Strengthening interagency collaborations between health and police in emergencies to optimise health, security, and economic expenditure

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Disclaimer: The views and findings presented are those of the investigators and do not represent those of the collaborating organisations

Background

Herbert John MITCHELL

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Herbert John MITCHELL

OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Herbert John MITCHELL**
TITLE OF COURT:	Coroner's Court
JURISDICTION:	Townsville
FILE NO(s):	COR2011/1318
DELIVERED ON:	14 December 2012

Background

1. *"Police are not medically trained …*
2. *expecting them to make medical decisions is inappropriate …*
3. *medically trained staff should be posted in all of the larger watch houses to make initial assessments and to carry out on going monitoring and re-assessment."*

[Submission considered at Coronial Inquiry into the death of Herbert John MITCHELL, Townsville, 14 Dec 2012]

Background

Tanya Day's family call for criminal investigation on final day of coronial inquest

Family members of an Aboriginal woman who died after suffering catastrophic brain injuries while locked in a Victorian police cell are adamant she will be remembered for more than her death.

RELATED STORY: Tanya Day got on a train to Melbourne. She never made it home

RELATED STORY: All eyes on coroner as key questions swirl around Tanya Day's tragic death

"She was a proud Yorta Yorta woman who loved her family, her community and was a strong voice for what she felt was wrong," Ms Day's daughter Belinda Day said.

Friday was the final day of the three-week coronial inquest into the death in custody of Tanya Day.

The 55-year-old was arrested for public drunkenness while catching a train from Bendigo to Melbourne on December 5, 2017.

Ms Day was taken to the Castlemaine Police Station, where she was left alone in a cell for four hours, despite repeatedly falling and hitting her head.

Rebecca Maher's death in custody could have been prevented if police called ambulance

By Emma James

Updated 6 Jul 2019, 12:06am

An inquest has found the death in custody of Wiradjuri woman Rebecca Maher was accidental, but failure by police to conduct a body search may have cost the 36-year-old her life.

Ms Maher's death was the first Aboriginal death in NSW Police custody since 2000.

The 36-year-old died in the early hours of July 19, 2016 from multi-drug toxicity after being picked up heavily intoxicated in Cessnock in the NSW Hunter Region.

She was held in a cell at Maitland police station for six hours before she was found unresponsive and pronounced dead.

Ms Maher was found with two bottles of pills, including the anti-anxiety medication Alprazolam, which she had been prescribed earlier that day.

as ruled on Friday that police failed to properly search Ms Maher over unfounded concerns she had HIV.

ng State Coroner Teresa O'Sullivan noted that had the police conducted an adequate search, Ms Maher y have been able to receive the medical care she required.

inquest heard from emergency medicine expert, Dr John Vinen, who said in a report to the court that Ms er "would have survived" if paramedics were called and she had been transported to hospital.

he coroner recommended police receive further training on how to adequately deal with people suspected having potentially infectious diseases.

he also said Ms Maher should not have been prescribed the Alprazolam because she had a history of drug ddiction.

he recommended the actions of the GP be investigated and said she would pass her findings to the edical council.

utside Newcastle Courthouse, Indigenous campaigner Aunty Tracey Henshaw said the recommendations ere meaningless.

Everybody that does a job has policies that they have to adhere to. The police should not because they wear a uniform be not made accountable for their policies," she said.

agistrate O'Sullivan stopped short of attributing direct blame for Ms Maher's death, but made further commendations that intoxicated Aboriginal people held by police have the same access to legal services rough the custody notification service as people who have been arrested.

he service offers 24-hour legal advice for Aboriginal people taken into custody and was one of the key commendations of the 1991 Royal Commission into Aboriginal Deaths in Custody.

the time of Ms Maher's death, the Aboriginal Legal Service NSW called for an independent investigation to the death, also noting her family was not notified of her death until 12.20pm, six hours after it happened.

Sedative issued by paramedics among 'various factors' hastening man's death, coroner rules

The Queensland coroner has found an Indigenous man who died after being restrained by police was should not have been given a sedative while he was handcuffed and having breathing difficulties.

Police and ambulance officers were called to a house at Kingston, south of Brisbane, in October 2015, where 33-year-old Shaun Charles Coolwell was in an agitated state.

An inquest into Mr Coolwell's death heard he had injured himself and was under the influence of amphetamines.

Handing down his findings in Brisbane on Monday, coroner Terry Ryan said the scene that confronted officers at the house was "undoubtedly challenging, dynamic and stressful".

"Mr Coolwell was clearly in need of restraint for his own wellbeing when Constables (Tamzin) Zarzycki and (Barend) Traber arrived," Mr Ryan said.

