CORONERS COURT

OF NEW SOUTH WALES

Inquest:	Inquest into the death of Dane Oliver Lockwood
Hearing dates	18 October 2022 and 19 October 2022
Date of findings:	28 October 2022
Place of findings:	Coroners Court of New South Wales at Lidcombe
Findings of:	Magistrate Erin Kennedy, Deputy State Coroner
Catchwords:	CORONIAL LAW – methylamphetamine, drug addiction, emergency department presentation of an ice affected patient seeking help, result of physical restraint on an individual on ice
File number:	2019/00259359
Representation:	Ms Donna Ward SC, Counsel Assisting, instructed by Ms Rebecca Hubbard, Department of Communities and Justice, Legal Ms Angela Cook, Counsel for the family of Dane Lockwood, instructed by Ms Trudy Cameron, Armstrong Legal Ms Lyn Boyd, Solicitor Advocate for the South Eastern Sydney Local Health District and NSW Ambulance, instructed by Ms Lucy Pinnock, Crown Solicitor's Office Mr Brent Haverfield, Counsel for the Commissioner of Police, Office of the General Counsel, NSW Police
Findings:	**Identity** The person who died was Dane Oliver Lockwood.

Date of death

He died on 19 August 2019.

Place of death

He died at the Prince of Wales Hospital, Randwick, NSW.

Cause of death

Dane died as a result of methylamphetamine toxicity; antecedent causes being the physiological effects of the restraint and Dane's resistance to restraint.

Manner of death

Accidental self-induced drug toxicity resulting in physical restraint.

Recommendations Nil

Table of Contents

Introduction

1. This is the inquest into the death of Mr Dane Oliver Lockwood.
2. Dane was 33 years old when he died at the Prince of Wales Hospital on 19 August 2019.
3. Dane was, and remains, the much-loved son of Belinda and Glenn Lockwood and older brother to siblings Grace and Timothy. He was part of a strong family, who had supported him through difficult times. He also had provided love and support to his family and his absence has deeply affected his entire family.
4. Dane attended at Prince of Wales Hospital after he had been taking methylamphetamine and hadn't slept for days. He sought help in the Emergency Department, but then changed his mind. He was scheduled pursuant to section 19 of the *Mental Health Act 2007* (NSW) and when he moved to leave, he was physically restrained by security, staff, ambulance officers and eventually police to keep him within the hospital. However, when transferred to the Resuscitation Bay he was found to be unresponsive and despite attempts, could not be resuscitated.
5. Dane was fighting a long-term addiction problem, and had experienced long periods of success and abstinence, he was making attempts to rehabilitate in the community surrounded by Narcotics Anonymous (**NA**), family and friend's support. He really wanted to succeed.
6. Dane discussed this with his friend Clinton Carle, even on the day he died, saying "All I want is to live, I just want a normal life and a job and a family."

The facts

Dane's attempts at rehabilitation

7. Dane's character is revealed through his repeated attempts to return to rehabilitation over many years including:
    - Palm Court in 2007;
    - We Help Ourselves in late 2013 – late 2014;
    - Langton Centre in 2015;
    - Adele House in Coffs Harbour in 2017; and
    - We Help Ourselves in 2018 (although the evidence from his then partner Kathy suggests he was also using drugs through at least part of this period).
8. Added to this was Dane's long-term attendance at NA and the work he did with his sponsor through that program. Importantly, although he had relapsed into

methylamphetamine use in 2019, the evidence establishes that Dane was again seeking help when he attended the Prince of Wales Hospital on the day he died.

9. Added to this history of drug abuse is the possibility that Dane experienced a psychotic illness, perhaps schizophrenia. Dane himself expressed this to the triage nurse at the hospital and it had previously been discussed with his mother during an earlier period of incarceration. Further, the pharmaceutical benefits scheme (**PBS**) material shows that Dane was prescribed the antipsychotic medication, olanzapine, by the various General Practitioners he would attend from time to time. As it was not a formal diagnosis, I can make no findings in relation to that in these proceedings, however it is important to reflect on the large number of people who remain undiagnosed for mental illness, self-medicate but sadly end up lost to serious drug addiction.

Overview of the events of 2018 – 2019

10. Mid- 2018 into early 2019 seems to have been a particularly difficult time for Dane with the breakdown of what had been a supportive relationship with his partner Kathy Petratos and the sad loss of the baby they had hoped for. Added to this, in April 2019 Dane's employment with his friend Clinton came to an end.
11. Clinton and Dane had known each other from childhood as neighbourhood friends and then went to the same high school, although they were in different years and so were not close friends at high school. In 2018 Clinton and Dane reconnected and Clinton gave Dane a chance to work for him as a pool technician. Full time employment commenced in about November 2018. It was around the same time that Dane moved into a share house with a flatmate who described him as friendly and easy-going.
12. Dane was committed to his new job and began training at the gym most days after work, being extremely health conscious. Dane was able to lift huge amounts of weight, including bags of salt and chlorine drums. He was physically very strong.
13. It was sometime in January 2019 that Dane spoke to his father about his work making him feel stressed and wanting to use drugs to cope. Clinton's hope was that Dane would be trained to perform the role, but there were minimum requirements to keep the job and Dane was struggling to meet them.
14. By April 2019 it became obvious to Clinton that Dane was not able to perform the job, and so his employment came to an end. They maintained a level of contact afterwards, even though Dane could be difficult at times. Still, Clinton would again

prove to be a supportive friend when things further unravelled for Dane in August 2019.

