JURISDICTION	**:**	CORONER'S COURT OF WESTERN AUSTRALIA
ACT	**:**	CORONERS ACT 1996
CORONER	**:**	Barry Paul King, Deputy State Coroner
HEARD	**:**	19 MAY 2020
DELIVERED	**:**	19 NOVEMBER 2020
FILE NO/S	**:**	CORC 1546 of 2017
DECEASED	**:**	CONGDON, LEVI SHANE CLEMENT

Catchwords:

Nil

Legislation:

Nil

Counsel Appearing:

Ms F Allen assisted the Coroner.

Ms R Hartley (State Solicitor's Office) appeared for the Western Australian Police Force.

Coroners Act 1996
(Section 26(1))

RECORD OF INVESTIGATION INTO DEATH

I, Barry Paul King, Deputy State Coroner, having investigated the death of ***Levi Shane Clement CONGDON*** *with an inquest held at Perth Coroners Court, Central Law Courts, Court 85, 501 Hay Street, Perth, on 19 May 2020, find that the identity of the deceased person was* ***Levi Shane Clement CONGDON*** *and that death occurred on 13 November 2017 at Royal Perth Hospital from methylamphetamine toxicity in the following circumstances:*

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INTRODUCTION

1. In November 2017, Levi Shane Clement Congdon was suspected by the Western Australia Police Force (WAPF) of involvement in illegal drug and money dealing activities. At the time, he was living with his girlfriend, Chantel Fernihough, in her house in Ascot (the house).

2. On the afternoon and evening of 13 November 2017, WAPF officers executed a search warrant at the house. They arrested Mr Congdon and searched the house. During the search, Mr Congdon appeared anxious.

3. At about 7.00 pm, Mr Congdon told officers that he was having an anxiety attack. At his request, Detective Senior Constable Andrew Curtis called St John Ambulance (SJA) and requested an ambulance. The search of the house continued.

4. A short time later, Mr Congdon's anxiety appeared to escalate and his behaviour became more agitated and manic. Officers began to suspect that Mr Congdon was experiencing excited delirium, possibly from taking illicit drugs. Detective Senior Constable Curtis called SJA and advised that Mr Congdon's condition had deteriorated and that he was showing signs of excited delirium. When an ambulance had not arrived after another 20 minutes, Detective Senior Constable Curtis called SJA and advised that Mr Congdon's behaviour was now manic and borderline violent.

5. At around 8.00 pm, Mr Congdon's condition deteriorated further. He became unconscious, started vomiting and then stopped breathing with no pulse. WAPF officers administered CPR, and Detective Senior Constable Curtis again called SJA.

6. SJA paramedics arrived at 8.05 pm. They conveyed Mr Congdon to Royal Perth Hospital (RPH), but he could not to be revived. He was 27 years old.

7. Following a post mortem examination, forensic pathologist Dr J McCreath found that Mr Congdon had died from methylamphetamine toxicity.

8. As Mr Congdon was under arrest at the time of his death, he was a 'person held in care' and his death was reportable under the *Coroners Act 1996* (WA).[1] An inquest was mandatory,[2] and the Coroner was required to comment on the quality of the supervision, treatment and care that Mr Congdon received while in that care.[3]

9. On 19 May 2020, I held an inquest at the Coroner's Court at Perth. The focus of the inquest was on the WAPF officers' actions leading up to Mr Congdon's death and the communication between WAPF and SJA.

10. The documentary evidence adduced at the inquest included a two-volume brief of evidence[4] that contained WAPF and SJA reports, witness statements, formal documents and Mr Congdon's medical records.