Mr Coolwell was handcuffed, lying face down in a hallway.

"It is clear from the review of the body worn camera footage that while Mr Coolwell was restrained in a prone position for almost 10 minutes, he only struggled for a very short time at the beginning of this period," Mr Ryan said.

Police asked ambulance officers to give Mr Coolwell a sedative, but Mr Ryan found "the administration of Midazolam was clearly inappropriate" in the circumstances.

Photo: Shaun Coolwell, 33, died after being administered Midazolam in 2015. (Supplied: Coolwell family)

RELATED STORY: Police used lawful and unnecessary force during man's arrest, family says

RELATED STORY: Coroner watching overseas probe into custody death of injured Aboriginal man

Key points:

- Police and paramedics faced a "challenging, dynamic and stressful" situation in dealing with Shaun Coolwell, the coroner found
- Mr Ryan said administering Mr Coolwell the sedative Midazolam was "inappropriate"
- But the coroner made no adverse findings against the paramedics

Prison health service concedes it missed opportunities to prevent Indigenous death in custody, inquest told

An Indigenous prisoner who communicated mostly through Aboriginal sign language was "not okay" when he was sent back to his dorm, an inquest into his death has heard, with authorities conceding they missed opportunities to intervene because of his deafness and language difficulties.

Jeremy Tunkin, 39, who had "moderate to severe" mixed hearing loss and a limited understanding of English, speaking mostly Pitjantjatjara, was found unresponsive in the dining area of a low-security wing of the Alice Springs Correctional Centre on August 8, 2017, and died a short time later.

He was found to have suffered from heart failure after presenting to medical staff with chest pains two days prior.

An inquest into his death set out to examine whether communication between staff and the deceased was adequate, and the appropriateness of his care, supervision and treatment whilst in custody.

The inquest was told there was some confusion among correctional and medical staff as to whether Mr Tunkin was suffering from a sore throat or chest pains, and it was believed he was "complaining about having drunk white stuff", understood to be calcium from inside of a kettle.

Registered Nurse (RN) Tony Augustine, who consulted with Mr Tunkin on August 6, told the inquest he had "extensive dealings with persons with hearing disabilities" and "worked hard to ensure he was satisfied with the level of communication he was able to have", but conceded that "initially he had trouble communicating with the deceased because of his hearing disability".

He sought further assistance from morning team leader and registered nurse Emma Jones, who gave evidence she arranged for the 39-year-old to be shown a kettle, because she believed there was a problem with his throat.

RELATED STORY: Aboriginal man died waiting for bail paperwork to be signed, inquest hears

RELATED STORY: Guard denies 'excessive' response before David Dungay's death

RELATED STORY: Woman's cuffed prison transfer prompts calls to change system for mentally ill

Key points:

- Inmate Jeremy Tunkin died of heart failure two days after reporting chest pains
- Potential opportunity for intervention missed, prison health service concedes
- Coroner applauds "proactive" response of health services, offers no recommendations

Background

What we know

…about the ED

…about people in the long-term custodial setting

…about people in the short-term watch-house /jail setting

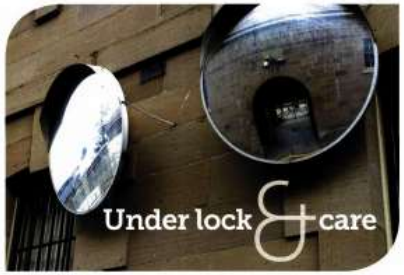
Background

What we know

…about the ED

…about people in the long-term custodial setting

…about people in the short-term watch-house /jail setting



Background

What we know

…about the ED

…about people in the long-term custodial setting

…about people in the short-term watch-house /jail setting

(Bureau of Justice Studies 2016)

Background

…we need to understand how evidence-based health services can be provided for people in custody (WHO, 2014)

The WHEN model (WHEN: watch-house emergency nurse)

Trialled May – July 2013

- Supplementation of domiciliary nurse service with triage competent ED nurses to provide 24 hour nurse presence
- 8 hour afternoon shifts (1300-2130hrs) and 10 hour night shifts (2100-0730hrs)
- 10 ED nurses rostered for 2-3 WH shifts per week in addition to general ED shifts
- Clinical supervision by Forensic Medical Officers (FMOs); professional supervision by ED Nurse Unit Manager (NUM)

Methods

Study 1:


EMA Emergency Medicine Australasia

Emergency Medicine Australasia (2019) doi: 10.1111/1742-6723.13301

ORIGINAL RESEARCH

Characteristics and outcomes of patient presentations made by police to an Australian emergency department

