Coroners Act 1996
[Section 26(1)]

Western *Australia*

RECORD OF INVESTIGATION INTO DEATH

AMENDED

Ref No: 43/ 15

I, Barry Paul King, Coroner, having investigated the death of ***John Stephen Passmore*** *with an inquest held at* ***Perth Coroners Court*** *on* ***5 and 6 November 2015****, find that the identity of the deceased person was* ***John Stephen Passmore*** *and that death occurred* ***between 26 March 2012 and 29 March 2012*** *at* ***Unit 6, 54 Gugeri Street, Claremont,*** *from* ***ligature compression of the neck (hanging)*** *in the following circumstances:*

Counsel Appearing:

Sgt L Housiaux assisted the Coroner
Mr M A G Jenkin (State Solicitor's Office) appeared on behalf of the North Metropolitan Health Service

Table of Contents

INTRODUCTION

1. On 29 March 2012 John Stephen Passmore (**the deceased**) was found hanging in his unit in Claremont with no sign of life. He had last been seen alive at about 10.00 am on 26 March 2012.

2. As the deceased was an involuntary patient under the *Mental Health Act 1996* at the time of his death, he was a 'person held in care' under section 3 of the *Coroners Act 1996*.

3. Section 22(1)(a) of the *Coroners Act 1996* provides that a coroner who has jurisdiction to investigate a death must hold an inquest if the death appears to be a Western Australian death and the deceased was immediately before death a person held in care.

4. An inquest to inquire into the death of the deceased was, therefore, mandatory.

5. On 5 and 6 November 2015 at the Perth Coroners Court, I held an inquest into the deceased's death. The evidence adduced at the inquest comprised documentary evidence and oral testimony. The documentary evidence consisted of an investigation report and associated attachments prepared by First Class Constable (now Senior Constable) Sarah Denny of the Western Australia Police.[1]

6. Oral testimony was provided by:

   a) Senior Constable Denny;[2]

   b) David Bishop, a community mental health nurse specialist who had looked after the deceased for several years and was the last person to see the deceased alive;[3]

[1] Exhibit 1, Tabs 1-19 and 22
[2] ts 5-11
[3] ts 11-20

c) Dr Babu Mathew, a psychiatrist at Graylands Hospital (**Graylands**) where the deceased had last been admitted from 12 May 2011 to 6 March 2012;[4] and

d) Dr Adam Brett, a consultant psychiatrist who had provided the Court with an independent report[5] of the deceased's management.[6]

7. Under section 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.

8. I have found that the supervision, treatment and care of the deceased was reasonable and appropriate in the circumstances.

THE DECEASED

9. The following background information about the deceased comes primarily from a statement provided by the deceased's twin brother, Mark Passmore.[7]

10. The deceased was born in Subiaco on 24 November 1958, making him 53 years old when he died. He was one of four children to his parents.

11. During his childhood, the deceased's family moved around Western Australia quite a lot and the deceased went to several schools. He was not academically minded but was a talented sportsman, especially at football.

12. The deceased left school at about the age of 16 and began a bricklaying course at TAFE. He then worked at an

[4] ts 20-37
[5] Exhibit 1, Tab 20
[6] ts 41-50
[7] Exhibit 1, Tab 8

abattoir for a couple of years before moving to Darwin to play football.

13. While he was in Darwin the deceased began to drink excessively and possibly used illicit drugs.

14. He continued to excel at football, but missed an opportunity to advance his career by making a flippant remark to a well-known coach of a North Melbourne club who had approached him to play for his team.

15. At about that time, a friend of Mark Passmore told him that the deceased was drinking too much and that Mark should get him out of Darwin.