11. Oral evidence was provided by (in order of appearance):

a. Detective Senior Constable David Whitehouse, the WAPF officer in charge of the search warrant;[5]

b. Detective Senior Constable Andrew Curtis;[6]

c. Mr Jan-Willem Weeda, an attending paramedic;[7] and

d. Mr Austin Whiteside, SJA Operations Manager - Systems & Performance.[8]

12. I have found that the quality of the supervision, treatment and care that Mr Congdon received while in police custody was reasonable and appropriate in the circumstances, but I have noted that police officers used the term 'excited delirium' with a mistaken understanding that it would be significant to SJA. That misunderstanding led to a delay in the SJA

[1] *Coroners Act 1996* (WA) s 3
[2] *Coroners Act 1996* (WA) s 22(1)(a)
[3] *Coroners Act 1996* (WA) s 25(3)
[4] Exhibit 1.1.1 to 1.1.25 and 1.2.1
[5] ts 4 - 30
[6] ts 31 - 56
[7] ts 57 - 69
[8] ts 69 - 84

response, but it is not clear whether the delay resulted in a missed opportunity to save Mr Congdon's life.

13. Since the inquest, I have been informed that the WAPF and SJA have taken steps to improve their inter-agency communication. However, I am not aware of any liaison between the agencies with respect to medical terminology and emergency protocols.

14. I have therefore recommended that such liaison occur in order to prevent a similar misunderstanding in the future.

LEVI SHANE CLEMENT CONGDON

15. Mr Congdon was born in Perth on 13 February 1990 and grew up in the Helena Valley area with his parents and older sister. He had studied at university and had worked in retail and as a fencing contractor with his father.[9]

16. Mr Congdon had a criminal history involving driving and fraud offences, and in 2011 he was convicted of sexual offences involving a minor. He was sentenced to four years' imprisonment and was released on parole in 2016.[10]

17. Mr Congdon was in good health, did not drink alcohol, ate well and exercised regularly at the gym.[11] However he took steroids and suffered from anxiety, for which he was prescribed medication.[12]

EVENTS LEADING UP TO MR CONGDON'S DEATH

18. In early 2017, Organised Crime Squad investigators commenced an operation to investigate an established network dealing with large amounts of methylamphetamine. That investigation identified Mr Congdon as being

[9] Exhibit 1.1.8 1 (Memorandum), 1.2.1 3 (Report)
[10] Exhibit 1.1.10 2, Exhibit 1.1.8 1 (Memorandum), 1.2.1 4 (Report)
[11] Exhibit 1.1.10 2
[12] Exhibit 1.1.10 2, 16, 1.1.12 7.

involved in the sale and supply of drugs and related money laundering activities conducted at the house.[13]

19. On 13 November 2017, WAPF officers obtained a search warrant under the *Misuse of Drugs Act 1981* to search the house. At 2.00 pm that afternoon, officers arrived at the house in unmarked police vehicles to execute the search warrant, but no one was home, so they parked their cars in the area and waited.[14]

20. Mr Congdon and Ms Fernihough were at Midland Gate shopping centre together from about 12.00 pm. At about 4.00 pm, Ms Fernihough left Midland Gate in her own car, while Mr Congdon went to get some food before returning home.[15]

21. At about the same time, a friend of Mr Congdon, who had earlier arranged to pick up some methylamphetamine from him that afternoon, drove to the house. However, when she saw the police cars at the house, she continued driving.[16]

22. At about 4.10 pm, Ms Fernihough arrived at the house and was arrested by officers. She was taken inside while other officers continued to wait outside for Mr Congdon.[17]

23. At about 4.55 pm, officers saw Mr Congdon's car approaching the house. They pulled out behind it and followed it without activating their emergency lights. Mr Congdon slowed as he approached the house but drove past it without stopping. The officers turned on their emergency lights and siren briefly. Mr Congdon continued for another 400 metres, turned a corner into the next street, and stopped in a car park.[18]

24. Mr Congdon got out of the car, and the officers arrested him on suspicion of intent to sell or supply a prohibited drug. They searched and handcuffed

