CORONERS COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Gregory Masters
Hearing dates:	24 August 2020 and 27 August 2020
Date of findings:	25 September 2020
Place of findings:	Coroner's Court, Lidcombe
Findings of:	Magistrate Harriet Grahame, Deputy State Coroner
Catchwords:	**CORONIAL LAW** – polypharmacy overdose – adequacy of medical care and treatment – whether restraint for administration of sedation was reasonable – whether cause of death can be ascertained – whether amitriptyline was ingested in hospital – whether death was self-inflicted
File number:	2017/67674
Representation:	(1) Counsel Assisting Mr Christopher McGorey of counsel, instructed by Ms Clara Potocki of the NSW Crown Solicitor's Office (2) Nepean Blue Mountains Local Health District Mr Peter Aitken of counsel, instructed by Mr Les Sara of Hicksons Lawyers (3) Matthew Kelaher Mr Steven Barnes of counsel, instructed by Ms Meesha McLeod of McCabe Curwood (3) Dr Sam Orde Mr Cameron Jackson of counsel, instructed by Mr John Kamaras of Avant Law

Non-publication orders:	I make the following orders:: 1. That the CCTV footage recorded at Nepean Hospital on 2 March 2017 and still shots of the CCTV footage located at tab 60 of the Coronial Brief of Evidence are not to be published under section 74(1)(b) of the *Coroners Act 2009*. 2. That the 2 still shot photographs of CCTV footage recorded on 2 March 2017 at Nepean Hospital with initial MK marked as Exhibit 2 are not to be published under section 74(1)(b) of the *Coroners Act 2009.* 3. That pursuant to section 65 of the *Coroners Act 2009* access to the CCTV footage recorded at Nepean Hospital on 2 March 2017 and still shots of the CCTV footage located at tab 60 of the Coronial Brief of Evidence is restricted. 4. That pursuant to section 65 of the *Coroners Act 2009* access to the 2 still shot photographs of CCTV footage recorded on 2 March 2017 at Nepean Hospital with initial MK marked as Exhibit 2 is restricted.
Findings:	The *Coroners Act 2009* in s. 81(1) requires that when an inquest is held, the coroner must record in writing his or her findings as to various aspects of the death or suspected death. These are the findings of an inquest into the death Gregory Masters. **Identity of deceased**: The person who died was Gregory Masters. **Date of death**: Gregory died on 2 March 2017. **Place of death**: Gregory died at Nepean Hospital, Penrith NSW. **Cause of death**: Gregory died of a polypharmacy overdose of Amitriptyline and Doxylamine in the context of underlying co-morbidities of obesity, cardiovascular disease and obstructive sleep apnoea. **Manner of death**: Gregory died as a result of a drug overdose in the context of poor health. It is likely that he intended to end his life at the time he ingested the Amitriptyline and Doxylamine on 26 or 27 February 2017. However, the evidence does not establish that he still held an intention to end his life on 2 March 2017, in particular at the time he was restrained to enable the administration of sedatives.

Recommendations:	None

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Introduction

1. This inquest concerns the tragic death of Gregory Masters. Gregory died in traumatic circumstances after being restrained in the Intensive Care Unit at Nepean Hospital on 2 March 2017. He had been brought to hospital on 27 February 2017 following a suspected overdose.

2. Gregory was 52 years of age at the time of his death. He is described by his family and friends as very family oriented. He took great interest in his relatives and loved attending family events and gatherings.[1] He enjoyed sports, especially football, and he loved animals.[2] Gregory had a passion for tattooing and became a tattoo artist. He was also involved in volunteer work for the Norman Lindsay Gallery.[3]

3. Gregory's final letter expresses his enormous love for his partner and the happiness he experienced with her travelling in their motor home.[4]

4. The profound grief felt by his family and partner is ongoing. I offer my sincere condolences to his family and loved ones.

The role of the coroner

5. The role of the coroner is to make findings as to the identity of the nominated person and in relation to the place and date of death. The coroner is also to address issues concerning the manner and cause of the person's death.[5] A coroner may also make recommendations in relation to matters that have the capacity to improve public health and safety in the future, where a need for such recommendations arises from the evidence.[6]

6. In this case, there is no dispute in relation to the identity of Gregory, or to the date or place of his death. For this reason the inquest focused on the medical cause of death and on the manner and circumstances surrounding Gregory's death.

The evidence

7. The court took evidence over two hearing days. Oral evidence was taken from a security guard involved in Gregory's restraint and from his treating doctor at the Nepean Hospital

[1] Statement of Stacey Ientil [4], tab 45.
[2] Statement of Cheryl Gordon [6], tab 50.
[3] Statement of Cheryl Gordon [10], tab 50.
[4] Letter to Marianne Batey, tab 46
[5] Section 81 *Coroners Act 2009* (NSW).
[6] Section 82 *Coroners Act 2009* (NSW).

Intensive Care Unit (**ICU**), among others. Gregory's medical care was reviewed by an independent specialist, who also gave evidence in conclave with the forensic pathologist who conducted his autopsy. The court also received extensive documentary material, compiled in a four volume brief of evidence. This material included witness statements, medical records, photographs and video recordings. While I do not intend to refer to all of the material in detail in these findings, it has been comprehensively reviewed and assessed.

8. A list of issues was prepared before the proceedings commenced and circulated to the parties, these included:

    i. Whether the cause of death can be ascertained?

    ii. Whether the medical care and treatment that Mr Masters received at Nepean Hospital between 27 February 2017 and 2 March 2017 was reasonable, adequate and appropriate in the circumstances?

    iii. Whether the use of restraint and administration of sedative medication on 2 March 2017, whilst Mr Masters was in the Intensive Care Unit at Nepean Hospital, was reasonable and appropriate in the circumstances?

9. To assist the court in focusing only on the matters in contention, those assisting me prepared a concise summary of the documentary evidence and medical records relating to Gregory's death. The summary was circulated to the interested parties during the course of the inquest for consideration and comment, prior to finalisation. I indicated that I intended to adopt it as the basis of my fact finding on non-contentious matters and urged comment or correction. I was alerted to no particular controversy. In my view, what follows is an accurate and useful distillation of the tendered material. I thank those assisting me for their hard work in the preparation of the following chronology.

Background and Chronology

10. Gregory Masters (**Gregory**)[7] died at Nepean Hospital on 2 March 2017 aged 52. He is survived by his de facto partner of about 9-years, Mari-Anne Batey, and his family including his adult children from an earlier relationship[8], Bradley Masters and Samantha Lee[9], and sisters, Michelle Brown and Cheryl Gordon.[10]

[7] Date of birth 17 March 1964.
[8] Deborah Lee is the mother of Gregory's children.
[9] Statement of Senior Constable Monique Cini [4]-[7], tab 10.
[10] Parents are Vivian Masters and Johnathon Boyd: Statement of Senior Constable Cini [4], tab 10.

Health

11. As at 2017 Gregory's physical health was poor.

12. Gregory suffered obesity, obstructive sleep apnoea, diverticulitis (a colon inflammation or infection), coronary artery disease and depression (for which he was prescribed Zoloft). He was a heavy smoker of cigarettes (about 30 cigarettes a day).[11]

13. Since about 2013 he experienced chronic facial pain, exacerbated by bouts of a facial nerve condition known as Trigeminal Neuralgia (**TN**).[12] He typically suffered TN episodes each month with each episode typically lasting 4 to 5 days during which he was bed ridden with pain.[13] He ceased his employment as a tattoo artist 2 years earlier owing to his difficulties with this condition.[14]

14. In the three years prior to his death Gregory attended on Dr Shobha Balu (general practitioner), Dr Samantha Critchley (general practitioner at Hazelbrook Medical Centre) and a neurologist Dr Johnathan Wood for treatment.[15]

15. In Dr Critchley's opinion Gregory suffered a chronic complex facial pain that was exacerbated by bouts of TN. His condition worsened in late 2016 along with his weight gain and worsening obstructive sleep apnoea. This negatively affected his mood and ability to cope with pain.[16] Between September 2014 and March 2017, Gregory's weight increased from 90[17] to about 110 kilograms.[18]

16. Gregory was prescribed numerous medications including Endone and Amitriptyline, the latter prescribed to him on 24 March 2015 and again on 11 October 2016 (two repeat prescriptions). Amitriptyline had been prescribed at the recommendation of an oral maxillofacial surgeon, Dr McHugh, for the management of Gregory's facial pain.[19] He was also prescribed Zoloft of depression as at 2017.