Julia CRILLY,[1,2] Ping ZHANG,[3] Cathy LINCOLN,[4] Paul SCUFFHAM,[3] Jo TIMMS,[1] Ken BECKER,[5] Nelle VAN BUUREN,[4] Andrew FISHER,[1] Danny MURPHY[6] and David GREEN[1,3]

Study 2:


International Emergency Nursing

Available online 3 September 2019, 100790

In Press, Corrected Proof

A structure and process evaluation of a police Watch House Emergency Nurse (WHEN) model of care

Julia Crilly, Josea Polong-Brown, Cathy Lincoln, Jo Timms, Ken Becker, Paul Scuffham, Nelle Van Buuren, Andrew Fisher, Danny Murphy, David Green

Study 3: Outcomes evaluation of the watch-house emergency nurse [WHEN] model of care (66 days: pre-during-post)

Ethics approval: from Q.Health, QAS,QPS, Griffith University

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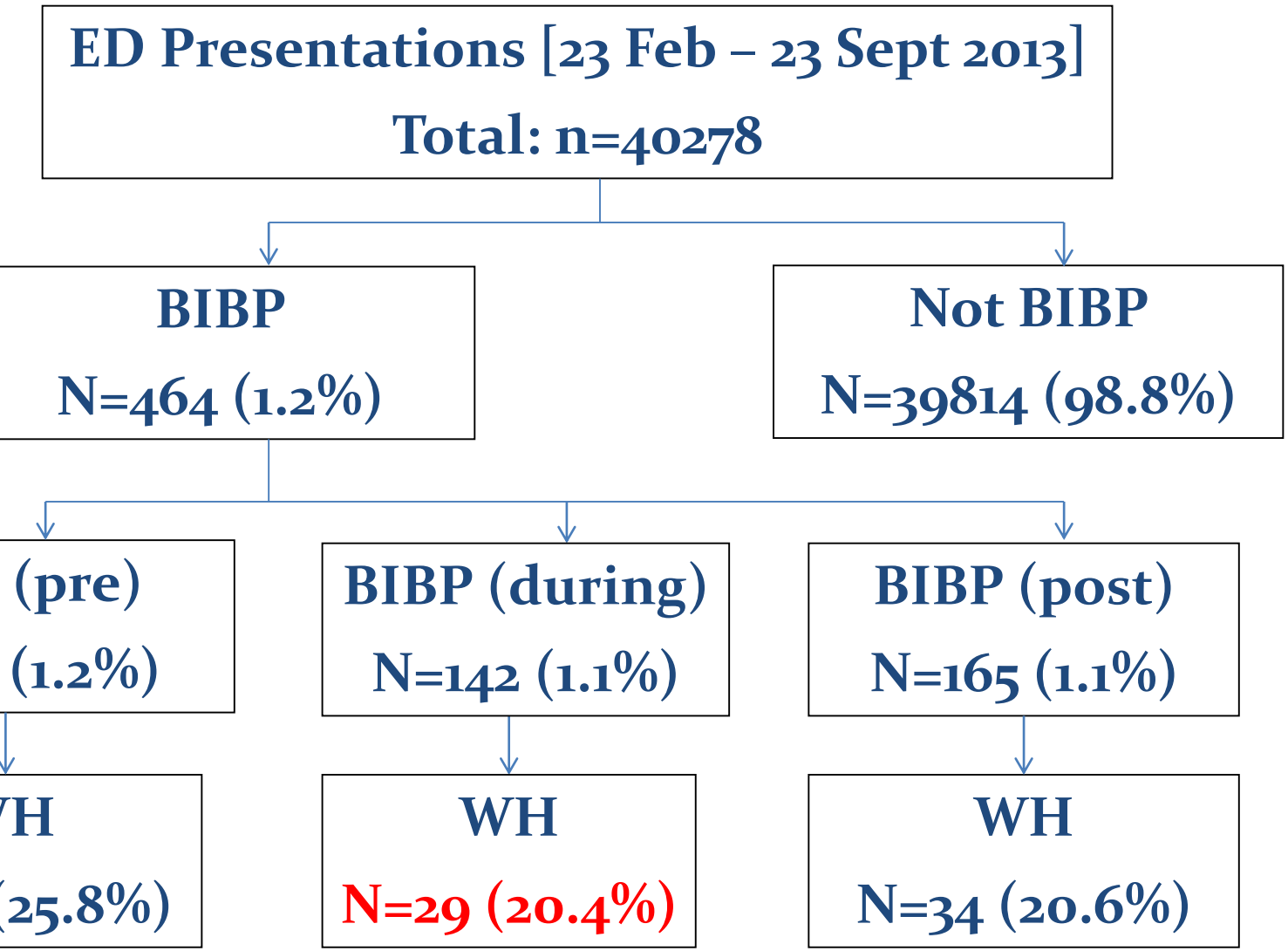
Setting

Public hospital

Police Station and watch house

Results


ED Presentations [23 Feb – 23 Sept 2013]
Total: n=40278
BIBP
N=464 (1.2%)
Not BIBP
N=39814 (98.8%)
BIBP (pre)
N=157 (1.2%)
BIBP (during)
N=142 (1.1%)
BIBP (post)
N=165 (1.1%)
WH
N=40 (25.8%)
WH
N=29 (20.4%)
WH
N=34 (20.6%)

Results: in the ED

What were the demographic characteristics of patient presentations from the WH?