[13] Exhibit 1.1.8 2 (Memorandum)
[14] Exhibit 1.1.12 2
[15] Exhibit 1.1.10 3
[16] Exhibit 1.1.8 35-36
[17] Exhibit 1.1.11 3-4
[18] Exhibit 1.1.12 4, 1.1.13 6, 1.1.15 4, 1.1.16 5

him behind his back.[19] Mr Congdon complained about the tightness and pain of the handcuffs, so the officers moved the handcuffs to the front of his body as he was calm and compliant. [20]

25. At around that time Mr Congdon asked to speak to his lawyer, which the officers arranged by mobile phone. He then stated that he would be answering 'no comment' to all questions.[21]

26. Mr Congdon began breathing heavily and said that he was dizzy, but he did not appear any more anxious or nervous than other people whom officers had searched in similar situations.[22] Detective Senior Constable Curtis asked him if he had consumed any alcohol or drugs, or if he suffered from any medical conditions. Mr Congdon said that he had not taken anything but that he suffered from anxiety and was having an anxiety attack. He told officers that he took Endep (amitriptyline) for anxiety and depression twice a day, and he asked for water and his wallet to obtain his medication.[23]

27. The officers found no medication in his wallet and informed Mr Congdon that he could have water at the house.[24] They searched his car, and Mr Congdon appeared to be fully conscious and aware of what was occurring, with no sign of any medical problems other than anxiety.[25]

28. At about 6.05 pm, the officers completed the search of Mr Congdon's car. They took him to the house to execute the search warrant.[26] He appeared more relaxed, with no signs of the anxiety that he had shown earlier.[27]

29. In the house, the officers took Mr Congdon upstairs while Ms Fernihough was detained downstairs. At some point, Detective Senior Constable

[19] Exhibit 1.1.12 4-5
[20] Exhibit 1.1.13 7, ts 34
[21] Exhibit 1.1.12 8, 1.1.15 9-10
[22] Exhibit 1.1.13 10, 1.1.16 6-8
[23] Exhibit 1.1.15 9, 1.1.12 7, 1.1.16 6
[24] Exhibit 1.1.12 7
[25] Exhibit 1.1.12 8-9, 1.1.15 6
[26] Exhibit 1.1.12 9, 1.1.13 12
[27] Exhibit 1.1.11 5-6, 1.1.15 12

Whitehouse introduced himself to Mr Congdon and asked if he was suffering any illness or whether he had taken any drugs or alcohol.[28]

30. Mr Congdon denied taking any drugs or alcohol and stated that he had anxiety. He said that he was suffering from an anxiety attack but that it was not as bad as others he had experienced in the past.[29] He said that the situation was new for him, and he had never been involved in a raid before. Detective Senior Constable Whitehouse gave him a chair just inside the balcony. The officers commenced the search at 6.25 pm.[30]

31. During the search, Mr Congdon was initially compliant and communicative, but he was sweating and appeared nervous and fidgety.[31]

32. The officers found a money-counting machine, empty clip-seal bags, used vacuum bags, a set of scales, and small liquid vials in the fridge. They asked Mr Congdon about some of the items, but he responded 'no comment'. His anxiety then appeared to increase and he became more agitated. When officers asked him if he was okay or if he needed a doctor or an ambulance, he said that he was okay and that he wanted to stay for the search. One of the officers assisted Mr Congdon to slow his breathing, which seemed to calm him down while the search continued.[32]

The first call to SJA

33. By around 7.00 pm, Mr Congdon's anxiety had not improved, and he was sweating profusely and shaking. He stated that he was feeling nervous and might be sick, and he asked to go to the bathroom. He did not vomit, but when he came out, he was given a bucket in case he needed to use it.[33]

34. Officers again asked Mr Congdon if he had taken anything, which he denied. He said that he was just having an anxiety attack. He asked officers to get his anxiety medication, but they could not find any. At