17. Gregory attended on Dr Wood in 2013 and 2014 for his facial pain. He was prescribed CR tablets in that time. Gregory was expected to undergo dental work to remove teeth in an

[11] Statement of Mari-Anne Batey [7], tab 46.
[12] Statement of Dr Matthew Hannon [12], tab 23; statement of Mari-Anne Batey [13], tab 46.
[13] Statement of Mari-Anne Batey [17], tab 46.
[14] Mari-Anne Batey report to police on 27.02.17; statement of Senior Constable Mark Donaldson [5], tab 11.
[15] Statement of Mari-Ann Batey [13]-[14], tab 46.
[16] Statement of Dr Samantha Critchley, tab 52 (Gregory's last attendance on Dr Critchley was 11 October 2016).
[17] Hazelbrook General Practice records, tab 56
[18] Dr Sairita Maistry report p.1,1 tab 5.
[19] Consultation 24.03.15, Hazelbrook General Practice records, tab 56 – ""Dr McHugh…says that jaw is out, needs occlusion splint, wants him to start amitriptyline had used up Targins, and finished endone a while ago"; Pathologist report p.2, tab 5; Statement of Dr Matthew Hannon [12], tab 23.

attempt to alleviate his pain. Dr Wood noted that there were elements of TN in his condition.[20]

February 2017

18. As at February 2017, Gregory and Ms Batey were living in his Recreational Vehicle (**RV**) motor home which was parked in the driveway of Ms Batey's daughter's house in Colyton. They purchased the RV to go travelling but had not yet managed to do so. In the weeks preceding 26 February 2017 Gregory appeared low in mood and pale in appearance.[21]

Sunday 26 February 2017

19. Around 4 pm on 26 February 2017, Gregory left alone in the RV to visit his friend Jacob "Jake" Norris who lived about 20 minutes away in Llandilo. Gregory took Ms Batey's mobile phone, at her request, as he had lost his.

20. At about 7: 00 pm Ms Batey attempted contacting Gregory, using his iPad, when he had not arrived back home. He did not answer the calls. Ms Batey assumed there was an issue with his reception or else he had stayed the night with his friend but had neglected to tell her.

Monday 27 February 2017

21. Ms Batey made further attempts to reach Gregory by phone without success. She called Mr Norris on the morning of Monday 27 February 2017. He advised Gregory had not arrived the previous day as expected.[22] Ms Batey then contacted police and reported Gregory was missing.

22. At about 10:44 am police attended on her to discuss the report.[23] She reported to police she usually cared for Gregory, but her own condition[24] had made doing so difficult in recent times. She was worried Gregory felt he was a burden on her and his depression had worsened. She believed he had a full box of Endone in his vehicle when he left. She thought one place he might go would be to Euroka Clearing in Glenbrook (a place they had previously visited and liked).[25]

[20] Statement of Senior Constable Monique Cini [83], tab 10 (last documented attendance on Dr Woods was 26 March 2014).
[21] Statement of Senior Constable Mark Donaldson [6], tab 11.
[22] Statement of Senior Constable Mark Donaldson [7]-[8], tab 11; statement of Jacob Norris [10], tab 49.
[23] Senior Constable Mark Donaldson and Constable Birch.
[24] Ms Batey suffers a nerve pain disorder (fibromyalgia).
[25] Statement of Constable Hayley Birch [6]-[8], tab 13.

23. Ms Batey also notified Gregory's family and friends that he was missing including Brendan Whitemore, Gregory's close friend.[26] Ms Batey also attended an RV store to ask if it was possible to track Gregory's RV through its electronic tracker.

24. Mr Norris and Mr Whitemore looked for Gregory at the Jellybean Pool area in Glenbrook and then through to the Euroka clearing at Ms Batey's request.[27] At the Euroka clearing they saw the RV hidden at the back of the reserve.

25. Mr Norris and Mr Whitemore forced entry into the RV. They found Gregory lying on his bed. He was conscious and moaning in apparent pain. There was no phone reception at this location.

26. Mr Whitemore drove to an area to call for assistance while Mr Norris started the RV and drove it out towards the main entrance until he got reception and called triple zero. Mr Norris then searched the van for drugs, at the suggestion of the triple zero operator, and found a box of medication on the bed next to Gregory which he later showed to the attending paramedics.[28]

27. At about 1:30 pm, ambulance paramedics arrived at the Glenbrook National Park (Blue Mountains National Park). Mr Norris drove the RV to a carpark so the paramedics could treat Gregory safely.[29] Police attended sometime after the arrival of paramedics.[30]

28. The paramedics found Gregory lying on the RV's bed, drowsy, drifting in and out of consciousness, but easily rousable. They were handed a packet of Dolased medication.[31] Dolased is an over the counter medication containing paracetamol, codeine and doxylamine (antihistamine drug[32]).[33] It appears this packet, which is sold with 40 tablets, was empty.

Admission to Nepean Hospital on Monday 27 February 2017

29. Gregory was transported by ambulance and admitted to Nepean Hospital at about 2:26 pm on Monday 27 February 2017.

[26] Statement of Mari-Anne Batey [31]-[32], tab 46.
[27] Brendan Whitmore also told police at the scene that they went to Jellybean Pool area at Ms Batey's request as that was a place Gregory was known to frequent: statement of Senior Constable Phillip Hannah [9]-[10], tab 12.
[28] Statement of Jacob Norris [17], tab 49.
[29] Statement of Linda Patterson [6], tab 34; statement of Ronald Mamo, tab 44.
[30] Statement of Senior Constable Phillip Hannah [9]-[10], tab 12.
[31] Ms Batey had purchased previously Dolased for her own use but her purchased Dolased was accounted for meaning the box found in the RV did not come from her supply.
[32] Dr Sairita Maistry report, tab 5.
[33] Statement of Linda Patterson [7], tab 43.

30. An electrocardiogram (**ECG**) was performed after his arrival which showed prolonged QRS complexes possibly suggestive of Amitriptyline toxicity and a paracetamol level in the toxic range.[34]

31. He was admitted to the Intensive Care Unit (**ICU**) at about 7:35 pm. He was administered naloxone to counteract the effects of suspected opioid toxicity and acetylcysteine to counteract the effects of paracetamol toxicity.[35] He was intubated at about 8:00 pm that same night following his Glasgow Coma Scale (**GCS**) dropping to 3/15.[36] At 11:39 pm he was administered sodium bicarbonate to counteract tricyclic antidepressant toxicity, and again on two occasions during the early hours of 28 February.[37]

32. Dr Sam Orde, an intensive care staff specialist, was the admitting ICU medical officer[38] and was involved in Gregory's subsequent treatment at the hospital.[39]

Tuesday 28 February to Wednesday 1 March 2017

33. Between 27 February and 1 March 2017, Gregory was intubated (receiving oxygen through mechanical ventilation). He was extubated on 28 February 2017 when he became agitated and started choking on his endotracheal tube. He was reintubated about 7-hours later when he showed signs of hypoxia.[40]

34. Gregory was extubated and placed on high flow nasal oxygen prongs at about 8:50 am on 1 March 2017. He required nasal prongs to keep his oxygen saturation at acceptable levels.[41] He was noted to exhibit mild confusion at the time. He was able to maintain his airway. Cardiac monitoring showed rhythm abnormalities, but his liver and renal function tests showed mild improvement.[42]

35. Ms Brown and Gregory's niece, Stacey Ientile visited him on the morning of Wednesday 1 March 2017. During that visit he was able to talk but seemed "*dazed and confused*" and would talk about random non-sensical things. His confusion appeared to improve over the course of the afternoon. Ms Batey visited him later that same morning.

[34] Dr Sairita Maistry report, tab 5.
[35] Dr Sairita Maistry report, tab 5.
[36] Dr Sairita Maistry report p.3, tab 5.
[37] Professor Anne-Maree Kelly 1st report, tab 64.
[38] Nepean records, tab 55.
[39] Statement of Dr Sam Orde, tab 21.
[40] Dr Sairita Maistry report p.3 tab 5; statement of Dr Sam Orde [5], tab 21.
[41] Statement of Dr Samuel Law [8], tab 26.
[42] Dr Sairita Maistry report, tab 5; Statement of Dr Sam Orde [7], tab 21.

Thursday 2 March 2017

36. At about 10:00 am on Thursday 2 March 2017 Gregory was reviewed by Dr Matthew Hannon and Dr Azadeh Atashnama, both psychiatric registrars.

