applied his handcuffs to Mr Osborne, at least in part, because security officers told him that Mr Osborne was "playing possum". This action was also consistent with his training.

55. Senior Constable Kirby said that after rolling Mr Osborne onto his side he could not detect a carotid pulse. Attempts were made to sit Mr Osborne up. He was unresponsive. Mr Osborne's handcuffs were removed after he was placed on a stretcher and Senior Constable Kirby commended CPR. At 5.13am, a hospital Medical Emergency Team was called to attempt to resuscitate him.

56. Mr Osborne was not able to be resuscitated and was pronounced deceased by the Medical Emergency Team at 5.48am.

Training of security staff

57. Mr Scott Trudgett is the Occupational Violence Prevention (OVP) Coordinator for Metro North Hospital and Health Service. Among others, this position covers the Caboolture, Prince Charles and the Royal Brisbane and Women's Hospitals, and is responsible for mandatory training in occupational violence prevention and risk assessment.

58. Mr Trudgett's evidence was that an OVP course is mandatory for all employees (18000 in MNHHS). A security officer would attend a course comprising four separate modules, including awareness, de-escalation, basic personal safety and team restrictive practices. This course would take three days to complete, depending on the individual circumstances. Where Operational Support Officers such as Mr Jones, form part of the emergency response team, they would receive the same training. Refresher training is provided and expected to be undertaken at least once

every 12 months.[3] However, compliance with this requirement is the responsibility of line management within each separate hospital.

59. Mr Trudgett's evidence was that training is provided in relation to factors such as excited delirium and drug toxicity. In addition they are also "taught that face down restraints, restraint stress and positional asphyxia are also contributing factors during restraining techniques".[4] In order to mitigate risks associated with restraint staff are instructed to complete the restraint quickly and avoid weight on the torso. They are to stand the patient up and relieve them of any weight by getting them out of the prone position as soon as possible, and to continuously monitor the restrained person.

60. The evidence indicated that Mr Laakso had not received any training in restrictive practices since April 2013. Although he was a member of the hospital's Code Black Team, Mr Jones had last undergone training in November 2009. Similarly, Mr Wiles had not undergone any training in restrictive practices, although he had assisted in the restraint of Mr Osborne.

61. Mr Duke's evidence was that he had undergone refresher training in July 2015 but this was of only one hour's duration. After he unsuccessfully completed additional training in December 2015, he resigned from his employment at the hospital for health reasons.

62. Senior Sgt Hayden's evidence was that Queensland Police Service officers are provided practical training in relation to the physiological impacts of restraint. Officers are required to undergo training in which they run in a gymnasium in order to build up lactic acid. They then have a ball placed under their stomachs to replicate the paunch of a restrained person.

63. QPS officers are also taught to identify how a restrained person will struggle for breath and panic, apparently elevating their level of resistance. While "playing possum" is seen as a legitimate concern, officers are required to move restrained persons to the recovery position as soon as possible.

64. While the security officers who gave evidence at the inquest did not articulate any concerns about holding Mr Osborne in a prone position, Constable Gray identified that this was a case of "classic positional asphyxia" where pressure on the abdomen causes blackout and potential suffocation. In this regard she recalled the training described by Senior Sgt Hayden.

[3] Exhibit B36.
[4] Exhibit B36, page 5.

Autopsy results

65. Experienced forensic pathologist, Dr Rohan Samarasinghe, conducted a post mortem examination on 19 August 2015. He concluded that the cause of death was the "effects of restraint and drugs".[5]

66. Dr Samarasinghe's autopsy report noted that the findings of this case were consistent with a sudden unexpected death during restraint in an agitated individual affected by drugs. He found no evidence of classic signs of asphyxia such as conjunctiva or other petechial haemorrhages with significant congestion.