15. In April 2019, Dane's former long-term sponsor with NA returned to live in Sydney, where he resumed sponsoring Dane. He says Dane had relapsed using methylamphetamine and alcohol and would then turn to Xanax to try and help him sleep.
16. In respect to the process of rehabilitation, on this occasion Dane decided to try and rehabilitate himself while remaining in the community, with help only from NA, family and friends.
17. Around June 2019, Belinda recalls Dane attempting to get back onto his antipsychotic medication, which was evidence to her that something was going wrong for him.
18. Dane filled his prescriptions for his anti-psychotic and anti-depressant medications in February, March, May and June 2019. This suggests he would have had sufficient medications at the time of his death, but he stopped taking it in August 2019.
19. Dane's NA sponsor says: "in the last two weeks (i.e. the last two weeks of Dane's life) Dane was using every day. This was (the) heaviest period that I have seen him using in the way he was. I have no experience with ice, I have never taken it so I never gave Dane medical advice, that's not my role. Dane seemed to be awake a lot more over this period. He would ring or text me at all hours of the night."
20. At a family dinner on 12 August 2019, Belinda asked Dane whether he was taking drugs again. Dane said, "If you're telling me, the answer will be no. If you're asking me, I will say yes".
21. The next day, 13 August 2019, Dane rang Clinton and asked to borrow $200. Clinton says Dane was pushy about the money, although he also said it was for food and groceries. Clinton left the money for Dane and when they next spoke about 3 days later Dane said he wanted to pay the money back. Clinton told him if he really needed it, he could keep it. At this point Dane admitted he had 'fallen off the wagon' and was drinking again. Clinton offered him a few days of work in September.
22. On 17 August 2019, Dane's NA sponsor asked him when he had last slept. Dane couldn't clearly answer.
23. At about 4.30am on 18 August 2019, Dane turned up unannounced at the family home asking after his sister Grace. Glenn told him that Grace was okay, but that he needed to get off the drugs and leave the family alone.
24. The family had remained staunch supporters of Dane through everything, but equally, his brother Timothy was a person living with the challenges of an intellectual disability, and Grace also needed family support. The family needed to keep

boundaries and rules to ensure everyone remained safe and protected. This was important within the family, to have boundaries to protect everyone. Belinda later checked on him via an SMS exchange, where Dane said he had been to “Martin’s” house and was now walking home.

25. Late that evening and into the early hours of 19 August 2019, Dane posted 3 videos to Instagram. In the videos it was clearly evident that Dane was thought disordered and grandiose.
26. Clinton was worried about the Instagram posts when he saw them. He called Dane and asked if he was okay, and Dane admitted he was not. They met up and Clinton bought Dane lunch and offered to drive him to the hospital when Dane suggested that’s where he needed to go. Dane said he had recently consumed crystal methylamphetamine.
27. During this conversation Dane also spoke to his NA sponsor who wanted him to speak to another member of NA who had specific experience with methylamphetamine addiction. Dane told Clinton he would go home and rest and would go to a NA meeting that night. Clinton said he would drive Dane to the meeting. Dane was acting strangely throughout this conversation and Clinton knew his friend needed help.
28. Later in the afternoon Dane rang his mum and she said she was just having her lunch. Belinda can’t remember what else was said or how the call ended.
29. That afternoon Dane left a message with his NA sponsor saying he was going to seek help at the hospital. He also informed his mother that he was going to attend the hospital.
30. Dane did attend the Prince of Wales Hospital as he had discussed with his NA sponsor and his mum. Whilst Dane was there he received a call from Clinton. During the conversation Clinton asked Dane if he wanted him to come to the hospital and Dane said he would. Clinton then had to make arrangements with his wife for the care of their young children before leaving to go and see Dane.
31. Dane later called Clinton sounding erratic. He said the hospital staff wanted him to take Valium and he was outside. Clinton told Dane, “go back into emergency and do what they say. You have gone to hospital for a reason.”
32. Sadly, by the time Clinton arrived at the hospital to be with his friend, Dane had already been moved to the Resuscitation Bay.

