Coroners Act 1996
[Section 26(1)]

Western *Australia*

RECORD OF INVESTIGATION INTO DEATH

Ref: 15 /18

I, Sarah Helen Linton, Coroner, having investigated the death of ***Paul DICKSON*** *with an inquest held at the* ***Perth Coroner's Court, Court 51, CLC Building, 501 Hay Street, Perth*** *on* ***16 March 2018*** *find that the identity of the deceased person was* ***Paul DICKSON*** *and that death occurred on* ***11 November 2013*** *at* ***Sir Charles Gairdner Hospital*** *as a result of* ***multiple injuries*** *in the following circumstances:*

Counsel Appearing:

Ms S Teoh assisting the Coroner.
Ms N Eagling (State Solicitor's Office) appearing on behalf of the North Metropolitan Health Service.

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INTRODUCTION

1. Paul Dickson (the deceased) was a 34 year old man with a long history of mental health issues. He had been diagnosed with severe paranoid schizophrenia that required ongoing medical treatment. In November 2013 the deceased was on a Community Treatment Order and was subject to regular psychiatric review and depot medication. The deceased was under the care of Osborne Park Mental Health Clinic while on the order.

2. On 11 November 2013 the deceased stepped in front of a moving truck on Main Street in Osborne Park. He sustained fatal injuries as a result of the ensuing collision. He died at Sir Charles Gairdner Hospital later that day.

3. By virtue of being on a Community Treatment Order at the time of his death, the deceased was a 'person held in care' for the purposes of the *Coroners Act 1996* (WA). In such circumstances, a coronial inquest is mandatory.[1] I held an inquest at the Perth Coroner's Court on 16 March 2018.

4. The circumstances of the death were relatively clear and there was no dispute that the deceased had intentionally stepped in front of the truck with an intention to end his life. The inquest focused primarily on the psychiatric care provided to the deceased shortly prior to his death and whether there were any warning signs that he was actively suicidal that were missed.

5. Dr Anthony Mander, a Consultant Psychiatrist, reviewed the deceased's records and provided an expert opinion on the quality of the care, treatment, supervision given to the deceased while on the CTO prior to his death. I have made reference to Dr Mander's expert opinion at various points throughout the finding.

BACKGROUND

6. The deceased was single and lived alone in rental accommodation in Osborne Park. He was unable to work due to his illness and received a disability support pension. Throughout his life the deceased had been supported by both his parents. Sadly, the deceased's mother passed away in mid-2013 after being diagnosed with a terminal illness. The deceased's father continued to support him but the deceased felt the loss of his mother, who had been a major support in his life, keenly.[2]

7. The deceased had first been diagnosed with schizophrenia in 1999. He was trialled on the antipsychotic medication clozapine and various other medications to stabilise his mood. The deceased relapsed repeatedly due to his non-compliance with his medications and required hospitalisation for treatment. Between January 1999 and November 2013 the deceased was admitted to hospital on 18 occasions, usually to Graylands Hospital. He was

[1] Section 22(1)(a) *Coroners Act.*
[2] Exhibit 1, Tab 8 and Tab 17 and Tab 18.

generally admitted as an involuntary patient and his admissions could be many months in length.[3]

8. When released into the community the deceased was often managed on a Community Treatment Order with a high degree of professional input. His care was often managed by staff at Osborne Park Mental Health Clinic (Osborne Clinic) and at other times by his GP. Despite the high degree of monitoring, the deceased's compliance with his treatment regime remained poor and he continued to abuse substances, which adversely affected his mental health.[4]

9. Over the years the deceased made occasional threats to self-harm and harm others and had described thoughts of suicide but there were no documented suicide attempts in his history.[5]

10. The deceased had been managed by his GP in later 2012 and early 2013 but was re-referred to Osborne Clinic on 11 June 2013 by staff from SCGH. At that time the deceased's mother was terminally ill and receiving care at SCGH. There were concerns that the deceased would need support in the community while his mother was so unwell. He was visited at home on 12 June 2013 by a clinical nurse specialist but was not happy to engage with Osborne Clinic.[6]

11. Osborne Clinic staff were contacted on 18 June 2013 by the deceased's aunt. She advised that the deceased's mother had recently passed away and was concerned that the bereavement might cause the deceased to relapse. It does not appear that any contact was made by clinic staff with the deceased at this time.[7]

12. The deceased's condition subsequently deteriorated, as was anticipated might occur, and he was admitted as an involuntary patient to Bentley Mental Health Unit on 4 September 2013. He had been found sleeping rough and was thought disordered, dishevelled and responding to auditory hallucinations. The deceased was commenced on olanzapine depot medication and his mental state improved significantly.