37. Gregory exhibited persistent confusion and memory issues about preceding events. In that review the doctor's noted Gregory had attempted suicide by overdose and that his planning included the writing of a suicide letter and driving to a remote location. His depression had worsened due to his ongoing facial pain and his belief he was a burden to his partner. During assessment he stated he had been prescribed Amitriptyline (Endep) and Endone in the past but could not recall any details around his recent use of these medications.[43] He gave a general impression of having no current suicidal ideation.[44]

38. The preliminary plan was to defer making a final diagnosis until further interview once his condition had improved. He was to be reassessed the next day.[45] The progress notes recorded he was not to be administered Amitriptyline. Their diagnosis at that point was "*depression with recent suicidal attempt*".[46]

39. Later that same day Dr Samuel Law, a Senior Resident Medical Officer, reviewed Gregory. Gregory presented as "*slightly confused*" but able to follow instructions. He still did not fully remember the events leading up to his admission, but his cognitive state was considered to be improving.[47]

40. At about 2:30 pm, Joharra Lebron RN saw Gregory whilst his family were present. She saw him try to take off his high flow nasal prongs and an indwelling catheter. His family stopped him doing so but he kept fiddling with that equipment. Ms Lebron RN and another nurse, Mhary Gacuma RN, transferred him from his chair into his bed at his family's request.[48] The family visit ended sometime prior to 4:30 pm.

41. At about 4:30 pm Dr Sebastian Knudsen attended on Gregory at his bedside during his ward round and discussed Gregory's case with him. Dr Knudsen states he did not observe anything unusual about Gregory's appearance or demeanour.[49] Around that same time Dr Orde and the ICU Nurse Unit Manager were performing Dr Orde's daily afternoon ward

[43] Statement of Dr Matthew Hannon [12], tab 23.
[44] Statement of Dr Matthew Hannon, tab 23.
[45] Statement of Dr Matthew Hannon, tab 23.
[46] Statement of Dr Sam Orde [7], tab 21.
[47] Statement of Dr Samuel Law, tab 26.
[48] Statement of RN Joharra Lebron [7], tab 33.
[49] Statement of Dr Sebastian Knudsen [7], tab 24.

round. Dr Orde saw Gregory in his bed-space (number 10), alone, sitting up in a chair. He was wearing high flow nasal prongs and appeared stable.[50]

Events preceding restraint

42. At about 4:40 pm Joharra Lebron RN found Gregory with his air prongs loose and bleeding. Despite her efforts to stop him, he removed his calf compressors and managed to stand up off his bed.[51]

43. Mhary Gacuma RN heard a call for help. He approached and saw Gregory standing up towards the back of the room with his high flow oxygen prong off. Gregory was "*throwing his arms around"* and appeared confused as another nurse attempted to settle him.[52] Ms Gacuma RN pressed the emergency button.[53]

44. At about 5 pm Dr Orde heard shouting and commotion coming from the ICU and saw Gregory, without clothing and distressed, running down the ICU corridor. Gregory appeared pale, grey, diaphoretic (heavy sweating), tachypnoeic (rapid breathing) and highly anxious. Blood was falling from his right hand where he had pulled out his right radial arterial line. He heard Gregory say "*find the police, I've been shot*".[54]

45. Dr Orde tried to calm Gregory down and took his shoulder to guide him back to bed. Gregory grabbed Dr Orde's wrist and resisted that attempt.[55] Gregory headed towards the ICU exit doors.

46. Dr Ian Seppelt, the other intensivist on duty, attempted to hold Gregory by the shoulders in an attempt to settle him down. Gregory became angry and resisted.[56] At some point another staff member unsuccessfully tried to position a recliner chair behind Gregory so he could sit down.[57] Gregory exited the ICU area when its doors were opened (by someone outside) to let another patient inside.

47. Gregory was unsteady on his feet as he ran out the ICU doors. He entered the waiting room outside the ICU entrance and called for police. He asked others in the waiting room for help and sat down near them. Dr Orde and Dr Seppelt followed and cleared the room.

[50] Statement of Dr Sam Orde [8], tab 21.
[51] Statement of RN Joharra Lebron [9]-[10], tab 33; Nepean Hospital progress note p.65, tab 55.
[52] Statement of RN Mhary Gacuma [10], tab 32.
[53] Statement of RN Mhary Gacuma [11], tab 32.
[54] Statement of Dr Sam [9], tab 21.
[55] Statement of Dr Sam [9], tab 21.
[56] Statement of Dr Sam Orde [10,] tab 21.
[57] Statement of RN Elizabeth Barrett [12]-[13], tab 31.

48. Dr Orde spoke to Gregory and attempted to persuade him to return to his bed and to hold an oxygen mask to his face. Dr Seppelt also tried the same, along with two other doctors who had joined them being Dr Alison Main (ICU Fellow) and Dr Mark Nalos (ICU consultant). Gregory refused. Dr Seppelt described Gregory as "*grey and hypoxic*."[58]

49. Numerous other staff were present for some or all of the event[59], including Dr Knudsen, Dr Emma Bowcock (ICU Registrar)[60] and Karen Willis RN (Clinical Nurse Unit Manager, NUM),[61] Mark Padgett RN[62] and Carmel Zucak RN.[63] Observations similar to those made by Dr Orde as to the general presentation of Gregory were made by the following persons: Zucak RN ("quite agitated"), Barrett RN (grey and hypoxic), Odlum RN (very breathless and grey-blue), Strong RN ("very blue"), Padgett RN ("grey and agitated"), Dr Bowcock (blue lips, blue, very unwell and "increasingly unwell", as time progressed), and Willis RN (when Gregory was seated in a chair: "grey in colour and…hypoxic").

50. At about 5:05 pm security guards Matthew Kelaher, Shane Brewer and Jason Beech arrived. On their arrival Gregory said to the effect "*Thank fuck you're here, I have been trying to get to you guys, these guys are trying to kill me*".[64] The guards asked Gregory to return to his bed, which he again refused to do.

51. Elizabeth Barrett RN knelt down in front of Gregory (in a sign of submission) in an attempt to attach an oxygen mask to him. Gregory initially accepted an oxygen mask but then took the mask off a few seconds later and threw it away.[65] One guard, Jason Beech, asked Gregory to lay on the ground without success.[66]

Administration of intramuscular sedatives

52. In Dr Orde's view, Gregory was delirious, short of breath, diaphoretic and was persisting with his refusal of treatment. He therefore asked security to take Gregory to the floor and restrain him so he and Dr Seppelt could administer intramuscular sedative injections, the objective being that he be sedated quickly before he injured himself or anyone else.

[58] Statement of Professor Ian Seppelt, tab 22.
[59] List of personnel involved, see Nepean Hospital Clinical Emergency Response Report tab 55.
[60] Statement of Emma Bowcock, tab 25.
[61] Statement of RN Karen Willis, tab 27.
[62] Statement of RN Mark Padgett, tab 28.
[63] Statement of RN Carmel Zucak, tab 29.
[64] Statement of RN Elizabeth Barrett [19], tab 31.
[65] Statement of Dr Sebastian Knudsen [12], tab 24; statement of RN Elizabeth Barrett [19]-[20], tab 31.
[66] Statement of Senior Constable Monique Cini [72], tab 10.

53. Airway equipment and a medical emergency trolley was brought into the waiting room beforehand.[67] His bed from bed space 10 was also wheeled into the waiting room in preparation to put Gregory back into his bed.[68]

54. Matthew Kelaher, Shane Brewer and Jason Beech took Gregory to ground and physically held him in a prone position (face down) on the floor. That restraint was captured on CCTV. In the course of restraint in the prone position (without being exhaustive):

    (1) Matthew Kelaher had hold of Gregory's left arm,

    (2) Jason Beech had hold of Gregory's right arm,[69]

    (3) Shane Brewer held Gregory's left leg, and

    (4) a medical ward's person held Gregory's right leg.

55. When the guards had sufficient control of Gregory in the prone position, Dr Seppelt administered 200 mg of Ketamine (less than 2 mg/kg) and Dr Orde administered 10 mg of Midazolam by way of intramuscular injection.[70]

56. CCTV shows the restraint.[71] At times, including several times in the latter stages of the restraint, Gregory turned his torso onto his left side. The restraint began at about 5:12:45 pm and ceased by 5:14:10 pm, spanning about 80 seconds.[72]

Post restraint

57. Gregory was unresponsive when he was turned onto his back.

58. Dr Orde and others attempted to provide oxygen with a bag mask valve kit however his airway became obstructed. Airway manoeuvres were attempted including the insertion of a nasopharyngeal airway to provide mechanical ventilation, however Gregory's hypoxia continued.

59. At 5:15 pm Gregory's heart rate began slowing and a femoral pulse could not be felt. Dr Main commenced cardiac compression and Dr Seppelt performed endobronchial intubation.