Events at the Prince of Wales Hospital Emergency Department

33. Video evidence taken from CCTV cameras within the Emergency Department and NSW Police body worn video cameras was available to watch what had unfolded. Dane was not well when he went into emergency.
34. The Emergency Department was full of patients waiting for attention, it was reasonably busy and what could be seen was people in the waiting room on the allocated chairs. People could be observed approaching the administrative area, coming and going. Dane was one of those people approaching for help.
35. Dane arrived at about 5.51pm. He walked into the waiting room, was seen to walk around and then leave. He then re-entered the area and knocked on the door to a triage room, and he told Nurse Crystal Braham that he was psychotic and needed help.
36. I pause here to comment on Counsel Assisting's closing remarks. She described this time at Prince of Wales Hospital as Dane asking the questions "will I stay, or will I go?", and that remark was so expressive of what was occurring. He first entered, then left, he then re-entered and told the nurse what was happening to him. It is a terrible scene where some part of Dane knew that he needed help. The other part, the drug affected part, was not helping him. After watching him speak and hearing about him through statements and his family, it was clear that Dane was an intelligent and articulate person. The argument between his true self and the severely drug affected part was evident in what transpired next.
37. Nurse Braham was concerned. Nurse Watson (who was also in the triage room) shut the door because she was intimidated by Dane's unannounced intrusion. But Nurse Braham walked out behind the reception desk and watched Dane from a distance and behind the glass. Nurse Braham then attempted to take him to the triage room, but he wouldn't leave his licence at triage.
38. Dane was intimidating to Nurse Watson, but even in the face of that Nurse Braham was trying to use her communication skills and understanding to help him. She didn't move to panic or have him restrained, she tried to win him over with her words and conduct. He told her that he was experiencing visual and audible hallucinations, the television had been talking to him and he thought 'he is God'. He told her that he had stopped taking his medication two weeks prior but denied that he would harm himself. He was erratic and not maintaining eye contact. He said that last night he smoked ice, but there was no intravenous drug use. He said that he had a history of schizophrenia.

39. I pause there to make these comments. We know now that Dane had consumed a considerable amount of methylamphetamine some time earlier, yet Nurse Braham was able to get this critical information from him, to assist his family in understanding what was going on with Dane at this point. She managed to do this task while feeling worried, she sat close to the door with the duress phone in one hand because of the aggression she had observed initially. She noted that he was chewing a lot, had a dry mouth and dilated pupils, and was not maintaining eye contact. She was concerned he was drug affected yet continued to engage with him and succeeded. Dane didn't want to have his blood pressure taken, but later allowed that to occur.

40. Dane then said he was leaving. Nurse Braham was concerned about the risk to himself and informed her Nurse Unit Manager Katie Sime. She asked for the use of a safe assessment room to help him de-escalate his behaviour, and the two attempted to move him to this room, Dane refused, and they ended up in the Ambulance Bay. Dr Short confirmed in her evidence that one needed to walk via the Ambulance Bay in order to reach the safe assessment room. Dane had some paranoia about NSW Ambulance Paramedics and believed they were going to hurt him and take him away. Nurse Braham tried to reassure him, telling him that they were there for other people. She did all of this maintaining a safe distance and while he was manic, pacing and yelling asking for water.

41. Dr Joanna Short then became involved. She had been told as the clinician she was replacing left, that there was a person appearing aggressive in the Ambulance Bay. It was said to her that he seemed aggressive, and it looked like escalation was likely. She noted that he was pacing, demanding attention, he refused to sit down and was intimidating. It was noted that Nurse Braham was attempting to de-escalate the issue.

42. Dr Short was able to have some sort of brief discussion with Dane and asked if he would like some medications to help him calm down. He agreed to some oral medication and told her that he had had olanzapine before. Dr Short then charted 10mg diazepam and 10mg olanzapine for Dane.

43. Nurse Braham stayed with Dane whilst another nurse, Nurse Kerstine Benolerao obtained the medication. However, when Nurse Benolerao returned, Dane refused to take the medication and became, according to Nurse Benolerao, even more escalated and was giving "threatening looks." Dane asked Nurse Braham to stay with him and even though she had other patients who needed to be seen in triage, she did as he asked. However, by this point he was not responding to verbal de-escalation.

44. Nurse Braham says someone gave Dane two cups of water but then he said, “I’m not going to take the tablets” and kept repeating “I’m God”.

45. Dane made three mobile phone calls whilst in the Ambulance Bay and was otherwise saying “I’m not staying unless you’re here Crystal…you can’t leave me Crystal”. This was a reference to Nurse Braham. Again, she remained with Dane.

46. Dr Short said that at this point Nurse Braham tried further verbal de-escalation with Dane, with no success. The team decided Dane would need IM/IV sedation. The Nurse Unit Manager was informed, and a bed was made available in the Resuscitation Bay. The goal was to help Dane settle. It was only once he settled, that further attempts could be made to assess and help him.

47. Dr Short says she asked a nurse to sign out 10mg IV diazepam and 10mg IV droperidol and to call security. At this point she was informed that Dane was trying to leave so Dr Short scheduled Dane as medically disordered.[1] This was on the basis that Dane had reported to the triage nurse that he was hearing voices from the TV and couldn’t differentiate between what was real and what was not. He had also stated that he thought he was going to die, and he admitted to using ice the previous day.

48. According to Nurse Unit Manager Sime, as she was clearing a space in the Resuscitation Bay, Dane started to escalate in the Ambulance Bay and walked towards the doors back into the Emergency Department waiting room. Nurse Unit Manager Sime and Nurse Braham followed and asked Dane to come back into the Emergency Department. At least one of them, and possibly both of them, activated their personal duress alarms.

49. On the CCTV footage, Dane can be seen drinking a cup of water as he re-entered the Emergency Department waiting room from the Ambulance Bay. He then turned around, as if to head back in the direction he had come, but ultimately walked out of the Emergency Department. This was another “should I stay or should I go?” moment for Dane. He was followed by Nurse Unit Manager Sime and Nurse Braham who were encouraging Dane to return.