[28] Exhibit 1.1.12 9-10
[29] Exhibit 1.1.12 10
[30] Exhibit 1.1.11 5
[31] Exhibit 1.1.15 12–13, 1.1.11 5-6, 1.1.12 10
[32] Exhibit 1.1.11 6-7, 1.1.12 11, 1.1.15 15
[33] Exhibit 1.1.11 8, 1.1.12 12, 1.1.15 13-14

about 7.10 pm, he asked for an ambulance, so Detective Senior Constable Curtis called '000' and spoke to an SJA communications officer.[34] Detective Senior Constable Whitehouse talked to Mr Congdon about relaxing and calming his breath, and he removed the handcuffs to ease his anxiety. At this point, none of the officers suspected any illicit drug use.[35]

35. When Detective Senior Constable Curtis called SJA, he told the communications officer that an ambulance was required by Mr Congdon because he was suffering from anxiety, hot and cold sweats and nausea. He also relayed Mr Congdon's answers to a series of questions asked by the communications officer.[36] The communications officer said that an ambulance was being organised and told Detective Senior Constable Curtis not to give Mr Congdon any water or food, to watch him very closely and to call back immediately if he got worse in any way.[37]

36. Detective Senior Constable Curtis then went outside to wait for the ambulance, which he expected to arrive within 30 minutes. The search continued downstairs while officers attended to Mr Congdon.[38]

37. Mr Congdon's condition deteriorated.[39] He was sweating profusely, appearing more animated and agitated and acting erratically. He was picking at his wrists and appeared to be having hallucinations.[40] Detective Senior Constable Whitehouse again asked him if he had taken any drugs or steroids, but he still denied this.[41] Officers also asked Ms Fernihough whether he had taken any drugs, but she said 'None that I know about'.[42]

38. When Detective Sergeant Paul Matthews saw the level of Mr Congdon's sweating and agitation, he thought that he may have been experiencing excited delirium, possibly from a drug overdose. Mr Congdon's behaviour and physical appearance seemed to Detective Sergeant Matthews to match

[34] Exhibit 1.1.24 1
[35] Exhibit 1.1.11 8-9, 1.1.12 12, 1.1.14 8, ts 11, 40
[36] Exhibit 1.1.12 13, ts 52-53
[37] Exhibit 1.1.25 3
[38] Exhibit 1.1.12 14; 1.1.13 15, 1.1.16 9, ts 43
[39] ts 43
[40] Exhibit 1.1.12 15, 1.1.11 9-10, 1.1.13 14
[41] Exhibit 1.1.11 10; 1.1.14 9
[42] Exhibit 1.1.13 15,

the symptoms of excited delirium described in his WAPF training. He told Detective Senior Constable Curtis to call SJA again and to tell the communications officer explicitly that Mr Congdon was suffering from excited delirium and to request SJA's attendance at Priority 1.[43]

The second call to SJA

39. At 7.39 pm, Detective Senior Constable Curtis called SJA and told the communications officer that the situation had changed: Mr Congdon was becoming delirious and his level of consciousness seemed to be dropping. He said that Mr Congdon's breathing was a bit elevated, that he was possibly a drug user and that he may be suffering from excited delirium or something approaching that. He also asked when the ambulance would arrive. The communications officer told him to continue with the previous instructions and that the ambulance was on its way, but the communications officer could not provide an estimated time of arrival.[44]

40. At about 7.45 pm, Detective Senior Constable Whitehouse also thought that Mr Congdon was showing symptoms of excited delirium, which he had been taught about in training.[45] Mr Congdon was moving constantly. He was standing up and then lying down. His leg was shaking and his breathing was heavy. The officers tried without success to help him to calm his breathing.[46]

The third call to SJA

41. At 7.56 pm, Detective Senior Constable Curtis called SJA again and told the communications officer that Mr Congdon was now becoming manic, unpredictable and borderline violent, and that the officers were having difficulty controlling him.[47] He confirmed that the ambulance was initially called for anxiety, but that Mr Congdon's behaviour was now becoming more and more unpredictable. Mr Congdon was sweating profusely, was very delirious and was now showing manic behaviour. The