13. On 16 September 2013 a family meeting was held. The deceased's father and brother were willing to try to support him although they expressed some apprehension about the risk of aggression towards the family as he had made threats in the past. The recent death of his mother was noted and the deceased's father indicated he believed the deceased was coping with the loss appropriately.[8] The deceased was transferred to an open ward that day and showed further improvement. He was taken off regular observations on 20 September 2013. There was an incident where the deceased left the premises and became intoxicated with alcohol and another when he tripped

[3] Exhibit 1, Tab 17.
[4] Exhibit 1, Tab 17.
[5] Exhibit 1, Tab 17.
[6] Exhibit 1, Tab 20.
[7] Exhibit 1, Tab 20.
[8] Exhibit 1, Tab 17 and Tab 21.

while on day leave and injured his right knee. His knee injury was treated at Royal Perth Hospital Emergency Department.[9]

14. The deceased was discharged on 24 September 2013 on a CTO with follow up arranged at Osborne Clinic with Dr Nicky Simmonds. He initially appeared well but he missed his depot medication appointment on 4 October 2013 and on 5 October 2013 he was referred to the afterhours mental health service after his father expressed concerns about his mental state. He reported the deceased was not eating despite family delivering his food and was drinking and smoking to excess. The deceased's father expressed concern that the deceased may not have fully recovered at the time of his last hospital discharge.[10]

15. The deceased was assessed at home the following day by Osborne Clinic staff and found to be unwell and psychotic, responding to unseen stimuli and appearing paranoid.[11]

LAST ADMISSION TO GRAYLANDS HOSPITAL

16. On 5 October 2013 the deceased was referred by Osborne Clinic staff to Graylands Hospital on forms under the *Mental Health Act 1996* (WA). There was evidence the deceased had been smoking and drinking heavily again. Osborne Clinic staff were also concerned about the deceased's potential for aggression as he was found to be in possession of a knife.[12]

17. On admission to hospital the deceased was initially hostile, guarded and irritable and was difficult to engage. He was responding to unseen stimuli and expressed persecutory delusions regarding potential intruders in his home. He seemed fearful of his surroundings and refused physical examination. The deceased was diagnosed with a relapse of chronic schizophrenia and recommenced on oral anti-psychotic medication and then later restarted on his long-acting injectable anti-psychotic.[13]

18. The deceased was reviewed by a psychiatrist on 6 October 2013 and diagnosed with exacerbation of chronic schizophrenia due to increased alcohol and cannabis abuse. He was admitted as an involuntary patient. The deceased's care was managed by Consultant Psychiatrist Dr M Tielman until 18 October 2013. From that time his care was transferred to Consultant Psychiatrist Dr Jayasheerie Nadarajah, as Dr Tielman had gone on leave.

19. The deceased was placed on alcohol withdrawal observations. Physical investigations were performed to rule out physiological conditions. The deceased showed a swollen knee and clear difficulties with his gait but refused to have his knee examined.[14]

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[9] Exhibit 1, Tab 21.
[10] Exhibit 1, Tab 18.
[11] Exhibit 1, Tab 18.
[12] Exhibit 1, Tab 17.
[13] Exhibit 1, Tab 18.
[14] Exhibit 1, Tab 17 and Tab 18.