67. However, Dr Samarasinghe considered that restraint/positional asphyxia would be considered a significant perimortem mechanism of death, particularly in view of the history. He also noted that amphetamines are recognised heart toxins and these would have played a major role in the death. He said that "individuals affected by illicit drugs such as amphetamines would be at high risk for sudden arrhythmogenic cardiac death during restraint. Often autopsies do not show any pathologies in such individuals."

68. The autopsy report noted that

> *Positional asphyxia (postural asphyxia) is a form of asphyxia which occurs when someone's position prevents the person from breathing adequately. Restraint asphyxia can be defined as obstruction of breathing as a result of restraint technique. It occurs when the position of a person's body interferes with the ability to breath. If this is not recognised, death can occur from asphyxia or suffocation or other mechanisms. Additional complex perimortem mechanisms can operate when an individual is affected by certain drugs such as stimulants. Often death results from fatal arrhythmogenic cardiac arrest.*

69. In order to appreciate the role that Mr Osborne's amphetamine use played in his death a report was also obtained from Associate Professor Mark Little, an Emergency Physician and Clinical Toxicologist employed as a Senior Staff Specialist at Cairns Hospital. Dr Little's opinion was that it is unlikely that the concentration of methamphetamine (1.2mg/kg), amphetamine (0.16mg/kg), amitriptyline (0.21mg/kg) and nortriptyline (0.53mg/kg) would have caused the death, irrespective of whether Mr Osborne was restrained.[6]

70. Dr Little thought that it was unlikely that the presence of methamphetamine, amphetamine and antidepressants would have affected Mr Osborne's capacity to withstand protracted restraint. In his

[5] Exhibit A18
[66] Exhibit B42.

opinion, the drugs had a direct cardiovascular effect, making Mr Osborne more agitated and aggressive. Combined with the restraint they are likely to have contributed to Mr Osbourne's sudden arrythmogenic cardiac arrest.

71. At the inquest, Dr Samarasinghe agreed with Dr Little's conclusion that the cause of death was multifactorial. Relevant causative factors were the proarrythmic effects of amphetamines on the heart, the agitation and violence resulting in production of an acidotic state. The prone position may have made Mr Osborne more anxious and subjectively feel breathing was more limited; and impaired recovery from the abnormal physiological state he was in, as evidenced by a change in his initial observations just prior to his cardiac arrest.

Investigation findings

72. Detective Snr Sgt Ryan's investigation report expressed concern about the period of time in which Mr Osborne was restrained face down. He considered that the period of restraint was inconsistent with the training provided to hospital staff. However, he noted that hospital staff attempted to maintain communication with Mr Osborne and monitored his oxygen levels and heart rate throughout the restraint.

73. Detective Snr Sgt Ryan considered that the provision of physical restraint such as handcuffs would have enabled those restraining Mr Osborne to reduce the amount of time he was held in a prone position and limit the duration of the struggle.

74. Detective Snr Sgt Ryan also noted that several of the hospital staff involved in restraining Mr Osborne had not completed the requisite refresher training in relation to occupational violence prevention.

75. Detective Snr Sgt Ryan concluded that there was insufficient evidence to support a criminal prosecution against any person in relation to the death. He found that the police officers who dealt with Mr Osborne on 17 August 2015 acted in accordance with relevant QPS policies and procedures.

76. Detective Snr Sgt Ryan made several recommendations in his investigation report directed to the chief executive of the Metro North Hospital and Health Service, including:

- whether handcuffs or wrist ties should be approved for use in restraining violent and aggressive patients;
- the use of Go Pro or Body Worn Camera type devices by Security Officers in dealing with violent and aggressive patients;

- reviewing the risk management practices in relation to the completion of required competency based refresher training; and
- reviewing the policy of clinically assessing all patients in the Emergency Department, rather than in the MHU.

Conclusions on Issues

The adequacy and appropriateness of the decision to request for the deceased to be restrained in the lead up to his death

77. I accept that at no time did hospital staff intend to cause Mr Osborne any harm. The attempts to persuade Mr Osborne to voluntarily leave Ward 2A were reasonable. He was given a number of minutes to leave the ward and the outcome of negotiations was a stalemate between him and hospital staff.