[43] Exhibit 1.1.13 14 – 15
[44] Exhibit 1.1.25 4, 1.1.24 1
[45] Exhibit 1.1.9 19, ts 14-15
[46] Exhibit 1.1.11 11
[47] Exhibit 1.1.25 6, 1.1.12 15

communications officer advised that the ambulance was about eight or nine minutes away.[48]

42. At about this time, Mr Congdon was losing consciousness and was shaking and frothing at the mouth, so the officers placed him on the floor in the recovery position. He then appeared to have no pulse, and he started vomiting. Detective Senior Constable Whitehouse and Detective Sergeant Edmunds started administering CPR, but Mr Congdon began vomiting again and his mouth and jaw became severely clenched, making it difficult for the officers to clear the airway and to get air into his lungs.[49]

The fourth call to SJA

43. At 8.01 pm, Detective Constable Curtis called SJA for the fourth time and told the communications officer that Mr Congdon had stopped breathing, that CPR was in progress, and that he needed the ambulance to be upgraded. The ambulance was then upgraded to Priority 1.[50]

44. Detective Senior Constable Whitehouse and Detective Sergeant Edmunds were performing chest compressions but could still not get air into Mr Congdon due to his vomiting and locked jaw.[51] At about this time, Ms Fernihough told officers that Mr Congdon may have been using steroids.[52]

45. The first SJA paramedics arrived at 8.05 pm, and a back-up crew with critical support paramedics arrived shortly thereafter.[53] The police officers continued chest compressions while the SJA paramedics tried to clear Mr Congdon's airway and provide air, but they were unable to ventilate or intubate him due to his severe locked jaw[54] An ambulance paramedic performed a cricothyrotomy to open the airway and was eventually successful, but the air entry remained strained and the bag valve mask was

[48] Exhibit 1.1.25 7, 1.1.24 1
[49] Exhibit 1.1.11 12-13, 1.1.14 9-12
[50] Exhibit 1.1.12 16, 1.1.25 8, 1.1.24 1
[51] Exhibit 1.1.14 11 – 12
[52] Exhibit 1.1.15 20
[53] Exhibit 1.1.12 16, 1.1.18 2, 4-6
[54] Exhibit 1.1.19 10

difficult to compress.[55] A defibrillator could not be used as Mr Congdon was asystole. A paramedic administered adrenalin and police officers continued chest compressions until a LUCAS machine was applied.[56]

46. A number of WAPF officers and paramedics then used a scoop stretcher to extract Mr Congdon to the ambulance, which was difficult due to his large build and the tightness of the stairs.[57]

47. The ambulance paramedics took Mr Congdon to the emergency department at RPH at 8.45 pm, but he could not be revived. A doctor certified that his life was extinct at 9.06 pm.[58]

CAUSE OF DEATH AND HOW DEATH OCCURRED

48. On 15 November 2017, forensic pathologist Dr McCreath performed a post mortem examination and found a muscular man with an enlarged heart, congested lungs, bruised wrists and evidence of medical intervention. Further investigations were arranged, including histology, toxicology, neuropathology, forensic biology and X-rays.[59]

49. On 18 March 2018, Dr McCreath reported that microscopic examination of tissue showed early aspiration pneumonia in the lungs and bleeding with vital reaction in the soft tissue of the right and left wrists. Neuropathological examination of the brain showed minimal patchy subarachnoid haemorrhage. Toxicological analysis showed the presence of methylamphetamine, amphetamine, diazepam, desmethyldiazepam and vecuronim. The level of methylamphetamine in Mr Congdon's blood was detected at 12 mg/L.[60]

50. Dr McCreath formed the opinion, which I adopt as my finding, that the cause of death was methylamphetamine toxicity.

[55] Exhibit 1.1.18 5-6, 1.1.19 10
[56] Exhibit 1.1.14 13, 1.1.18 4, 1.1.19 15-16
[57] Exhibit 1.1.18 7, 1.1.19 17-18
[58] Exhibit 1.1.2, 1.1.23
[59] Exhibit 1.1.3
[60] Exhibit 1.1.4 (mortuary admission sample)

51. The evidence suggested that Mr Congdon was not a regular user of illicit drugs. However, it is apparent that he had ingested a highly toxic dose[61] of methylamphetamine a short time prior to being stopped by the WAPF officers, presumably to avoid them discovering it in his possession, and died as a result.