50. The next event caused everyone present great concern. Nurse Unit Manager Sime recorded that she and Nurse Braham followed Dane out of the Emergency Department while trying to convince him to come back inside. He was not actually free to leave at this time, as he had been scheduled as an involuntary patient. They saw Dane get into his car, turn it on, pull out of the parked position and drive 50 metres up the road. Then the car suddenly stopped and reversed, almost hitting an

[1] Section 19 of the *Mental Health Act 2007* (NSW).

ambulance parked in front of the Emergency Department. Dane turned the car to face the waiting room entry. Nurse Unit Manager Sime recalls Nurse Braham asked, “is he going to drive into the waiting room?” However, this concerning behaviour ceased, and Dane got out of the car and walked into the Emergency Department yet again. Nurse Unit Manager Sime described Dane having an intimidating/threatening manner as he walked into the waiting room.

51. In the meantime, hospital security had been summoned to the Emergency Department. Dr Short confirmed in her evidence there had not been an opportunity to brief security about what was going on or how Dane might be encouraged to stay at hospital whilst keeping physical restraints in reserve, to be used as a last resort. The following events occurred very quickly, there was really no time for a planning session.

52. Dane saw the security staff as he was walking through the Emergency Department and turned to leave. The security guard closest to Dane, Michael Donnellan, reached out and placed a hand on Dane’s left arm. Dane continued to head towards the door and two other security guards, Steven Kritikos and Ibrahim Al-Jawabreh, joined Mr Donnellan and moved to restrain Dane.

53. Nurse Braham continued talking to Dane and beckoning to him. Dane began to move or fall forwards, over some of the Emergency Department waiting room seats. His leg was caught up in Mr Donnellan’s legs. Security guards tried to pull Dane backwards, but in the process Mr Al-Jawabreh ended up on Dane’s back and had Dane in a choke hold. Dane bit Mr Al-Jawabreh more than once during the restraint.

54. Dane ended up on his knees and was then sat on the floor. Although there is no sound on this part of the video footage, the witnesses recall Dane calling out. The scene was loud and chaotic.

55. When Dane was on the ground, Nurse Braham attempted to restrain Dane on his lower legs, but Dane kicked his legs towards Nurse Braham. She said, “I stopped assisting in physical restraint as I was too small and being continuously kicked by the patient. I attempted to continue to verbally de-escalate him as I had built a rapport with him. He was calling me out by name and asking me to help him and was asking for the Valium and not to put him to sleep. Dane was saying, “Crystal, help me.”

56. Dr Short did not witness the initial restraint. When she came through into the waiting room Dane was being restrained on the floor. At this point he was prone. She too attempted to help by holding one of his legs, but he was too strong and tried to kick her. Dr Short stepped back to protect herself. She advised the Nurse Unit Manager to contact Police for extra support.

57. Nurse Benolerao approached Dane to administer the IM medication Dr Short had previously ordered for Dane, before the situation escalated. She attempted to give him the injection towards his left upper leg/buttock, but Dane kicked out his right leg towards Nurse Benolerao, narrowly missing her face. She was forced to step back from her first attempt to give the injection.
58. At about 6.24pm, Nurse Benolerao made another attempt to administer the droperidol injection, but Dane was still moving. This time though, the injection was able to be administered shortly thereafter.
59. According to Nurse Unit Manager Sime, "after the droperidol had been administered I noticed that one of the security guards was holding Mr Lockwood down by the throat. I asked him to move his hand in order to protect the airway. The security guard re-adjusted his grip."
60. Two NSW Paramedics came into the Emergency Department after the droperidol injection was administered and they participated in the restraint. Paramedic Cameron Calvert asked Nurse Unit Manager Sime for a mask which was then applied to Dane.
61. The need for the application of a mask was explained by Paramedic Calvert as follows, "this was for the protection of all of us from the biting. Although I did not see any actual biting, I saw the deceased lunging out with sudden head movements towards myself and security. I thought he certainly could bite or spit at me or others without the mask. I could see blood on the deceased's mouth as well at this time. I could not tell if the blood was from him or when he perhaps bit security earlier."
62. At about 6.28pm, Nurse Bobby Karlek administered a second 10mg IM injection of droperidol into Dane's left lateral thigh.
63. The CCTV shows that after the second injection was administered, NSW Police arrived. By this time two additional hospital security guards were also assisting with the restraint.
64. Probationary Constable Paul Calvisi said in his interview following Dane's death, "there was no time really for any plan to sort of take shape. We sort of basically went with what we saw and um, sort of improvised from there."
65. The other attending police officer, Constable Jackson Towns, had his handcuffs ready and spent some moments talking to Nurse Unit Manager Sime before moving in to apply the handcuffs to Dane. The body worn camera footage at this time includes audio recording and captures Constable Towns saying, "Dane I need you to relax mate."
66. Dane was then heard to say something about "two lethal injections."

67. On the footage, Constable Towns can be seen pulling back his left hand in response to Dane's movement as he attempted to use the handcuffs. Someone said, "Dane, stop mate."

68. Dane was fighting back and saying things like "what the fuck?" and "they're drugging me." At one point he grabbed onto the jacket of one of the security guards and his fingers had to be prised away so that the security guard could be released. The security guards tired from the efforts involved in the restraint.