Characteristic	Pre (T1) N=40	During (T2) N=29	P value T1 v T2
Median age, years (IQR)	35 (27-48)	40 (30-45)	0.592
Sex: female	15%	7%	0.453

Results: in the ED

What were the ED clinical characteristics of patient presentations from the WH?

Characteristic	Pre (T1) N=40	During (T2) N=29	P value T1 v T2
Diagnostic group			**0.049**
Trauma	15%	24%	
Psychiatric	13%	7%	
Toxicology	15%	0%	
Miscellaneous	15%	3%	
All Other	43%	66%	

Diagnostic groups based on ED ICD 10 AM codes

Results: in the ED

What were the ED clinical characteristics of patient presentations from the WH?

Characteristic	Pre (T1) N=40	During (T2) N=29	P value T1 v T2
Triage category			**0.213**
1 (immediately)	0%	0%	
2 (within 10 mins)	23%	31%	
3 (within 30 mins)	38%	52%	
4 (within 60 mins)	33%	17%	
5 (within 120 mins)	8%	0%	

Triage category based on the Australasian Triage Scale (ATS)

Results: in the ED

What were the outcomes of patient presentations from the WH?

Outcomes	Pre (T1) N=40	During (T2) N=29	P value T1 v T2
ED LOS (all), mins†	154 (66-236)	170 (124-225)	0.640
Admission rate, n (%)	23%	31%	0.579

†Analysis reflects median and interquartile range

Results: in the ED

What were the economic outcomes?

Costs	Pre (T1)	During (T2)
Standardised per week: TOTAL	$96,478	$88,604
Difference vs During (95% CI)	$7,874 (9,572; 5,977)	ref.

Results: in the WH

How many detainees received health care?

1,313 health care delivery episodes provided to 351 detainees

- **1,094 patient specific (1:1)**
- **219 medication rounds (general)**

Results: in the WH

Why was health care required?

Medical issue	N=1,094
Drug misuse	383
Alcohol misuse	243
Chronic disease	220
Mental health	187
Injury	99
Other	225

Note: Analysis based on patient specific health care delivery episodes (i.e. excludes medication rounds)
May be >1 medical issue

Results: in the WH

What assessment activities did the nurse do?

Observation/Tests	N=1,094
Standard observations	860
Glasgow Coma Scale score	851
Opiate Withdrawal Scale score	334
Alcohol Withdrawal Scale score	252
Blood Sugar Level	54
Breath Alcohol Concentration	31
Peak flow	21
BHCG (pregnancy test)	14
Other	117

Note: Analysis based on patient specific health care delivery episodes (i.e. excludes medication rounds)
May be >1 observation/test

Results: in the WH

Who did the nurse communicate with re health care?

Source	N=1,094
Police	427
Forensic Medical Officer (for medication)	611
Forensic Medical Officer (for observation)	167
Forensic Medical Officer (for treatment)	74
General Practitioner	32
Pharmacy	14
Emergency Department (for referral)	19
Emergency Department (for advice)	7
Other	34

Note: Analysis based on patient specific health care delivery episodes (i.e. excludes medication rounds)
May be >1 communication.

Results: in the WH

What was the reason for ED transfer?

Transfer reason	n
Alcohol related	31
Drug related	22
Injury	17
Chest pain	16
Mental Health	9
Altered level of consciousness	7
Diabetes	5
Seizure	3
Other	42

Note: Analysis based on patient specific health care delivery episodes (i.e. excludes medication rounds)
May be >1 reason

Limitations & Recommendations

Limitations	Recommendations
•Single site study •Retrospective data used	•National and international analysis of people BIBP (including from WH) •Understand police decision making re decision to transport to ED •Understand detainees perspectives of WHEN health care •**Evaluate healthcare delivery models in other watch-houses**

Conclusion

24/7 nurse presence in WH and ready access to Forensic Medical Officer for clinical supervision appeared to:

1. Reduce number of transfers from WH to ED
2. Impact on the appropriateness of transfers to ED from WH
3. Cost effective model of care

Thank you

: @CrillyJulia

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