52. I find that death occurred by way of misadventure.

SUPERVISION, TREATMENT AND CARE OF MR CONGDON

53. The evidence established that WAPF officers assisted Mr Congdon when he began to appear unwell, and they made appropriate and timely calls to SJA. It is also clear that the search was suspended at an appropriate time and that the officers prioritised first-aid care to Mr Congdon and continued to assist the paramedics once they arrived.

54. WAPF Internal Affairs Unit (IAU) investigators attended the scene shortly after Mr Congdon was taken to hospital, and the Homicide Squad took carriage of the investigation as a critical incident involving police (CIIP).[62]

55. A final report prepared by IAU in December 2019 concluded that:[63]

a. there was no evidence suggesting that the relevant officers failed in their duty of care while Mr Congdon was in their custody;

b. the officers' decision to continue the search after the first telephone call to the SJA was reasonable in the circumstances;

c. there was no evidence of misconduct or breaches of police regulations or procedures, and no supervision or accountability issues;

d. there was no reasonable suspicion of criminal conduct by any person; and

[61] McIntyre, Nelson, Schaber and Hamm, *Antemortem and Postmortem Methamphetamine Blood Concentrations; Three Case Reports*, Journal of Analytical Toxicology 2013; 37; 386-389, Advanced (2013)
[62] Exhibit 1.1.9 4
[63] Exhibit 1.1.9 92-95

e. the actions of police did not cause or contribute to Mr Congdon's death.

56. The CIIP report concluded that all the officers involved in the incident did everything they could to prevent Mr Congdon's death and that the officers' actions were justified and lawful. The investigation also identified no evidence of criminality on the part of any person.[64]

57. Based on the evidence at the inquest together with the findings of the internal WAPF reports, I am satisfied that the supervision, treatment and care provided to Mr Congdon by WAPF officers was exemplary.

COMMUNICATION BETWEEN THE WAPF AND SJA

58. Data from the SJA IC Business Manager voice recorder and Computer Aided Disptach System showed the following timeline in relation to the calls and ambulance priority allocation:[65]

a. 7.08 pm '000' Call requesting ambulance. Call triaged as Priority 3.

b. 7.34 pm Call allocated to ambulance crew. Stood down two minutes later due to a higher priority call.

c. 7.39 pm Second call. Change in patient condition - altered level of consciousness. Call upgraded to Priority 2.

d. 7.56 pm Third call. Call back for ETA.

e. 8.01 pm Fourth call. CPR in progress. Call upgraded to Priority 1.

f. 8.05 pm First SJA crew arrived on scene.

59. While the evidence at the inquest showed that the WAPF officers and SJA officers acted in an exemplary manner, it also highlighted a serious gap between the two agencies' understanding of each other's emergency communication protocols, which likely affected the allocation of the priority level at the time of the second call.

[64] Exhibit 1.1.8 41-42
[65] Exhibit 1.1.24A

60. WAPF officers initially believed that Mr Congdon was having an anxiety attack but that his condition deteriorated after the first phone call. Based on their medical emergency training, they thought that he was experiencing excited delirium, possibly from a drug overdose or some other reason.[66] They understood that the term 'excited delirium' denoted a medical emergency and that it would be understood as such by SJA so that an ambulance would attend as quickly as possible.[67]

61. In oral evidence, Detective Senior Constable Whitehouse said that WAPF training stipulated that officers should use specific terms to identify certain medical emergencies, such as 'excited delirium' or 'positional asphyxia', to SJA and to request Priority 1 ambulance attendance to indicate the situation required the highest level of emergency. However, he understood that SJA would still prioritise the dispatch as they saw fit. He said that, according to the training, 'excited delirium' described manic behaviour which could occur as a result of taking illicit drugs as well as in other circumstances, including mental disorder. [68]