69. At about 6.34pm, the handcuffs were applied, and Dane was searched. According to Paramedic Calvert even in the course of the search and after he was handcuffed, Dane lunged out. Dane grabbed Paramedic Calvert in the groin causing immediate pain. Paramedic Calvert pushed Dane's hand away, pinned Dane's arm to the floor and raised his fist towards Dane. He didn't strike Dane but admits he was really angry because Dane had grabbed him.

70. At about 6.37pm, Dane was lifted onto a hospital gurney in the supine position. Dane is heard to call out "help" and Nurse Unit Manager Sime says, "It's okay Dane, it's okay", but he called out again.

71. Restraint continued as Dane was wheeled from the Emergency Department waiting room to the Resuscitation Bay. Dane continued to move his feet and at one point raised his knees suddenly.

72. Returning to the statement of Paramedic Calvert, he says Dane's level of resistance was slowly decreasing once he was on the gurney, possibly due to the sedatives taking effect. Restraint continued because it was still possible that Dane would move suddenly.

73. As evident from the CCTV footage played in Court, Dane was still being restrained for a period in the Resuscitation Bay whilst there was a discussion about who would restrain Dane's arms once the handcuffs were removed.

74. Initial steps towards restraint had commenced at about 6.21pm and continued until sometime around 6.42pm, at least. During that period there were moments where Dane might have been attempting to comply and moments where Dane began to feel the effects of the sedation, but it remained a highly charged situation throughout.

75. According to Dr Short, once in the Resuscitation Bay the handcuffs were simultaneously removed, and Dane was shackled to the bed with wrist restraints. At this point Dane appeared to be cyanotic. 15 litres of oxygen were immediately applied via a non-breather mask and an oxygen saturation probe attached. Dane was no longer making any purposeful movement or responding to painful stimuli. A pulse check was carried out and there was no pulse, so cardiopulmonary

resuscitation (CPR) and advanced cardiac life support (ACLS) were immediately commenced.

76. The initial rhythm Dane returned was asystole and he thereafter remained asystole/pulseless electrical activity (PEA) throughout the cardiac arrest, except for one episode of ventricular fibrillation at 6.57pm when he was shocked and a later episode of ventricular tachycardia when he was again shocked.
77. There was a discussion around putting Dane on extracorporeal membrane oxygenation (ECMO), but he was not a suitable candidate. A bedside ultrasound showed cardiac standstill, his pupils were fixed and dilated, and a decision was made to cease resuscitation.
78. The time of Dane's death was marked as 7.21pm.

Autopsy results

79. An autopsy was performed by Dr Melissa Thompson on 22 August 2019, recording the direct cause of death as methylamphetamine toxicity.
80. Droperidol was detected at a concentration within the reported therapeutic dosage range. She found that the subcutaneous bruises she located on Dane's left lateral upper thigh and buttock were consistent with the droperidol injections having been administered there.
81. Dr Thompson said in relation to the cause of Dane's death that, in addition to the methylamphetamine toxicity, the physiological effects of the restraint and Dane's resistance to restraint might be seen as an antecedent cause of death.
82. She elaborated on this in her oral evidence. She explained that there is a very wide range of accepted methylamphetamine level that can permit her to make a finding of death as a result of drug toxicity and that the ranges she relied upon focus upon post-mortem levels. She explained that there are many reasons for the wide range. Firstly, one individual's reaction to a drug can be very different from another. Secondly, she explained that the time of taking the drug remained unknown. Thirdly, the tolerance, if any, that Dane had built up is unknown and fourthly, the purity of the drug was unknown. She said however, that it was reasonable to conclude that the struggle for over 20 minutes in a physical manner put further pressure on his already drug affected body and would have contributed to his death in this case.
83. Dr Thompson indicated that her conclusion as to cause of death takes in a constellation of factors, not just the methylamphetamine level.
84. One factor she took into account is that deaths as a result of methylamphetamine toxicity have been reported at very low levels. The drug is produced inconsistently and illegally.

85. Another factor is the way the drug triggered a behavioural disturbance which likely impacted upon things such as Dane's cardio vascular and neurological functioning. This led to Dane needing to be restrained. This in turn further affected the physiological functioning of Dane-and may have ultimately triggered an arrythmia or acute ischemia which is not detectable on autopsy.
86. Dr Thompson could not say whether the aspiration event leading to Dane regurgitating stomach contents occurred before or during resuscitation attempts.
87. Dr Thompson again emphasised the level of methylamphetamine at the time was within the toxic range, that is, Dane still had enough in his system to be associated with toxic effects. Although his blood pressure was recorded as normal just before the event, that did not detract from her overall findings.