[67] Statement of Emma Bowcock [17], tab 25.
[68] Statement of RN Mhary Gacuma [20], tab 32.
[69] Jason Beech in his statement states he twisted Gregory right arm so his shoulder was touching the ground and his palm was facing the ceiling (did so without applying full force but enough to prevent Gregory pushing off the ground): Statement of Jason Beech [11]-[14], tab 39, supplementary statement Beech [4], tab 40.
[70] Statement of Dr Sam Orde [13], tab 21; Statement of Dr Ian Seppelt [12], tab 22.
[71] CCTV stills tab 60.
[72] Professor Anne-Maree Kelly 1st report p.15, tab 64.

Intubation was complete by about 5:18 pm. His saturations, heart rate and cardiac output improved.[73]

60. At 5:20 pm Gregory was lifted off the ground and shifted to bed 10 in the ICU. A decision was then made to change the intubation tube to a larger size. Soon after, Gregory's saturations dropped, and his heart rate fell.[74]

61. At 5:35 pm the treating team was unable to feel a pulse. Cardiopulmonary Resuscitation (**CPR**) was administered manually and then with a LUCAS cardiac compression device along with the administration of adrenaline. Other procedures were also carried out including investigations for a possible pneumothorax.[75]

62. Dr Orde acted as the team leader during the resuscitation attempts. Dr Seppelt was looking after Gregory's airway. Dr Marek Nalos performed a Trans Thoracic Echo. Mark Padgett RN assisted with the placement of a LUCAS device. Other nurses also contributed to the resuscitation efforts.[76]

Certification as to death at 6:05 pm

63. At 6:05 pm the medical team ceased CPR.[77] Gregory's heart rhythm was recorded as being asystole between 5:49 pm and 6:05 pm.[78]

Police response

64. Senior Constable (**SC**) Monique Cini (officer-in-charge) and Detective Senior Constable (**DSC**) David Bennett attended Nepean Hospital at about 7:25 pm and met with Inspector Tracey Stone.

65. At about 7:50 pm a crime scene was established for bed 10 by SC Tania Rothwell.[79]

66. At about 8:08 pm SC Cini requested the syringes used on Gregory prior to death, however those items had been disposed of by that time. Those were likely placed in a sharps bin soon after use and cleared before SC Cini's arrival. Samples of the Midazolam and Ketamine

[73] Statement of Dr Sam Orde [16], tab 2.
[74] Statement of Dr Sam Orde [17], tab 21.
[75]Statement of Dr Sebastian Knudsen [16], tab 24; Dr Sairita Maistry report p.4, tab 5,
[76] Statement of RN Andrew Strong [11], tab 34.
[77] Statement of Dr Sam Orde [22], tab 21.
[78] Clinical Emergency Response Report 02.03.17 by Dr Seppelt, tab 55.
[79] Statement of Senior Constable Tania Rothwell [3] and [6], tab 18; statement of Senior Constable Monique Cini [49], tab 10; statement of Constable Stefanie Montalto [4]-[6], tab 15.

medication, understood to be from the batch from which the medication administered to Gregory was sourced, were seized.[80]

67. A copy of the available CCTV footage, incident reports prepared by security personnel and the Nepean Hospital's standard operating procedures (**SOPs**) for the restraint of patients or visitors were obtained[81].

68. At about 1 am on 3 March 2017 police seized Gregory's personal belongings including the following medication boxes (X0002423156): [82]

    (a) 1 x empty 12 tablet packet of Sudafed.

    (b) 1 x empty 50 tablet packet of Amitriptyline 50 mg consisting of two empty blister packs (prescribed to Gregory on 17 May 2016).

    (c) 1 x empty of Endone 5mg box containing 2 blister packs (10 tablets per blister pack) (prescribed to Gregory on 30 December 2016).

    (d) 1 x empty 50 tablet packet of Amitriptyline 50 mg, consisting of 5 blister packs (prescribed to Gregory on 11 October 2016).

    (e) 1 x empty 20 to 30 tablet packet of Endone 5 mg, consisting of 3 blister packs (prescribed to Gregory on 11 October 2016).

    (f) 1 x empty 20 capsule packet of Dozile (Doxylamine Succinate).

    (g) 1 x empty 40 tablet packet of Dolased.

69. The seized medication boxes were contained within a pink plastic hospital bag which was retrieved by a nurse from a cupboard located next to Gregory's bed within ICU.[83]

Letter provided to police on 5 March 2017

70. On 5 March 2017 Ms Batey provided police a handwritten letter.[84]

71. It appears the letter was found by Brendan Whitemore in the RV on 27 February 2017. He left that letter with Ms Batey's son, Timothy, that same day. That was given to Ms Batey on her return from hospital after Gregory's admission.

[80] Statement of Senior Constable Monique Cini [62], tab 10.
[81] Statement of Senior Constable Monique Cini [56] and [79], tab 10.
[82] Statement of Senior Constable Monique Cini [61], tab 10; photographs of seized medication, tab 61.
[83] Statement of Senior Constable Monique Cini [61], tab 10; and supplementary statement, tab 10A.
[84] Statement of Detective Senior Constable Angela Sheedy [5], tab 19.

72. The letter was addressed to "*My Sweetheart Marianne*" and states inter alia that "*the pain in my face is becoming unbearable and the meds are making me sick and I cant handle it any longe*r".[85]

73. Gregory's sister, Ms Gordon, later identified the handwriting as that of Gregory.[86]

Toxicological analysis

74. The post-mortem toxicological analysis, of a femoral blood sample taken on 6 May 2017, detected Amitriptyline (2.2. mg/L), Doxylamine (0.39 mg/L), Ketamine (0.96 mg/L), Midazolam (0.009 mg/L), paracetamol (< 5 mg/L), Sertraline (0.26 mg/L) and pseudoephedrine (0.09 mg/L), tetrahydrocannabinol and THC acid.[87] The presence of opioids was not detected.

Post-mortem

75. Microbiological testing of post-mortem blood and swabs of the lungs and spleen detected multiple bacterial classes. Noting that Gregory had been administered prophylactic antibiotics during admission and that no organisms were cultured during admission or infective changes noted in the lungs, the pathologist considered these bacterial classes to be indicative of post-mortem contamination.[88]

76. During post-mortem examination, Dr Sairita Maistry (pathologist) noted (without being exhaustive):

    (1) no petechial haemorrhages were seen on the sclerae (white outer layer of the eye), bulbar conjunctivae (clear membrane covering the outer surface of the eye), palpebral conjunctivae (clear membrane coating inside of the eyelid), facial skin or oral mucosa.

    (2) the surface of Gregory's back was free of lesions (e.g. damage resulting from injury or disease).

    (3) bruise to the dorsum of the right hand, right elbow and bruise to left wrist.

    (4) linear abrasion on right calf.

    (5) no signs of injury or bruising on the scalp.

[85] Handwritten letter, annexed to statement of Mari-Anne Batey, tab 46.
[86] Statement of Cheryl Gordon, tab 51.
[87] Dr Sairita Maistry report p.16, tab 5.
[88] Dr Sairita Maistry report p.5, tab 5.

(6) no factures or soft tissue injuries to the neck region.

(7) spinal column intact.

(8) a bruise to the left anterior abdominal wall, linear bruising over the sternum and bilateral anterior rib fractures (all in keeping with resuscitative efforts).

Neuropathological and radiological analysis

77. A neuropathological examination showed no significant microscopic abnormality, nor evidence of haemorrhage, hypoxic or ischaemic injury, seizure-induced changes or trauma. A radiological report showed no evidence of recent intracranial haemorrhage or raised intracranial pressure or calvarial fracture, no fracture to the neck, no sign of sternal fracture or thoracic spine facture and no fractures of the upper or lower limbs.

78. At the time the autopsy report was completed, it was Dr Maistry's view that the cause of death could not be ascertained.

Did Gregory ingest further Amitriptyline after his admission to Nepean Hospital?

79. Ms Batey, Gregory's partner expressed concern that Gregory may have obtained or been given Amitriptyline while at Nepean Hospital.

80. Ms Batey told police in her statement that she "*found a number of empty medication boxes. One of the boxes I had never seen before and was Doxalot or something similar, it was in a blue packaging and none of them were left in the packet. There was a box of endone that only had about 13 tablets in it. There were two boxes of Amitriptyline, 1 box was full and the other wasn't full and only had about a third of the box left.*"[89] I note that these boxes were empty when they were seized by police on 3 March 2017 and became exhibit (X0002423156).[90]

81. Ms Batey stated she took the medication boxes containing Amitriptyline, which she found in the RV, to Nepean Hospital after Gregory had been taken to Hospital.[91]

82. During the investigation Ms Batey told police that she had been informed by a Nepean Hospital doctor around 28 February 2017 that Amitriptyline medication was being given to Gregory (after his admission) as he told staff this was his regular medication. Ms Batey told the doctor that Gregory had not "*been on amitriptyline for years*". He had taken that

[89] Statement of Mari-Anne Batey [42], tab 46
[90] Statement of Senior Constable Monique Cini [90], tab 10; photographs of medication boxes, tab 61.
[91] Statement of Mari-Anne Batey [42], tab 46.

medication "*a few years ago*" for facial pain but stopped as it did not work. Ms Batey said the doctor appeared to be alarmed at hearing this. He told her they would immediately cease giving Amitriptyline.[92]

83. As a consequence of this conversation, Ms Batey believed Gregory may have ingested further Amitriptyline after admission.