62. Detective Senior Constable Curtis also believed that the term 'excited delirium' described a medical emergency and that, when conveyed to an SJA communications officer, an ambulance would be dispatched to the scene at Priority 1. He was therefore very concerned that the ambulance had not arrived shortly after the second call.[69]

63. However, Mr Jan-Willem Weeda, a full-time SJA paramedic for six years who was in the ambulance dispatched after the second call, said that the ambulance dispatch was a Priority 2 for a patient suffering an anxiety attack. He said a Priority 2 is an urgent case but not life threatening, so the ambulance leaves immediately but drives under normal road conditions.[70]

64. In oral evidence, Mr Weeda said that he had never heard the term 'excited delirium', but he acknowledged that a person intoxicated by amphetamines would be delirious and paranoid, with heightened awareness and

[66] ts 14 – 15
[67] ts 18, 28, 45
[68] ts 18, 24
[69] Exhibit 1.1.9 35, 43; ts 45-47
[70] ts 59

confusion.[71] He said that some of the characteristics of a person with amphetamine intoxication, when they are still breathing and their heart is going, are agitation and restlessness, paranoia and sweating, and that all body systems are in overdrive. He said he knew this from his experience over the years rather than from any training.[72]

65. Mr Weeda said that methylamphetamine raises your whole bodily process and the metabolic rate goes up, you get more anxious, more aware, and you get an adrenaline overdose and the consequences of that. He said this also occurs with anxiety, so he would not blame any officers for accepting that as an anxiety attack at first. He also said that he knew from his practical experience that there were other signs, such as dilated pupils, excessive sweatiness and jittery movements. He agreed that he would not expect WAPF officers trained in senior first aid to be able to differentiate between the early stages of methylamphetamine toxicity and an anxiety or panic attack.[73]

66. Mr Whiteside provided evidence that the SJA communications officers taking '000' calls follow a specific guideline and the scripting as provided by the medical Priority Dispatch System, called ProQA Paramount, which is used by all ambulance services in Australia and New Zealand, excluding the Northern Territory. The software requires the SJA communications officer to select a chief complaint from a set list based on the information provided by the caller. The selected chief complaint then has a set of pre-determined drop-down questions that are asked, and based on the answers received, an outcome is obtained which has a priority response and dispatch code attached.[74]

67. In oral evidence Mr Whiteside explained that the chief complaint remains in place unless something changes during the call which would require a different category. If that occurs, a different set of pre-determined questions would apply to the new protocol.[75]

[71] ts 64
[72] ts 63-64
[73] ts 68-69
[74] Exhibit 1.1.24 email dated 18 May 2020
[75] ts 73, 81

68. Mr Whiteside said that, based on the information provided during the first phone call, the SJA communications officer selected 'Chief Complaint 26 – Sick Person', and allocated a Priority 3 response, both of which were appropriate. He said that a Priority 3 is non-urgent and the ambulance attendance target goal is to arrive within 60 minutes.[76] He also said that, under Protocol 26, there is only one sub-component that is a Priority 1 response, and that is where the patient is not alert.[77]

69. In relation to the second call, Mr Whiteside said that the call was upgraded to a Priority 2 response because of the change in the patient condition as described by Detective Senior Constable Curtis. The SJA communications officer changed the previous answer in the system from 'fever/chills' to 'altered level of consciousness', resulting in the upgrade. The chief complaint remained unchanged.[78] Mr Whiteside stated that if there was reference to an overdose, 'Protocol 23 – Overdose/Poisoning' would have been more appropriate. However, for a 'Chief Complaint 26', no other symptoms would result in a Priority 1 categorisation except for the patient being not alert.[79]

70. Mr Whiteside stated that, before the inquest, he was not aware of the term 'excited delirium' until he read it in the SJA communications transcript that day and looked it up, but had not recognised it as a medical condition.[80]