78. Given the close proximity of Mr Osborne to sleeping and vulnerable patients recovering from surgical procedures, and his level of intoxication from illicit drugs, I accept that the decision to have Mr Osborne restrained and removed from the ward was justified.

79. While it was theoretically possible to allow Mr Osborne to proceed directly to the MHU for an assessment, potentially minimising the need to restrain him, I accept the evidence of hospital staff that this was not practical in the circumstances, and that a comprehensive assessment of his medical needs could not occur in the MHU.

The adequacy and appropriateness of the manner by which the deceased was restrained in the lead up to his death

80. Mr Osborne was not acting in an aggressive manner in the lead up to the initial attempts to restrain him in Ward 2A (apart from banging on the door at MHU).

81. However, I conclude that after attempts were made to escort Mr Osborne from that ward, and the subsequent restraint began, Mr Osborne violently resisted, and it was necessary to apply significant force to maintain the restraint in the interests of patient and staff safety. I note in particular the evidence of Mr Duke that this was among the most violent struggles he had experienced in his career as a security officer.

82. I also accept the evidence of Mr Duke and other witnesses that while Mr Osborne was restrained for over 10 minutes, he only struggled significantly for a short time at the beginning of this period. This is consistent with the audio recording of Mr Csepreghy's telephone call for police assistance.

83. The evidence of Dr Samarasinghe and Dr Little was that restraint of Osborne in a prone position was a factor that contributed to his death. Consistent with the evidence of Snr Sgt Hayden, the contribution of this factor could have been minimised had Mr Osborne been rolled onto his side after he stopped resisting. Handcuffs may have made that course

easier, and it is unfortunate that handcuffs were not made available to Caboolture Hospital security staff at that time.

84. The QPS officers who attended at the Caboolture Hospital in response to Mr Csepreghy's call for assistance were only tangentially involved in the restraint of Mr Osborne. I find that they acted professionally and appropriately, and in accordance with QPS policies and procedures.

The adequacy and appropriateness of the manner by which the deceased's vital signs were checked during the restraint

85. I accept that the Code Black Team monitored Mr Osborne's vital signs during the restraint. An oxygen saturation test was conducted. While there was inconsistent evidence as to whether one or two tests were conducted, and whether the result was 93% or 97%, these discrepancies are not surprising given the dynamic environment at the time. If the meter remained in situ, then it is possible that both readings were returned.

86. The fact that the oxygen saturation test was done shows an awareness from the attending medical staff that Mr Osborne's health was at risk during the restraint. Ms Kelman in particular was conscious of the need to maintain a "window of safety" and took active steps to ensure Mr Osborne's health was monitored.

87. It is difficult to reconcile the oxygen saturation levels recorded by hospital staff, and their view that he was in good health, with the evidence of the QPS officers that it was immediately apparent that Mr Osborne was unresponsive when they arrived at Ward 2A.

88. The accounts of Senior Constable Kirby and Constable Gray are strengthened by the fact that very soon after their arrival, and handcuffs were applied and removed, Mr Osborne was unresponsive and in urgent need of resuscitation.

89. I accept the submission of Counsel Assisting that Mr Osborne's skin pallor is likely to have changed just as the police officers arrived at Ward 2A. Having regard to the fact that qualified hospital staff were monitoring Mr Osborne's vital signs I do not accept that they simply failed to notice Mr Osborne's deteriorating health as the restraint progressed.

The adequacy and appropriateness of the training provided to employees of the Caboolture Hospital with respect to physically restraining a person

90. While the senior hospital staff in attendance throughout the restraint had received high levels of training, I conclude that the training of the four persons who physically restrained Mr Osborne, including Mr Wiles, was inadequate. However, having regard to the multifactorial causes of the death, I cannot conclude that the lack of training played a role in Mr Osborne's death.