Expert evidence

88. Two expert reports were prepared to assist the Inquest.

Associate Professor Holdgate

89. Emergency Medicine Specialist, Associate Professor Holdgate had reviewed the footage and notes. She provided an independent overview of the overall incident at the Prince of Wales Hospital. In her view the conduct of the medical staff was appropriate. She considered that the nursing staff de-escalated the initial presentation through appropriate management in trying to calm Dane down and reason with him. She considered that he was presenting in a manner that was well outside the normal range and was in a heightened and unpredictable state. It was her evidence that the presentation of those affected by methylamphetamine in Emergency Departments is generally on the increase.
90. Although not critical of the use of droperidol, Associate Professor Holdgate went on in her report and considered whether an alternate drug to droperidol could have been better used. In her report she suggested that ketamine could have been used instead.
91. Dr Short was asked about this in oral evidence and explained it was a possibility but that patients can have an unpredictable response to ketamine, and she was concerned that Dane was in the public waiting room of the Emergency Department and she didn't want to risk making things worse. She also referred to the possibility that ketamine can make psychosis worse and can trigger laryngospasms.
92. Associate Professor Holdgate was asked to comment upon this and she agreed that it is usual practice to give droperidol, following which it is appropriate to assess and give a further dose if necessary. To use ketamine in an uncontrolled environment

such as the waiting room, where attention could not be given to respiratory needs immediately following, pending any adverse reaction, in her view would have been a significant decision. She highlighted that there were a series of difficult choices that needed to be made by Dr Short this night.

93. Associate Professor Holdgate had observed the footage carefully and was taken to extracts from it in her oral evidence. In her view the physical restraint of a patient is always fraught. It is frightening for the patient. In this case Dane was not in a clear and logical state of mind. She highlighted the fact that physical restraint, let alone a physical take-down and struggle, is always unpleasant. This was further exacerbated by the fact that he was situated in the waiting room, putting not only himself, but other patients and staff in danger.

94. She said that she observed that when Dr Short was present, Dr Short stood and monitored Dane carefully as matters progressed, and she noted this was appropriate clinical practice (I pause to observe that in some parts of the footage Dr Short is obscured as Dane is restrained near a column in the ED room which blocks full CCTV coverage of the scene). Associate Professor Holdgate also observed the nursing staff and found that they attempted to monitor security, provide assistance and continue to attempt to verbally de-escalate the behaviour of Dane.

95. Associate Professor Holdgate noted that anyone will naturally resist restraint. Ideally, she said 5 people are required to perform this task, but in the circumstances they had to act and make do with the limited resources present. She said physical restraint is always a precursor to chemical restraint. The idea is to have the person sedated as quickly as possible.

96. Even taking into account the footage of Dane being restrained within the resuscitation bay, Associate Professor Holdgate highlighted that Dane had been exhibiting behaviour consistent with the highest level of severe behavioural disturbance seen in an Emergency Department. Associate Professor Holdgate said that physical restraint was of last resort and should be kept to minimum time. However, in Dane's case she said he was scheduled, he was in her view a danger to himself and others, and he could not leave the hospital. She found that as distressing as it is to watch, it was the only action that could be taken in this case. Hindsight might have resulted in a different drug being used, but that in itself would have been a significant clinical decision to make given the risks associated with ketamine in an uncontrolled environment.

97. Associate Professor Holdgate also addressed the issue of the use of a mask during the restraint. She told the Court: "The use of an oxygen mask (not connected to oxygen) to protect staff from biting and spitting is common practice amongst

emergency health care workers. While there is a theoretical risk that such a mask may inhibit effective respiration, these masks are not tight fitting and do not seal around the face. It is possible to entrain air around the edges of the mask and exhaled air similarly readily escapes around the mask. In the footage Dane is seen to be rapidly and vigorously breathing and it is unlikely that the mask would have significantly restricted his respiration or contributed to his deterioration… In my opinion the mask is very unlikely to have significantly contributed to Dane's deterioration."

Associate Professor Gunja

98. Associate Professor Gunja, Forensic Toxicologist, also provided an expert report. One issue he raised was the possibility that the second dose of droperidol was inadvertently injected into a vascular compartment. In oral evidence he explained he was talking about small blood vessels. He indicated that this is not suggestive of error, it is just a clinical fact that this can happen in a small percentage of cases which can then lead to rapidly elevated blood levels.
99. As against this, both Dr Short and Associate Professor Holdgate emphasised that such a rapid elevation would likely have left Dane unresponsive at an earlier time than the CCTV footage suggests. It was Associate Professor Holdgate who, through careful review of the footage, identified the fact that the time markings in the progress notes written after Dane died were in conflict with the timing of events shown on the CCTV. I accept that the timing as revealed through the CCTV footage is reliable.
100. The evidence does not permit a finding that the second dose of droperidol was inadvertently injected into a vascular compartment (it remains a possibility) but I accept Associate Professor Gunja's evidence that even if it was, this was not suggestive of error.
101. Associate Professor Gunja also raised an important point about the levels of methylamphetamine and the reported toxic levels. He noted that methylamphetamine administered hours or even days before can have an ongoing impact on the human body because, for instance, the drug can trigger a physiological effect which persists even after the drug is being metabolised. This accords with evidence from Dr Short that the use of the drug can then trigger a psychosis, which seems to have occurred with Dane.
102. In his report Associate Professor Gunja noted that as a habitual user of methamphetamine it was possible that Dane may have higher tissue absorbance

leading to increased PM redistribution as compared to an infrequent user. Dr Thompson was asked about this but was not aware of the tissue storage phenomenon. She acknowledged a potential distinction between habitual and naïve users of the drug but emphasised that death can result regardless of post mortem concentrations. I understood this to be broadly consistent with Associate Professor Gunja who emphasised in oral evidence that he raised the point of higher tissue absorbance in a regular user as a possibility, but one simply does not know if it applied in Dane's case.