84. I accept Ms Batey brought medication boxes to Nepean Hospital shortly after Gregory's admission. However, on consideration of all the evidence, I am not satisfied that Gregory was given Amitriptyline medication from his own supply by the Nepean Hospital treating team or prescribed that medication during his admission.

85. When Gregory was initially admitted to Nepean Hospital the paramedics were only aware of the Dolased medication found in the RV. It does not appear from the records that the paramedics advised the hospital staff that Gregory was suspected of having taken an overdose of Amitriptyline medication as well.

86. However Dr Orde told the court that the treating team suspected, based on Gregory's symptoms at the time of admission, that he had overdosed on a Tricyclic Antidepressant (e.g. Amitriptyline) before his arrival to hospital. Specifically, Gregory presented with prolonged or abnormal QRS complexes[93] which the treating team attributed to sodium channel blockage caused by an overdose of Tricyclic Antidepressant medication. Dr Orde told the court that:

> "*When you take this form of anti-depressants, it's got what's known as sodium channel blocking effects. So that can affect the heart by widening a portion of the ECG that is quite classic of a tricyclic antidepressant overdose. And that is why we needed to give him things like sodium bicarbonate when he first came into the hospital, and it also causes profound loss of consciousness as well, which if you don't treat it and support it, it can cause horrible things like seizures and coma*."[94]

87. Without being an expert toxicologist, Dr Orde told the court he was "f*airly confident*" an overdose of Dolased medication was not sodium blocking and would not have accounted for the QRS widening which was recorded.[95]

88. Dr Orde told the court that:

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[92] Statement of Mari-Anne Batey, tab 46.
[93] Electrical impulse as it spreads through the ventricles; and Transcript 24/08/20 page 13, lines 1-6.
[94] Transcript 24/08/20 page 12, lines 30-38.
[95] Transcript 24/08/20 page 13, lines 1-6.

"*[Gregory] was not prescribed any amitriptyline by any doctor and it was not administered by any ICU nurse whilst he was in the ICU. This guy's just had a life-threatening overdose of amitriptyline. There is no way we would be giving him more amitriptyline three days after a life-threatening overdose, and there's nothing on our medication reports about him being written up for that. That would be an extremely stupid thing to do*."[96]

89. Dr Orde was also adamant that "*there is no way a medication would be given without it being documented in the medication chart. That would not happen*."[97] Dr Orde reviewed the medical records and found "*no evidence the team has given amitriptyline in the medical records or in the drug chart*."[98]

90. This view is consistent with the expert opinion of Professor Alison Jones, specialist physician and clinical toxicologist, who carefully reviewed Gregory's medical records and post mortem toxicological results. She found that Gregory's clinical course was consistent with him having ingested a 'serious overdose' of Amitriptyline many hours prior to his admission to Nepean Hospital (rather than him also ingesting Amitriptyline medication during his admission).[99]

91. I note the following factors:

    a. no record was made in the hospital records of Amitriptyline being administered to Gregory after admission.

    b. as Dr Orde said, it would be remarkable for the treating team to have given him a medication that he had been suspected of overdosing on especially when he was being administered medication to counter its effects. The objective of treatment was in fact to stabilise Gregory whilst he detoxified from that medication. I accept Dr Orde's evidence in this respect.

    c. in the opinion of Professor Jones, in the days after Gregory's admission his GCS (Glasgow Coma Score) dropped and recovered in a typical manner before returning to a fully recovered score of GCS 15. The most likely scenario is that he ingested Amitriptyline *before* admission but not afterwards.[100]

[96] Transcript 24/08/20 page 22, lines 5-14.
[97] Transcript 24/08/20 page 22, lines 26-30.
[98] Transcript 24/08/20 page 22, lines 32-35.
[99] Professor Alison Jones report p.6, tab 64B.
[100] Professor Alison Jones report pp.7-9, tab 64B.

d. Professor Kelly also considers it unlikely that Gregory consumed Amitriptyline *after* admission, considering the course recorded in his medical records.[101]

e. the setup of the ICU makes it inconceivable that Gregory would have managed to take the medication from his cupboard without notice. Dr Orde told the court that the unit requires no less than one nurse for two patients. Nursing staff are situated within metres of each patient and the nurses' station is based in the centre of the ward with beds encircling it to provide another level of observation.[102]

f. Professor Kelly's opinion that acute Amitriptyline ingestion is typically associated with increased heart rate and decreasing blood pressure. This was not evident in Gregory's case in the lead up to the events preceding his death on 2 March 2017.[103]

92. Professor Kelly and Dr Maistry told the court they were comfortable excluding Amitriptyline ingestion *after* admission as a factor in Gregory's death taking into account:

- the evidence from Dr Orde that when Gregory was admitted on 27 February, his presentation was consistent with a tricyclic antidepressant overdose.
- the evidence from Dr Orde about the setup of the ICU, and the kind of close observation it provided.
- Dr Jones' expert opinion that the more likely scenario is that Amitriptyline was consumed *before* admission, not after admission.[104]

93. Taking all the evidence into account, it appears likely Ms Batey may have misheard what the doctor said to her about stopping Gregory's Amitriptyline medication or misunderstood the doctor's explanation. Given the shocking nature of what had just occurred it would not be surprising if there was some kind of miscommunication.

94. I am unable to be certain about whether there was medication in any of the boxes Ms Batey brought to Nepean Hospital. While noting the boxes were empty when police removed them, there is, in my view, no cogent evidence that Gregory consumed further Amitriptyline whilst a patient at Nepean Hospital.

95. Accordingly, having reviewed all the available evidence I am satisfied that the Nepean Hospital treating team did not administer or knowingly permit Gregory to ingest Amitriptyline

[101] Professor Anne-Maree Kelly 3rd report p.4, tab 64AA; Professor Kelly 4th report p.6, tab 64AAA.
[102] Supplementary statement of Carmel Zucak, tab 29AA.
[103] Professor Anne-Maree Kelly 3rd report p.4, tab 64AA.
[104] Transcript 27/08/20, page 3, lines 18-42.

after his admission. The medical evidence strongly suggests Gregory only took Amitriptyline *prior* to his admission.

Was the care and treatment at Nepean Hospital generally appropriate?

96. The court heard from directly from Dr Orde who was the intensive care consultant on call during the week that Gregory was admitted to Nepean Hospital ICU and also the consultant in charge of the Medical Emergency Team (**MET**) who cared for Gregory the evening he died on 2 March 2017. He was an impressive and thorough witness who demonstrated care and concern for his patient. He outlined the treatment Gregory received from the time he was moved from the Emergency Department (**ED**). His account was consistent with the medical records available to the court.

97. The court was assisted by the evidence of Professor Anne-Maree Kelly, Professor and Academic Head of Emergency Medicine at Western Health in Footscray, Victoria. She has over 30 years of experience in emergency medicine. Her experience extends to the management of patients with acute intoxications. Professor Kelly was supplied with Gregory's relevant medical records and a variety of statements which had been prepared for this inquest. She was also given access to CCTV footage of Gregory's restraint shortly before his death.

98. In summary, Professor Kelly was not critical of the medical care provided throughout Gregory's admission. In her view, the care offered by Nepean Hospital was both appropriate and reasonable. Specifically, in Professor Kelly's opinion:

- Gregory received appropriate assessment and treatment in the ED including intubation when he became comatose as well as medication to reverse paracetamol toxicity;
- he was appropriately referred to the ICU for ongoing care;
- he then received appropriate ICU interventions, including support of his ventilation and treatment to counteract Amitriptyline toxicity, and was appropriately monitored;
- when he became hypoxic after his initial extubation, he was appropriately reintubated for a further period of respiratory support;
- an assessment by psychiatric services was arranged;
- when the events of about 5:00 pm on 2 March 2017 occurred, there was a prompt response focussed on providing emergency care in the least restrictive way possible by

a range of staff (coercion/encouragement/de-escalation). When this was not possible and it was deemed Gregory was at risk of death if not treated, the decision was appropriately made to sedate him using restraint in order to minimise risk to Gregory and staff;

- the restraint was employed for a very brief period, just long enough to achieve the clinical goal of sedation;
- Gregory's deterioration immediately after the restraint was promptly recognised and responded to; and
- Gregory's further care, including management of his subsequent cardiac arrest, was in accordance with guideline recommendations.[105]

99. I accept her opinions in this regard.

100. Both Professor Kelly and Dr Maistry considered that the decision to sedate Gregory, and the use of restraint to enable that to occur, was reasonable, appropriate and necessary in the circumstances.[106] I accept their opinions in this regard.