20. With treatment the deceased's psychosis started to improve and he started to communicate with staff although he remained highly thought disordered. Enquiry was made on several occasions regarding suicidal ideation. The deceased repeatedly dismissed these questions as irrelevant to himself. He did, however, begin to express grief in relation to the death of his mother.[15] At the time of Dr Tielman's last review before going on leave, the deceased appeared significantly improved although he continued to exhibit psychotic symptoms.[16]

21. While still in Graylands Hospital the deceased eventually agreed to investigation of his knee and was diagnosed with a ruptured meniscus of his right knee. He was seen at the Sir Charles Gairdner Hospital (SCGH) Orthopaedic Clinic on 24 October 2013, with surgery planned for 8 November 2013. He was also reviewed by the clinical psychologist and welfare officer and his treating psychiatrist at Osborne Clinic, Dr Simmonds, was consulted regarding discharge planning.

22. On 25 October 2013 the deceased was assessed and considered to be at low risk of suicide. He showed a significant improvement in his mental state but remained on the secure ward due to his knee injury, which limited his mobility as he required a wheelchair. He was noted by staff to be pleasant and polite on approach and compliant with ward management and treatment.[17]

23. On 30 October 2013 the deceased was reviewed by Dr Nadarajah and two medical officers, Dr Fazli and Dr Boksmati. Dr Fazli knew the deceased quite well and was able to provide Dr Nadarajah with a detailed history of the deceased. The deceased presented as settled, pleasant and appropriate. His mood was euthymic with a reactive affect. He appeared in good spirits and denied persecutory delusions or hallucinations. Dr Nadarajah recalled the deceased specifically denied any suicidal intent or plans. He indicated that he was looking forward to going home as he had plans to get his Foxtel reconnected. The deceased had been visited by his father, who was supportive, and the deceased's father was reported to be happy for the deceased to be discharged into the community and was willing to assist him with his plans for Foxtel connection.[18]

24. The deceased's planned follow up in the community was discussed and he indicated he was agreeable to discharge on a CTO under the care of Dr Simmonds and to continue on his depot medication. Dr Farsley had already made arrangements with Dr Simmonds in this regard in preparation for the deceased's discharge. The deceased's last depot medication was administered on 30 October 2013, prior to discharge. His next depot was due in the community on 13 November 2013.[19]

25. The deceased was discharged on a CTO the following day, being 31 October 2013. His discharge medications were: olanzapine depot, temazepam and the

[15] Exhibit 1, Tab 18.
[16] Exhibit 1, Tab 18.
[17] Exhibit 1, Tab 17.
[18] T 17 – 18; Exhibit 1, Tab 18 and Tab 19.
[19] T 18 – 19.

vitamin thiamine. An appointment was made for the deceased to be reviewed by Dr Simmonds on 14 November 2013 (two weeks later). The CTO was due to expire on 30 January 2014.[20]

26. Dr Mander indicated that in his view the deceased was ready to be discharged back into the community at that time. He observed that it is difficult for a patient to hide severe symptoms when being closely observed around the clock in hospital so Dr Mander felt reasonably confident that the deceased was well assessed before discharge and seemed fit for discharge. Dr Mander also noted that the deceased was going back into the community to a service that knew him, which was a positive factor.[21]

27. Dr Mander also agreed it was appropriate for the deceased to be released onto a CTO has he had shown himself to be non-compliant in the past and the advantage of a CTO was that it ensured more opportunity to manage and monitor the deceased.[22]

LAST REVIEW IN THE COMMUNITY

28. The deceased was reviewed at home on 6 November 2013 by Clinical Nurse Specialist Ian Read who was employed by the Osborne Park Clinic at the time. Nurse Read was not the deceased's case manager but he had known the deceased as a regular patient at the clinic since 2008 and often cared for the deceased when his regular case manager was on leave before becoming his case manager on 25 September 2013. Nurse Read was aware the deceased was treated for long-term paranoid schizophrenia, which was often exacerbated by his illicit drug use and alcohol.[23]

29. Over the years Nurse Read had observed that the deceased's presentation at baseline was quite pleasant and settled, although he often showed little motivation to be active. On other occasions the deceased could be violent and abusive and exhibit strange behaviour.[24]

30. On 6 October 2013 Nurse Read visited the deceased at home for the first time after he was released from Graylands on the CTO. Nurse Read was aware at that time that the deceased's mother died and his father was his main family support. The deceased met Nurse Read on the doorstep and he was not receptive to discussion. The deceased seemed perplexed, vexed and vague and he looked dishevelled. He was reminded that he needed to attend the clinic for his olanzapine depot on 13 November 2013 and in response the deceased shrugged his shoulders and said, "If I care."[25] The deceased then closed the door.