103. One area of improvement he proposed was ensuring that ante mortem blood results could provide better assistance in assessing true toxicity levels.
104. In essence, in my view Associate Professor Gunja highlighted the fact that ingestion of the illicit substance of methylamphetamine carries with it significant dangers. The body might respond negatively, strain may be put on the body and death can result even when the levels appear to be low. He also highlighted we can never know the amount or purity of the substance taken by Dane, and therefore cannot fully understand the impact of the level on his body.

Concluding remarks

105. There is no doubt that this was a tragic, unexpected loss for Dane's family.
106. The evidence of Dr Short and the statements in the brief from those present explain the very difficult situation that the medical staff were faced with. Dane attended hospital and knew he needed help. He knew he needed to get medical treatment. We now know that he had a toxic level of methylamphetamine in his system.
107. The inquest also had the benefit of hearing directly from Dane in recordings he made earlier in the morning. He was thought disordered, he had not slept for a lengthy period of time, and he was deluded in what he was seeing and hearing. These facts were observed by hospital staff.
108. Dr Short noted that he was talking to the television set, and that he believed he was God. Yet even in this state he called friends and family and recognised that he needed help.
109. Nurse Braham was one person that night who managed to connect with Dane. She showed understanding and compassion. She tried her professional best to calm him and de-escalate the situation. Nurse Braham is the reason we have much of the critical evidence of the thinking of Dane prior to his death.
110. The hospital staff were faced with a medical crisis. They had limited means and resources to deal with it in the immediate moment that it faced them. They had an

obligation to all patients to keep them safe in that environment. There was an obligation to keep staff, the general public and Dane himself safe.

111. Dr Short was a thoughtful and careful witness. She is committed to drug and alcohol rehabilitation and works in a second role at St Vincent's Hospital Sydney doing just that. She showed compassion, concern, and care for Dane that day. She wanted to get him to a place that reduced stimuli, but they could not coax him to the safe room, making it only as far as the Ambulance Bay. That was not ideal, but that was the only route to the safe room at that time. Dane initially agreed to take medication, but then decided to leave, another example of the uncertainty he exhibited about needing help but wanting to leave.

112. Dr Short then did schedule him pursuant to section 19 of the *Mental Health Act 2007* (NSW). This was appropriate at that point. It is important to remember from that moment he was no longer a voluntary patient, he could not leave. Reasonable force could be used to detain him.

113. He then did leave and exhibited escalating dangerous behaviour, in the form of driving. This was not caught on film because it occurred in a different area of the car park to where the CCTV cameras are located. Staff were entitled to be concerned about what they saw. This behaviour reinforced the danger that Dane was in, and the danger he posed to others.

114. There were observations by nurses and Dr Short that Dane was aggressive. It was not suggested that he was violent towards any person, and this distinction should be made. Dane was not wanting to hurt anyone else. He was however trapped in a drug affected state, and the aggression that staff described was in my view a relevant observation in relation to diagnosis of Dane. He was unpredictable and demonstrating an inability to regulate emotion as he would ordinarily be able to do.

115. There is no doubt that for Dane's family and friends, watching the scene of the security guards and others trying to restrain Dane for over 20 minutes was traumatic and appeared careless and reckless. This would be so but for the fact that they were required to restrain him, in an unsafe environment, with no or little notice and on the basis that everyone hoped he would sedate quickly, which did not unfortunately occur. It also needs to be mentioned that the hospital is not a place that is necessarily equipped for physical altercation. Security guards are generally not trained to the standard of NSW Police in forceful take-down. Medical staff certainly are not. When the police arrived the tone changed, they were clearly then in charge, using methods that they are trained in. Even though they had limited information they stepped in and directed as they are trained to do.

116. In fact, Dr Short sedated Dane a second time much faster than is suggested in the *NSW Health Guideline Management of Patients with Acute Severe Behavioural Disturbance in Emergency Departments*. She noted that she did so for a number of reasons, firstly, that the aim was to stop the physical restraint. Secondly, she gave evidence that in effect, time was seeming to pass slowly the longer the restraint went on. Even the second dose took quite some time to take effect. This action reflected the strength that Dane was exhibiting to resist for such a long period. Importantly, Dr Short said that she was looking for the moment that he could be released from the hold. That time did not arrive.

117. The struggle itself, after the initial taking to the ground, involved holding Dane down. At times arms and legs were in unacceptable positions, but nurses acted to correct this. They were looking out for him. Dane was struggling, and that struggle did not cease, his feet can be seen moving constantly whilst restrained in the Emergency Department, reflecting the pressure that he was still capable of exerting to break his way out of the hold.

118. I agree that Dane was resisting the security guards, he wanted to break free. He was afraid, not understanding what was happening and severely drug effected. He could not have at that time understood that these were the people who wanted to help him, to whom he himself had gone to for help. He was not intending to hurt anyone else. The behavioural disturbance might have been ice, or the period of days without sleeping, which can itself trigger a psychosis. The consumption of methamphetamine put into train or triggered a series of cascading events, leading to his death.

119. A general observation is that there has been a dramatic rise in methamphetamine consumption which, according to anecdotal evidence from Dr Short and Associate Professor Holdgate, shows no sign of slowing.