91. Mr Duke's training was ad hoc, and, on his evidence, the refresher training was unduly brief. I note, however, that he was assessed as compliant at the refresher training in 2015. There were significant gaps in Mr Jones' training from 2009. Mr Laakso's training was out of date, and on Mr Trudgett's evidence, he had not been trained under the more refined process implemented in June 2013. Mr Wiles was never trained even though he actively assisted in the restraint of Mr Osborne.

92. I concur with the submission of counsel assisting that these were serious deficiencies. It is self-evident that inadequate training in restrictive practices can have a serious impact on the welfare of persons being restrained, particularly large, drug affected individuals such as Mr Osborne.[7]

93. Mr Trudgett's evidence was that Occupational Violence Prevention trainees were taught that persons should be moved from the prone position as soon as possible, "providing that it is safe to do so". While this proviso catered for the code black team's concerns about Mr Osborne playing possum, I consider that the concern about this was overstated in this case.

94. In my view, the training provided to the security officers failed to sufficiently address the risks involved in restraining a person in the prone position, irrespective of whether weight is placed on the person's torso. None of the persons directly involved in the restraint thought they would act differently if the same circumstances presented in future. The evidence of Mr Duke and Mr Jones was that they were unaware of the risks of laying the restrained person in a prone position.

[7] Mr Osborne was 183cm tall and weighed 95.6kg.

Findings required by s. 45

95. I am required to find, as far as is possible, the medical cause of death, who the deceased person was and when, where and how he came by his death. After considering all the evidence, including the material contained in the exhibits, I am able to make the following findings:

Identity of the deceased – Warren Andrew Osborne

How he died –	Mr Osborne died due to the combined effects of drugs and being restrained in a prone position for over ten minutes. A number of factors contributed to his death, including the proarrythmic effects of the amphetamines and other stimulants he had taken on his heart. The restraint also resulted in production of an acidotic state with marked release in catecholamine and lactate. It is not possible to separate the various factors that contributed to Mr Osborne's death.
Place of death –	Caboolture Hospital, 120 McKean Street, Caboolture
Date of death–	17 August 2015
Cause of death –	The effects of restraint and drugs

Comments and recommendations

96. Section 46 of the *Coroners Act 2003* provides that a coroner may comment on anything connected with a death that relates to public health or safety, the administration of justice or ways to prevent deaths from happening in similar circumstances in the future.

97. Following Mr Osborne's death, the Caboolture Hospital has implemented the following changes which are likely to reduce the prospect of a re-occurrence of the events contributing to Mr Osborne's death:

- hand cuffs and body worn cameras are available for use by security officers;
- malfunctioning fire doors near the Emergency Department have been replaced, and wards are secured by locked doors after hours;
- membership of Code Black Teams has been refined so that Operational Support Officers no longer form part of those teams;

- further CCTV cameras have been placed throughout the hospital including public areas in the wards on level 2;
- additional CCTV cameras and monitors have been placed in the Emergency Department; and
- additional funding has been allocated for further security officers.

98. Although it is clear that the position with respect to training has improved, the mechanism by which training is co-ordinated, monitored and delivered by Metro North Hospital and Health Service remains unclear.

Recommendations

1. *I recommend that a review be conducted in order to establish clear lines of communication and authority between Metro North Protective Services and the line managers within individual hospitals within that health district to ensure that mandatory training in occupational violence prevention is undertaken, particularly by those on emergency response teams, within the timeframes specified.*

2. *I recommend that, consistent with Queensland Police Service policy[8], hospital and health service officers who are members of emergency response teams who fail to demonstrate competence in restrictive practices training are not to be deployed to perform such practices.*

3. *I recommend that the Metro North Hospital and Health Service consider adopting aspects of the Queensland Police Service's practical training in relation to the physiological impacts of positional asphyxia to reinforce the risks of prone restraint to those engaged in this practice.*

99. I close the inquest.

Terry Ryan
State Coroner
Brisbane
29 January 2018

[8] Operational Procedures Manual, Chapter 14.3.10