Was the restraint of Gregory carried out in an appropriate manner?

101. A number of witnesses gave evidence about the need to restrain Gregory on 2 March 2017. Given the proximity of the restraint to his death, the issue required careful consideration. Dr Orde, Dr Maistry and Professor Kelly each considered it necessary to restrain Gregory in the circumstances that developed. Attempts had been made to calm him and yet he remained agitated and distressed. Dr Orde gave compelling evidence about how unwell Gregory appeared at this time. I accept that medical staff made all reasonable attempts possible to get Gregory to return to his bed and accept care. His need for immediate treatment was urgent. There were also valid considerations relating to the safety of medical staff and members of the public to consider.

102. The court accepts that Dr Orde's decision to restrain Gregory was correct and that proper arrangements were made so that restraint could occur for the shortest period possible to achieve the clinical goal of sedation. There were ample medical staff present, some of whom had also tried to calm or re-direct Gregory. Dr Orde judged Gregory to be "*delirious, short of*

[105] Professor Anne-Maree Kelly 1st report pp.16-17, tab 64.
[106] Professor Anne-Maree Kelly and Dr Sairita Maistry joint report, tab 64C.

breath, diaphoretic, unwell and refusing all medical therapy."[107] Once security staff were in place, emergency equipment was nearby and Doctors Orde and Seppelt were ready to administer the necessary medication, Gregory was brought swiftly to the ground.

103. Dr Orde gave the court his assessment of the restraint process:

> *"At the time nothing seemed untoward to me in terms of the way he was being restrained. I've looked at the video again afterwards and noticed there was a knee on his back. As I say again, there did not seem to be anything untoward in the way that he was being restrained at that time that seems excessive or seemed like it was going to cause trouble to him, was going to harm him. It was there to try and protect him and to stop him hurting others. It did not appear to me that the restraint was untoward."*[108]

104. I have had the opportunity to view the relevant CCTV footage of this process. Each security officer and person directly involved in the restraint appears to apply pressure to Gregory's arms or legs. It appears that the intention was to get Gregory into a prone position to begin with so as to enable the doctors to administer the sedative medication as quickly as possible.

105. In my view, the CCTV also shows that during the brief restraint one security officer, later identified to me as Mr Kelaher, places his knee or shin across Gregory's back in an attempt to effect control. Watching the video, I formed the view that Gregory at times shifted from side to front and moved up and down to resist the restraint.

106. I note that given the stressful circumstances and short period of time that Gregory was restrained, it is not surprising, that few witnesses had a full recollection of how the restraint took place. However, I note that one registered nurse, Steven Teuma gave an account of seeing one of the guards having his knee on Gregory's back.[109]

107. Mr Kelaher gave evidence before me, denying that he had placed his leg or knee on Gregory's back. In his view, the CCTV showed him straddling Gregory and this accorded with his recollection of events. He told the court that he had both feet on the ground at all times. He also made a supplementary statement where he stated that he did not apply force.

108. Mr Kelaher stated that he did not believe that he was making contact with Gregory's lower back[110], that he had "*both feet on the ground at all times,*"[111] that any contact with Gregory "*is*

[107] Statement of Sam Orde [13], tab 21.
[108] Transcript 24/08/20 page 19, lines 17-25.
[109] Statement RN Steven Teuma [14], tab 30.
[110] Transcript 24/08/20 page 41, lines 4-48.
[111] Transcript 24/08/20 page 42, lines 35-36.

only in consequence of where I'm positionally standing"[112]. Mr Kelaher specifically disagreed that he was using his knee to control Gregory.[113]

109. In my view, Mr Kelaher is mistaken about this. While he may straddle Gregory for some of the time, in my view, the CCTV footage clearly shows Mr Kelaher's knee or shin making contact with Gregory's back while Gregory is in the prone position. It cannot be determined from the CCTV footage how much force was being exerted during that contact. It appears from what is depicted that it was likely done in an effort to control Gregory, namely to prevent him lifting off the ground in resistance to the restraint.

110. The footage shows Dr Orde was very close by, ready to administer a sedative, during this process. After observing Dr Orde and listening to his evidence, I am confident that had anything untoward occurred in terms of the amount of force being applied to Gregory's back or how the restraint was otherwise being effected, that would have been apparent to Dr Orde at the time. I am also confident that Dr Orde would have immediately raised this concern with the guards and would have disclosed the same when he gave evidence before me. I also note that Gregory had no bruising or marking on his back at the post mortem examination. It seems likely that the pressure was not extremely forceful, and it was clearly short lived.

111. I accept that Gregory was likely to have been resisting to some degree. He was not a small man, weighing some 110 kilograms. There is evidence that he was delirious. He was likely to have been sweaty. He was clearly difficult to restrain. While the application of prone restraint should be directed to the limbs, and force to the back should be avoided wherever possible, it appears to have occurred on this occasion due to the specific challenges that arose.

112. I accept that Mr Kelaher was genuinely trying his best to secure Gregory as quickly and efficiently as possible to enable the sedatives to be appropriately administered. Mr Kelaher became involved in the restraint at the direct request of the treating team. I accept he conducted himself with the least amount of force he considered necessary at the time. After hearing his evidence, I am also confident that Mr Kelaher has reflected on this event himself and that he understands the importance of avoiding, wherever possible, any contact with a person's back during restraint.

113. I was concerned nevertheless to understand the training staff like Mr Kelaher received in relation to restraint before and after Gregory's death. The restraint of a person against their will is clearly a matter of public interest and warrants careful examination. The procedure involves inherent risk. This is particularly so when force of any kind is applied to a person's back/torso area while they are being physically restrained in a prone position on the ground.

[112] Transcript 24/08/20 page 47, lines 15/16.
[113] Transcript 24/08/20 page 43, line 27.

114. Mr Kelaher had worked in a security role for about ten years by the time of Gregory's restraint on 2 March 2017. He initially worked for Railcorp NSW where he underwent training and received his security officer licence (classification 1A and 1C). He then commenced working for the Nepean Blue Mountains Local Health District (**NBMLHD**).

115. Mr Kelaher told the court that he had received some instruction during his initial security officer licence training in relation to the need to avoid contact with a person's back when restraining them on the ground in a prone position. Mr Kelaher stated that he received no further training or refresher training specifically targeted at restraint techniques after commencing employment with the NBMLHD. He relied on the experience he had acquired on the job.[114]

116. The court received comprehensive evidence about the training now provided by NBMLHD to security officers and others including medical staff with respect to restraint. This evidence was principally provided by Mr Mitchell Grimston.

117. At the time of Gregory's death, Mr Grimston was working as a Safety Culture Coordinator (Nurse Educator) across NBMLHD. As part of his role, Mr Grimston was responsible for the coordination and roll-out of the "Violence Prevention & Management" (**VPM**) training following a critical incident that occurred at Nepean Hospital Emergency Department in January 2016.[115] The VPM program was developed by NSW Health to meet the requirements of the NSW Health policy PD2012_008: Violence Prevention & Management Training Framework for the NSW Public Health System.[116]

118. The VPM program was commenced by NBMLHD in May 2016. Prior to that, a training program known as "CPI: Non-violence Crisis Intervention" was used by NBMLHD to train staff in safety and crisis intervention management.[117]

119. The VPM program consists of various courses. The VPM: Personal Safety training course was commenced at NBMLHD in May 2016. The course includes *"verbal and normal verbal communications[118], de-escalation skills, situation awareness and risk identification and management"*.[119] The course comprises four hours of theoretical training, four hours of practical training and online components.[120] The course does not deal with restraint

[114] Transcript 24/08/20 pages 35-38.
[115] Statement of Mitchell Grimston [3], tab 66.
[116] Statement of Mitchell Grimston [5], tab 66.
[117] Transcript 24/08/20, page 24, lines 21-25. Purportedly due to licensing and training requirements, a decision was made for the NBMLHD to transition to the VPM policy and program.
[118] Presumably this is meant to say "non-verbal".
[119] Statement of Mitchell Grimston [7], tab 66.
[120] Transcript 24/08/20 page 23, lines 36-46.