31. Nurse Read did not consider the deceased's presentation to be alarming or particularly difficult to his usual presentation although he did think the

[20] Exhibit 1, Tab 1.
[21] T 11.
[22] T 11.
[23] Exhibit 1, Tab 23.
[24] Exhibit 1, Tab 23.
[25] Exhibit 1, Tab 23 [31].

deceased may have been under the influence of drugs. Nurse Read completed a risk assessment sticker indicating that he believed the deceased was at low risk of harm to himself and moderate risk to others as he may behave in a way that was offensive to people. Nurse Read used the sticker to record a baseline for the deceased as it was the first time he'd seen him since his hospital discharge. Nurse Read indicated on the sticker that the deceased required further review in two days when he hoped the deceased may have settled down a little if he was under the influence of drugs. He also wanted to discuss the depot injection again.[26]

32. Nurse Read attempted to contact the deceased's father by telephone the following day but did not get a response and again on 8 November 2013. Nurse Read attempted another home visit with the deceased on 8 November 2013 but the deceased was not at home.[27]

33. It is not surprising the deceased was not at home on 8 November 2013 as he was admitted to the Day Procedure Unit at SCGH at 11.30 am that day for his knee surgery. His operation was later cancelled but the reason for the cancellation is not clearly documented. The deceased's mental state after 8 November 2013 is not known as it is not documented in any of the notes.

34. Dr Mander reviewed Nurse Read's statement. Dr Mander said he was looking for an intent by staff to make sure that they've picked a newly discharged person in that first week after the deceased was released onto the CTO because that is when the patient is most vulnerable. Dr Mander appeared satisfied that this was the case and the appropriate arrangements had been made.[28] Dr Mander said that Nurse Read "was doing exactly what I would have expected of him."[29] Nurse Read had been comparing the deceased's current presentation with what he knew of the deceased's presentation in the past and found there was nothing to particularly raise his concerns above the usual that might suggest that there "was any raised risk over the normally raised risk."[30]

35. Nurse Read had also been trying to make contact with the deceased's father but hadn't been successful. Dr Mander agreed this was an appropriate step as the deceased's father would have been a good source of information if things weren't going well, noting that it would be unlikely that this information would come from the deceased himself.[31] Unfortunately, no contact was made before the deceased's death so that collateral information was not available.

EVENTS ON 11 NOVEMBER 2013

36. At 6.36 am on 11 November 2013 the deceased recorded what could be described as a 'suicide message' on his mobile telephone. In the message he

[26] Exhibit 1, Tab 23.
[27] Exhibit 1, Tab 17.
[28] T 11 – 12.
[29] T 12.
[30] T 12.
[31] T 12.

mentioned leaving his policy to his Sister, said that he loved his Dad and wanted his Mother to rest in peace. He also said something in relation to Justin Bieber that was less logical, and I note there was a Justin Bieber song playing in the background of the recording. The deceased then indicated that he hopes the recording worked and said goodbye before he placed the phone down. The deceased then walked up to Main Street in Osborne Park, which is a relatively busy road in the area.[32]

37. The deceased was observed to pace up and down on the footpath beside Main Street for approximately 15 minutes while various cars passed by. He appeared to perhaps be waiting for someone.[33]

38. At 7.15 am the deceased was seen standing on the side of the road very close to the kerb moving from side to side. Then, without warning, the deceased jumped in front of a passing truck that was travelling south on Main Street. The truck driver swerved but was unable to avoid the deceased and the lefthand side of the truck struck the deceased's body.[34]

39. The truck driver immediately stopped his truck and saw the deceased lying on the roadway. It was apparent he was seriously injured.[35]

40. At 7.18 am the truck driver telephoned the police and reported that the deceased had jumped in front of his truck and was seriously injured.[36]

41. An ambulance attended and conveyed the deceased to SCGH in full resuscitation but he could not be revived. His death was confirmed on arrival at the hospital.[37]