120. The prevalence of use and disastrous consequences of addiction triggered the conduct of the NSW Special Commission of Inquiry into the Drug “Ice”. This Inquiry concluded in January 2020 with over 100 recommendations: such is the complexity of issues thrown up by the use of illicit drugs and this drug in particular.

121. Evidence on behalf of the Prince of Wales Hospital given by Dr David Murphy, A/Director of the Prince of Wales Emergency Department, referred to both a change to the physical design of the Emergency Department and to principles of care for the assessment of patients presenting with toxicological, behavioural or addiction-related problems.

122. As to the physical design of the Emergency Department, design and planning commenced at least as far back as 2017, i.e. before Dane’s death. Dr Murphy

emphasised in his statement that the physical re-design will permit Prince of Wales Hospital to:

> … adapt the principles of care found in the Royal Melbourne Hospital's Behavioural Assessment Unit model (the RMH Model). This model recognises the difficulty in determining the cause of behavioural disturbance in patients with mental health conditions and/or drug or alcohol usage and addresses the risks associated with managing such patients, including risks associated with patient and staff safety.

123. In this way the physical re-design invokes consideration of the RMH Model.
124. The RMH model incorporates intense observation, early targeting care, allowing people to come to hospital and be managed in a way that separates them from other patients. The relevant document talks about the design of that unit to be co-located with services, with the aim of reducing the incidence of restraint.
125. The Prince of Wales Model will adapt that model and operate in a fashion that is also similar to the Psychiatric, Alcohol and Non-prescription Drug Assessment Unit (PANDA) model used at St Vincent's Hospital.
126. The Prince of Wales version:

> … will initially be a 24 hour 4 bed unit, with scope to increase to 6 beds. The EDAU will be managed by ED staff, with referral from the ED. It will offer tailored multidisciplinary treatment from ED, Drug and Alcohol, Toxicology and Mental Health treatment teams. The design of the EDAU and the model of care adopted will allow intense observation, early targeted interdisciplinary care, a low-stimulus environment, and intensive engagement with specialist and community services.
>
> The EDAU has been designed around avoidance of restrictive interventions. Passive safety systems will be employed, such as a low-stimulus environment with natural light from a central courtyard, separation from the main ED, and passive egress prevention through time delays on exit doors.

127. This is a sensible response to the *health* crisis arising from ice addiction (and other causes of behavioural disturbance). It is not suggested that such a unit will prevent escalation in all cases, but it is an important step in giving those patients an opportunity to seek help in a way that might reduce the need for restraint.
128. One can anticipate though that the demand will exceed supply, based upon the evidence of Dr Short and Associate Professor Holdgate.
129. The Emergency Department is full of ill people, and in some cases people in need of extremely urgent medical treatment. They are vulnerable, and yet they are then exposed to other psychologically ill or drug affected patients in the very same area.
130. The staff are all there to do the job of saving lives. They are then put in the invidious position of having to engage in a forceful, dangerous situation to try and do their job and protect the other patients. They do so in an unsafe and uncontrolled space and are limited by resources.
131. It is a general systemic failure in the current model that let Dane and his family down. It let the staff and patients down. The general systemic failure starts at the point where criminals manufacture and supply drugs of addiction leading to a raft of social ills that so often present in the Court system: broken families, violence and criminal charges.
132. People living with the illness of addiction need both an adequately funded health as well as a law and order response.
133. Dane's death highlights that significant changes are required for those who are brave enough and invested enough to seek help for serious drug addiction.
134. To this end I direct the Registry to send a copy of my findings to the Minister for Health so that Dane's experience is shared and the important potential for improvement via the EDAU at the Prince of Wales Hospital is acknowledged.
135. To the family and friends of Dane, I offer my sincere and respectful condolences for their significant loss. The loss they described in the family statements was of a fun, intelligent and interesting man. A person who contributed to society and cared about society on many different levels. They described a brother who was emotionally supportive and caring, and a son who was loved for being a clever, loving individual.

Acknowledgements

Firstly, to Detective Sergeant Thomson, who put a great deal of thorough time and effort into preparing and presenting a very extensive and helpful brief of evidence, and who remained throughout proceedings to provide assistance.

Secondly to the various representatives Ms Cook, Ms Boyd, Ms Pinnock, Ms Cameron and Mr Haverfield for their assistance and input during the Inquest.

Thirdly to Dane's family, who took the time to share valuable information to the Inquest and provide insight into Dane about who he really was in life. That was such an important part of the Inquest.

Finally, to the team, Counsel assisting Ms Ward SC and Ms Hubbard, who put countless hours into preparation and careful presentation to allow the Inquest to proceed in a very thoughtful and dignified manner. I am very grateful.

Findings

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

Identity

The person who died was Dane Oliver Lockwood.

Date of death

19 August 2019.

Place of death

Prince of Wales Hospital, Randwick, NSW.

Cause

Dane died as a result of methylamphetamine toxicity; antecedent causes being the physiological effects of the restraint and Dane's resistance to restraint.

Manner

Accidental self-induced drug toxicity resulting in physical restraint.

Magistrate E Kennedy
Deputy State Coroner
28 October 2022