techniques. Mr Grimston explained in his statement that staff were targeted to attend this training based on their work role and location, including, understandably, early completion of the training by security staff. There is evidence that Mr Kelaher and Mr Beech completed the VPM: Personal Safety training course in May and June 2016 respectively. Mr Grimston was unable to locate any record of Mr Brewer completing the course.[121]

120. The VPM: Team Restraint training course commenced at NBMLHD in January 2017, with a staged roll-out across the NBMLHD inpatient mental health clinicians and security guards. This three day course was held fortnightly for five months, with a reduction in frequency thereafter to three times per year to capture new staff. At the time of the incident involving Gregory, none of the three security guards involved in Gregory's restraint had attended the VPM Restraint training course.[122] The officers involved in the restraint of Gregory undertook this training after his death, successfully meeting the training requirements.[123]

121. The VPM: Team Restraint participant manual, provided to participants during the course, provides direction on how to perform restraint techniques, including the number of staff required to ensure the safety of everyone involved. There are also particular references to prone restraint and positional asphyxia.[124]

122. Mr Grimston outlined to the Court when it is considered appropriate to use the prone position during a restraint. He explained there is no *"black-and-white [scenario] when a certain restraint technique is going to be appropriate or is inappropriate"* and that the process of determining the correct restraint technique involves a *"dynamic"* or *"constant"* risk assessment.[125] Mr Grimston explained that one needs to assess *"the risk to the person involved, whether that be a patient or … a staff member o[r] visitor, versus the risks of the physical restraint itself".*[126]

123. Mr Grimston further explained that the VPM: Team Restraint training model teaches participants that:

> *"when you take a patient from a standing to a restraint on the floor it is first in the prone position, because it's the safest way to do it with minimising risk of head strikes on the ground, and manual handling risks to staff members backs for example if you take them down to supine. So we teach going from standing to prone*

[121] Statement of Mitchell Grimston [7], tab 66.
[122] Statement of Mitchell Grimston [9], tab 66.
[123] Statement of Mitchell Grimston [10], tab 66.
[124] Statement of Grimston [11], tab 66.
[125] Transcript 24/08/20 page 27, lines 41-44.
[126] Transcript, 24/08/20 page 27, lines 44-46.

position, and then the rapid transition from prone to supine if it is safe to do so for the patient and for the staff members involved".[127]

124. The accompanying participant manual also discusses prone restraint, various prone restraint techniques and some of the associated risks with prone restraint, stating that *"the risk has been found to increase the longer the person is held in that position. There have been a number of recorded deaths in this position"*[128]. The manual also references the *"maximum time a person will be held on the ground in face-down restraint is 3 minutes to allow sufficient time to administer medication and/or remove the person to a safer environment"*.[129] Mr Grimston explained that the manual was at times *"awkwardly"* worded and that accordingly, the manual "*is used to supplement the face-to-face training*"[130]. Mr Grimston told the court that from *"the beginning of 2017 onwards we emphasise [in the training] that there is no safe time for prone restraint."*[131]

125. Mr Grimston further outlined that the course involves a practical component whereby participants are able to practice the various restraint or hold techniques.[132] When asked whether in practice the techniques would assist in restraining a 110 kg male who was resisting (as Gregory was), Mr Grimston pointed to the successful use of the training model in other settings, for example in a forensic or custodial setting with Justice Health employees. He noted that the restraint techniques *"can be used effectively, … restraining the limbs only".*[133]

126. Mr Grimston was also asked about the use of knees during restraint. He noted that the participant manual *"does not teach [participants] to use pressure on the torso."*[134] He explained that the manual does not expressly prohibit certain techniques, but rather the training focuses on particular appropriate techniques and that "*deviations*" from those techniques are not taught.[135] He explained that the training emphasises that during a restraint involving taking hold of the limbs of a person, *"the staff members are kneeling at the patient's elbows… the staff member's knees are either side of the patient's elbows".*[136]

127. In terms of ongoing training and development, Mr Grimston explained that the participant manuals are designed for participants to refer back to as refresher material and that since

[127] Transcript 24/08/20 page 26, lines 3-9.
[128] See attachment 5 of statement of Mitchell Grimston "HETI Violence Prevention and Management Team Restraint techniques, participant manual" page 59 of 82, tab 66.
[129] *Ibid.*
[130] Transcript 24/08/20 page 29, lines 27-28.
[131] Transcript 24/08/20 page 30, lines 1-2.
[132] Transcript 24/08/20 page 33, lines 9-10.
[133] Transcript 24/08/20 page 30, lines 27-32.
[134] Transcript 24/08/20 page 28, lines 38-39.
[135] Transcript 24/08/20 page 28, lines 45-49.
[136] Transcript 24/08/20 page 33, lines 40-46.

May 2018, videos of the techniques have become available on My Health Learning[137]. Within NBMLHD, security staff are required to complete a range of additional training, in accordance with NSW Health, Health Education Training Institute (**HETI**) Mandatory Training Matrix (red flag),[138] as well as Chief Executive mandated training (blue flag) training. This includes training regarding the use of restraint.[139]

128. Since the 2 March 2017, NSW Health has revised parts of its policies. PD2012_008: Violence Prevention & Management Training Framework for the NSW Public Health System has been superseded by PD2017 _043: Violence Prevention and Management Training Framework for NSW Health Organisations.[140] Mr Grimston identified that the key changes established in the PD2017 043 are as follows[141]:

> *"(a) The inclusion of the term 'difficult' behaviour throughout the document.*
>
> *(b) The explicitly identification of short-term/temporary staff and managers as being included in the target audience.*
>
> *(c) Training must be multi-disciplinary in nature.*
>
> *(d) Drills must now be undertaken.*
>
> *(e) There must be an identified manager role to ensure adequate PPE (including personal duress alarms available).*
>
> *(f) As to Category 2 staff there was the removal of the requirement to be trained and competent in use of correct restraint procedures.*
>
> *(g) Identification that completion of online pre-requisite modules and VPM: Personal Safety course would meet requirements of Category 1 and Category 2 staff in PD.*
>
> *(h) Category 3 staff must be trained and capable in awareness of positional asphyxia, risk factors and warning signs.*
>
> *(i) Identification that completion of VPM Team Restraint meets the objectives for category 3 staff.*

[137] Statement of Mitchell Grimston [12], tab 66.
[138] Statement of Mitchell Grimston [15], tab 66.
[139] Statement of Mitchell Grimston, Appendix 2 identifies this training related to restraint, as well as the completion dates for the staff members concerned.
[140] Statement of Mitchell Grimston attachment 14, tab 66.
[141] Statement of Mitchell Grimston [14], tab 66.

(j) Identifies that security audits may include collation of VPM training data."

129. Since 2 March 2017, NBMLHD has also amended its training program, releasing "Code Black - Personal Threat Procedure", a restraint training program for the Medical Emergency and Security and Mental Health personnel, for the purpose of having a greater number of responders trained in restraint processes, and each team member being cognisant of each other's role.[142]

130. As stated above, the officers involved in the restraint of Gregory undertook the training Mr Grimston referred to in his evidence *after* Gregory's death. Mr Kelaher told the court that even prior to the training he had some awareness of the risks of positional asphyxia. Consistent with what Mr Grimston outlined, Mr Kelaher recalled that the training emphasised that restraint should be carried out by way of limb restraint without force being applied to the back region.[143]

131. Dr Orde was also asked about restraint training for medical staff. He stated,

> *"Yes, pre-2017 there is training when - training is part of ICU and emergency medicine training. It is not an uncommon experience for us to have to sedate and restrain patients unfortunately, and it would be a standard part of intensive care training. So pre-2017 all I could say is that it was a, it's a standard part of intensive care medicine training."*[144]

132. When asked whether there been any changes in terms of training since 2017, Dr Orde responded:

> *"There has. No we [sic], orientation of new doctors to the hospital there is mandatory training in how to de-escalate and try to take care of patients when they're agitated, and there's some mandatory on-line training as well."*[145]

133. On the basis of Mr Kehaler's evidence about a lack of training on restraint after he commenced employment with the NBMLHD, *before* the events on 2 March 2017, I would have given serious consideration to the making of broad recommendations to encourage the NBMLHD to review its restraint training for security personnel and other staff. However, I am now satisfied on the basis of Mr Grimston's evidence that since Gregory's death the NBMLHD recognises the risks involved in restraint and has now implemented appropriate training for relevant staff.

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[142] Statement of Mitchell Grimston [15], tab 66.
[143] Transcript 24/08/20 page 48, lines 44-46.
[144] Transcript 24/08/20 page 21, lines 10-20.
[145] Transcript 24/08/20 page 21, lines 22-26.