42. An examination of the truck found no faults that would have contributed to the collision and there was no evidence that the nature of the driving played a role. The driver was reported to be driving below the speed limit and witnesses to the event believed the truck driver had no chance to avoid a collision.[38] The driver spoke to police and indicated that, from what he saw before the collision, it appeared to him that the deceased deliberately jumped in front of his vehicle.[39]

CAUSE OF DEATH

43. A post mortem examination was performed on 13 November 2013 by a Forensic Pathologist, Dr Judith McCreath. The examination showed extensive non-survivable injuries.[40]

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[32] Exhibit 1, Tab 8, p. 2 and Tab 22.
[33] Exhibit 1, Tab 8, p. 3.
[34] Exhibit 1, Tab 8, p. 2.
[35] Exhibit 1, Tab 8, p. 2.
[36] Exhibit 1, Tab 8, p. 2.
[37] Exhibit 1, Tab 7.
[38] Exhibit 1, Tab 8 and Tab 9.
[39] Exhibit 1, Tab 15.
[40] Exhibit 1, Tab 4.

44. Toxicology showed carbon monoxide saturation of approximately 10% and the presence of olanzapine (his depot medication) and tetrahydrocannabinol and its metabolite (noting the deceased was a regular cannabis user).[41] There is evidence the deceased was standing on the side of road near passing traffic for some time before his death, which is likely to explain the carbon monoxide level.

45. At the conclusion of all investigations Dr McCreath formed the opinion the cause of death was multiple injuries. I accept and adopt the conclusion of Dr McCreath as to the cause of death.[42]

MANNER OF DEATH

46. It is not always easy to determine whether a person with a severe chronic mental illness, such as the deceased, has the requisite capacity to form an intention to take their life in circumstances such as these. However, in this case my task was assisted by the voice recording made by the deceased very shortly prior to his death.

47. On the other hand, the deceased was known to experience psychotic episodes after using cannabis and the results of the post mortem examination confirmed recent cannabis use.

48. I asked Dr Mander whether he believed the deceased's use of cannabis prior to his death was likely to have been involved in his death. Dr Mander noted that the deceased had used THC substances for a long time and felt it unlikely that it was a key factor in causing a worsening psychosis.[43]

49. The deceased's behaviour on this occasion was out of character, as he had not previously been known to make a serious attempt at taking his life, but Dr Mander considered it was not surprising when the death of the deceased's mother was taken into account.[44] Dr Mander believed the deceased's mother's death was likely to have disturbed whatever stability the deceased had managed to find in his life and pushed him over the edge into suicide.[45]

50. The evidence supported the conclusion, the deceased planned his death and that his behaviour immediately prior to stepping out into the traffic probably indicated the deceased was mustering up the courage to take that final act. Dr Mander suggested that it was not a coincidence that it was a truck that the deceased stepped in front of, being indicative of a firm intention to end his life.[46] Dr Mander expressed the opinion that the deceased was chronically psychotic but he did not consider that the available information suggested the deceased's behaviour was consistent with acting under a psychotic impulse rather than a reasoned decision to take his life. That was

[41] Exhibit 1, Tab 6.
[42] Exhibit 1, Tab 5.
[43] T 12.
[44] T 7.
[45] T 7 – 8.
[46] T 8 – 9.

so even given the presence of tetrahydrocannabinol in the deceased's system.[47]

51. Based upon the available evidence before me, I find that the manner of death was by way of suicide.

QUALITY OF SUPERVISION, TREATMENT AND CARE

52. Under s 25(3) of the *Coroners Act 1996*, where a death investigated by a coroner is of a person held in care, the coroner must comment on the quality of the supervision, treatment and care of the person while in that care.