71. He said that, if the SJA communications officer had picked up on 'excited delirium' and was uncertain about it, the communications officer could have escalated it to the clinical support paramedic sitting in the room, who could have upgraded the priority based on the paramedic's clinical knowledge, but that did not occur in this case.[81]

72. In relation to the third call, Mr Whiteside said that, although the information provided to the SJA communications officer included further changes in Mr Congdon's condition, there was nothing that they could

[76] ts 72
[77] ts 74
[78] ts 73
[79] ts 74
[80] ts 73, 81
[81] ts 74

identify that would upgrade the call to a Priority 1.[82] He agreed that, if this was referred to the clinical support paramedic, it may have been upgraded, but he said that 'manic' is not a clinical condition that would suit escalation, so it remained as a Priority 2.[83]

73. Even with the benefit of hindsight, Mr. Whiteside said that a change in priority may have been warranted at that time by the clinical support paramedic, but not necessarily by the communications officer who took the information.[84]

74. In relation to the fourth phone call, Mr Whiteside confirmed that the call was upgraded to Priority 1 because Mr Congdon had stopped breathing.[85]

75. Finally, Mr Whiteside said that all '000' calls are triaged the same way no matter who the caller is. He said there were four priority symptoms in a medical emergency: chest pain, alertness, breathing difficulties and serious haemorrhage, but it's not only based on that.[86] SJA communications officers need to clarify what the medical emergency is and determine the chief complaint based on all the information that is provided to them; they do not analyse the symptoms to try to determine a cause.[87]

76. The evidence at the inquest showed that, despite the WAPF officers and SJA communications officers acting in accordance with their training and procedures, the term 'excited delirium' did not have the effect of communicating a medical emergency to the SJA communications officers as the police officers believed it would, and this was at the heart of the miscommunication.

[82] ts 75
[83] ts 76
[84] ts 76
[85] ts 77
[86] ts 79
[87] ts 78

RECOMMENDATION

77. Mr Whiteside stated in oral evidence that SJA has taken a number of steps since Mr Congdon's death to improve communication with the WAPF and to ensure that SJA staff understand the term 'excited delirium', including:

a. a clinical update has been put out to all the staff in relation to medical conditions which are not covered by the pro-forma call-taking process, with a reminder that, if a condition or information comes to an SJA communications officer that is not obvious, a referral should be made to a clinical support paramedic;[88] and

b. the issue has been raised with SJA's clinical governance area to establish education not only for the State Operation Centre, but to make sure the term 'excited delirium' is widely known across the organisation.[89]

78. Following the inquest, the Court was informed that WAPF training involving excited delirium was introduced into the broader critical skills and emergency training for officers in 2009, and it remains a crucial part of that training.

79. Correspondence to the Court on behalf of WAPF and SJA confirmed that the agencies met earlier in 2020 to discuss ways to work collaboratively to increase awareness amongst the relevant areas of WAPF and SJA. The CEO of SJA has also indicated that SJA is looking to review the most recent teachings at the College of Pre-Hospital Care, where paramedics and ambulance officer undergo regular continuing education training.

80. In order to encourage consultation between the two agencies in relation to communication and training, including a mutual understanding of each other's medical emergency terminology and protocols, I make the following recommendation:

[88] ts 76
[89] ts 84

That the WAPF and SJA implement a liaison process with respect to the training each agency provides to their officers about medical emergency terminology and protocols.

81. I also suggest that any future emergency training provided to WAPF officers also incorporates an explanation of the SJA emergency priority allocation protocols, so that WAPF officers are aware of how to communicate appropriate information to SJA communications officers relevant to the level of an emergency.

CONCLUSION

82. While Mr Congdon did not appear to be a regular user of methylamphetamine, it was clear that he had access to it and that he had ingested a fatal dose of it.

83. One tragic aspect of Mr Congdon's death is that, had he informed the WAPF officers early enough about taking the drug, the first call to SJA would have been significantly different and may have saved his life.

B P King
Deputy State Coroner
19 November 2020