134. For this reason I do not consider it necessary to make recommendations in this respect.

Medical cause of death

135. While Dr Maistry was initially unable to ascertain a cause of death, the position was clarified by obtaining further expert advice. The court was assisted by the detailed report of Professor Alison Jones, who analysed the quantity and effects of the drugs found during the post mortem toxicological examination.[146] In her view, Gregory's death occurred predominantly due to an overdose of Amitriptyline and Doxylamine. She explained "*this would have caused sedation resulting in profound respiratory depression and coma initially, which Mr Masters would have succumbed (GCS 3) had he not been intubated and cared for in ICU*."[147] She agreed that this polypharmacy overdose would have been exacerbated by hypoxia, underlying obesity and cardiovascular disease.

136. Professor Kelly and Dr Maistry were called to give concurrent evidence with the benefit of having Professor Jones' report. They agreed that "*the primary cause of death was a polypharmacy overdose in a man with underlying co-morbidities of obesity, cardiovascular disease and obstructive sleep apnoea*."[148] I accept their opinion in this regard and find that it is established to the requisite standard.

137. They also agreed that:

- at the time of Mr Masters' restraint his condition was serious and without prompt intervention he was at risk of death;
- having tried less restrictive interventions, clinical staff had no choice but to restrain Mr Masters in order to sedate him and provide potentially life-saving treatment; and
- Mr Masters may have suffered a cardiac arrest due to acute deterioration and hypoxia, even if he was not restrained.[149]

138. I also accept their opinions in this regard.

139. The court was nevertheless concerned to understand the possible role that the restraint may have played in Gregory's death. In the opinion of Professor Kelly, assuming the pressure applied to Gregory's back was of short duration and localised to the lower back and hip area

[146] Professor Alison Jones report p.5, tab 64B.
[147] Professor Alison Jones report, pp.5-6, tab 64B.
[148] Professor Anne-Maree Kelly and Dr Sairita Maistry joint report, tab 64C; Transcript 27/08/20 page 8, line 50 and page 9, lines 1-8.
[149] Professor Anne-Maree Kelly and Dr Sairita Maistry joint report pp.1.2, tab 64C.

rather than the chest area and the downward pressure was appropriately controlled, the restraint event was unlikely to have contributed significantly to Gregory's death.[150]

140. Professor Kelly told the court that, in her opinion, *"if any pressure was applied…it was not severe pressure and certainly not enough to have, to have caused significant damage or significant compromise to the respiratory system*"[151]. She also gave evidence that "*the pelvis is actually a rigid ring and in fact putting, putting moderate pressure is not going to cause any trouble at all, because it can't compress and therefore it is much less likely that tissues would have been pushed up into the chest causing any breathing problems*."[152]

141. In the opinion of Dr Maistry it was not possible to conclusively exclude the contribution of the restraint process. She made it clear that she referred to the restraint procedure generally, comprising various positions and actions including prone posture, knee on back, arms being held behind the body and Gregory's own physical reaction to the process.[153]

142. Dr Maistry expressed the view that individuals have different emotional and physiological responses to restraint. The process of restraint can pose a significant burden on the body including increased heart rate, blood pressure, release of catecholamines which can have a detrimental effect on the organ systems and could cause the generation of a fatal cardiac arrhythmia resulting in sudden collapse or death. For this reason, she could not conclusively exclude the contribution of the restraint process to death.[154] In oral evidence, Dr Maistry confirmed that she was not able to isolate or say what if any role the knee played, relative to the other aspects of the restraint.[155] It also remains possible that Gregory's agitated state in the lead up to the restraint, including when he made his way from his bed into the waiting room and stated his fear about having been shot, could have contributed to serious physiological responses quite separate from the restraint itself.

143. Professor Kelly and Dr Maistry gave evidence concurrently. Both agreed that polypharmacy overdose exacerbated by complications associated with obesity and cardiovascular disease and obstructive sleep apnoea could be recorded as the *most likely* cause of death.[156]

144. I have carefully considered the evidence before me. I understand and accept Dr Maistry's view that one cannot be *certain* that restraint did not play any role in Gregory's death.

[150] Professor Anne-Maree Kelly and Dr Sairita Maistry joint report p.2, tab 64C; Transcript 27/08/20 page 4, lines 38-50 and page 5, lines -135.
[151] Transcript 27/08/20 page 5, lines 14-17.
[152] Transcript 27/08/20 page 5, lines 31-34.
[153] Statement of Dr Sairita Maistry, tab 64D.
[154] Statement of Dr Sairita Maistry, tab 64D.
[155] Transcript 27/08/20 pages 7, lines 6-13.
[156] Transcript 27/08/20 page 8, line 50 and page 9, lines 1-8.

However, given the strong evidence given by Professor Kelly in this regard, I view it as unlikely, in all the circumstances, that it played a material role. On the balance of probabilities, I do not find that Gregory's restraint was a contributing cause of his death.

Was the death intentionally self-inflicted?

145. As stated above, after Gregory's death, police were provided with a letter addressed to his partner Ms Batey. The letter had apparently been found in the RV where Gregory was discovered very unwell on 27 February 2017. The letter spoke of his ongoing pain and the fact that he couldn't "*handle it any longer*" and that his "*quality of life is not there anymore*".[157] Also at the scene were empty packets of medication. According to his partner, Gregory had never attempted suicide or anything like that since she had known him. On 26 February 2017 his partner recalls Gregory was complaining about pain on the side of his face from his TN and that he was grey in colour and didn't seem himself.[158]

146. A finding that a death is intentionally self-inflicted should not be made lightly. The evidence must be extremely clear and cogent in relation to intention.[159] While it is difficult to know exactly what was in Gregory's mind at the time he took the medication, he later told a psychiatric registrar, Dr Hannon that he had "*intended to commit suicide"* and that he had written a suicide letter and driven to a remote location.[160] He spoke of worsening depression in the lead up to the overdose due to ongoing pain and that he had started to believe that he had become a burden on his partner.[161] He also described his memory of events as "*cloudy*."[162]

147. It is also apparent that on 2 March 2017, prior to his final deterioration, Gregory was seen by two psychiatric registrars. They undertook a mental state assessment as part of the consultation and gained, "*the impression that there was no further suicidal ideation*" and that Gregory "*expressed a sense of future orientation and an intent to work towards resolving his relationship and health issues*".[163]

148. In all the circumstances, the evidence before me establishes that Gregory intended to end his life when he ingested the Amitriptyline and Doxylamine, which occurred sometime between 26 and 27 February 2017, before his admission to Nepean Hospital. The evidence does not establish that he still held an intention to end his life on 2 March 2017. Immediately

[157] Handwritten letter annexed to Statement of Mari-Anne Batey, tab 46.
[158] Statement of Mari-Anne Batey [24]-[25], tab 46.
[159] The proper evidentiary standard to be applied to a coronial finding of intentional taking of one's own life is the Briginshaw standard (*Briginshaw v Briginshaw* 60 CLR 336).
[160] Statement of Dr Matthew Hannon [13], tab 23.
[161] Statement of Dr Matthew Hannon [13], tab 23.
[162] Statement of Dr Matthew Hannon [10], tab 23.
[163] Statement of Dr Matthew Hannon [14], tab 23.

prior to his restraint he appeared confused and delirious, but there was no evidence that he was suicidal. For this reason, I do not make a formal finding that his death was intentionally self-inflicted.

Findings

149. The findings I make under section 81(1) of the *Coroners Act 2009* (NSW) are:

Identity

The person who died was Gregory Masters

Date of death

Gregory died on 2 March 2017.

Place of death

Gregory died at Nepean Hospital, Penrith NSW

Cause of death

Gregory died of a polypharmacy overdose of Amitriptyline and Doxylamine in the context of underlying co-morbidities of obesity, cardiovascular disease and obstructive sleep apnoea.

Manner of death

150. Gregory died as a result a drug overdose in the context of poor health. It is likely that he intended to end his life at the time he ingested the Amitriptyline and Doxylamine on 26 or 27 February 2017. However, the evidence does not establish that he still held an intention to end his life as on 2 March 2017, in particular at the time he was restrained to enable the administration of sedatives.

Conclusion

151. Finally, I offer my sincere thanks to counsel assisting Christopher McGorey, and his instructing solicitor, Clara Potocki for their hard work in the preparation of this inquest.

152. I also thank the officer in charge Detective Senior Constable Monique Cini for her comprehensive coronial investigation.

153. Once again, I offer my sincere condolences to Gregory's family, partner and friends. I acknowledge that the pain of losing a loved one in these circumstances is profound and that their grief is ongoing.

154. I close this inquest.

Magistrate Harriet Grahame
Deputy State Coroner
25 September 2020
NSW State Coroner's Court, Lidcombe