53. Dr Mander described the deceased as very typical of the sorts of patients that are managed in the public mental health service. Dr Mander noted the deceased's onset of schizophrenia occurred when he was very young and proceeded to chronicity, which had a significant negative impact on the deceased and those around him. His case was accompanied by a relative lack of insight, poor compliance with treatment and complications such as substance abuse. All of these factors left him especially vulnerable. He was relatively unsupported in the world, other than his parents and the professionals who tried to help him, so his mother's death was a major factor for him.[48]

54. By virtue of his illness and life circumstances, Dr Mander considered the deceased's risk of suicide was permanently increased. The deceased was also known to have threatened to kill himself on a number of occasions in the past. However, Dr Mander commented that "suicide is very difficult to predict because of what we call the low base rate. In other words, out of all those people who say they are thinking about suicide, the actual number that do go on to commit suicide is relatively small."[49] For the person who frequently talks about doing such an act, it becomes even more difficult to make a decision about whether the person is truly at risk or not. Dr Mander equated it to the old fable of 'the boy who cried wolf.' The deceased fell into that category.[50]

55. Dr Mander considered the real question was "did the staff appreciate high risk and did they actually take steps to access that and mitigate that in a reasonable way?"[51] In that sense, Dr Mander explained that the staff would be looking for a change in the person that suggests a move from chronic to acute risk. The change might come from something that you see or hear in the person, such as reporting hallucinations and delusions when normally they were kept under control. It might also come from information from parents or friends or neighbours, who have alerted the mental health practitioners to a noticeable change in behaviour. However, if there was no change in presentation, then the person's management would continue as

[47] T 9 – 10.
[48] T 5.
[49] T 6.
[50] T 6.
[51] T 6.

normal.[52] There was nothing to indicate a change in the deceased's presentation that would have warranted a hospital admission.

56. Dr Nadarajah, who had approved the deceased's discharge onto the CTO was asked whether he had any cause for concern in relation to the deceased's presentation as described by Mr Read on 6 November 2013. Dr Nadarajah indicated that he did not and expressed the opinion that any clinician in that situation would have done the same. Dr Nadarajah noted that they don't want to be admitting patients to be an inpatient under the *Mental Health Act* in a secure ward quickly after discharge unless it is necessary as it is important to give them the time and opportunity to settle in and for the practitioner to establish more rapport.[53]

57. Dr Mander also observed that most community mental health nurses are managing around 30 patients, most of whom are very similar to the deceased in terms of their condition.[54] They will all fluctuate in their condition, and ability to manage in the community, over time.

58. Dr Mander observed that "it is almost impossible to predict suicide in an individual person at an individual point in time."[55] However, there are features that can predict increased risk at times. Dr Mander cited statistics that the suicide rate in schizophrenia studies is in the range of between three and 15 per cent and he felt that the deceased was in that range of 15 per cent and probably higher "because he was so chronically unwell"[56] and because his illness had started when he was young, "at the very point when he has got to get through his maturational tasks."[57] He also noted that the deceased had other known increased risk factors that are common in the community, such as being male, young, physically unwell and having a lack of social supports, problems with money and housing and drug use.[58]

59. Dr Nadarajah agreed the deceased's long history of severe mental illness increased his risk of suicidal ideation and suicide attempts over the long term. However, Dr Nadarajah also agreed with Dr Mander's comments that suicide risk is dynamic and unpredictable and in the case of the deceased his risk would have fluctuated.[59]

60. Dr Mander expressed the opinion that the deceased's mental health care was in line with best practice for treatment of schizophrenia, which involved management in the community with inpatient stays when required. Dr Mander went so far as to say that he "was actually impressed with the way the services had worked over the years for him."[60]

61. Based on the information available, and particularly the expert opinion of Dr Mander, I am satisfied that the deceased's psychiatric supervision,

[52] T 6 – 7.
[53] T 20.
[54] T 12.
[55] T 13.
[56] T 14.
[57] T 15.
[58] T 14.
[59] T 19.
[60] T 15.

treatment and care, both in hospital and in the community, was appropriate and of a reasonable standard.

CONCLUSION

62. The deceased had a long history of chronic mental illness when he stepped in front of a truck and ended his life. While the initial impression might be that it was his mental illness that prompted him to take that drastic action, the evidence before me supports the conclusion that he made that decision for the same reasons as many young men in the community do at a time of situational crisis. I am satisfied that the deceased's sudden decision to end his life was unexpected and he did not show any signs to his treating mental health team prior to doing so.

S H Linton
Coroner
29 August 2018