16. The deceased returned to Perth showing signs of mental illness.

THE DECEASED'S MENTAL ILLNESS HISTORY

17. Following his return to Perth, the deceased commenced a long history of mental illness and contact with psychiatric hospitals. In 1982 he was admitted to Heathcote Hospital for the first time. He had another four admissions to Heathcote Hospital and Graylands until 1992, after which he had another 10 admissions to Graylands.[8]

18. The deceased was eventually diagnosed with severe chronic paranoid schizophrenia, characterised by bizarre delusions, auditory hallucinations and severe thought disorder. He also lacked motivation and drive, and had restricted interests and emotional expression. He was often irritable, hostile and threatening to mental health staff and to his parents.[9]

19. The deceased had no insight about his psychiatric problems and never accepted that he had any, so he had to be managed as an involuntary patient for long periods, either as an inpatient or on community treatment orders.

[8] Exhibit 1, Tab 13
[9] Exhibit 1, Tab 13

Various anti-psychotic drugs were prescribed to him without real success. He would rarely be compliant with oral prescriptions, so as an outpatient he was usually given depot intramuscular injections.[10]

20. In 1996 the deceased assaulted his mother when he was acutely unwell and believed that she was possessed by the devil.[11] He was living with his mother at the time.

21. After that incident the deceased was admitted as an involuntary patient to Graylands for over 15 months, during which time he was given several types of anti-psychotic medications, again without appreciable success. During this admission he was tried on clozapine, an anti-psychotic drug that can be useful for treatment-resistant schizophrenia. It is used as a last resort medication because of potential side-effects and patients receiving it must be closely monitored.[12] It had to be taken orally.

22. The deceased improved somewhat from increased dosages of clozapine, but he believed that it was poisoning him and causing him to choke, so he soon refused to take it.[13]

23. When the deceased was discharged from Graylands in July 1997, he moved into his own accommodation in Claremont. He received follow-up management at the Subiaco Community Mental Health Clinic, also known as the Subiaco Clinic, Avro House or the Avro Clinic.[14]

24. The deceased was managed by the team at the Subiaco Clinic until his last admission at Graylands. His case manager from February 2000 to October 2007 was Mr Bishop.

25. Mr Bishop said that the deceased was always floridly psychotic and very unpredictable. He talked to himself

[10] Exhibit 1, Tab 13
[11] Exhibit 1, Tab 13
[12] Exhibit 1, Tab 13
[13] Exhibit 1, Tab 13
[14] Exhibit 1, Tab 13

incessantly and his mood would change instantly. He would be rude, derogatory and aggressive to Mr Bishop in the morning, and in the afternoon he would greet him like a friend and go out for coffee or play a game of chess with him. He was, said Mr Bishop, one of the most troubled souls and most unwell people he had managed.[15]

26. In March 2006 the deceased told community mental health staff that he felt suicidal and that he had tried to hang himself because he had been harassed by Mental Health Services staff who had interfered in a relationship that he was developing with a woman. He was admitted to Graylands and after a few days denied feeling suicidal any longer. The deceased's father told doctors at the time that the deceased was in a habit of threatening suicide when he was upset or distressed.[16]

27. In November 2006 the deceased was again admitted to Graylands after claiming to have suicidal ideation and to have attempted to hang himself with a belt.[17]

28. After the admissions in March 2006 and November 2006 the deceased had no further reported incidents of suicidal ideation and was considered by clinicians to be at low risk of suicide.[18] However, in dealing with staff at the Subiaco Clinic, he would at times threaten to kill himself, saying that they put him on this dangerous trip and that the medications were killing him. His psychiatrist at the Subiaco Clinic, Dr J S Fletcher, noted that the deceased believed that he, the deceased, had been brought to this world accidently by aliens and that aliens were trying to abduct him back to his own world but the medication was preventing him from being abducted. The deceased had said that worlds were trying to take over worlds and that it all had to do with energy and constancy.[19]

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[15] ts 12-14 per Bishop, D P
[16] Exhibit 1, Tab 13
[17] Exhibit 1, Tab 13
[18] Exhibit 1, Tab 13
[19] Exhibit 1, Tab 12

THE DECEASED'S LAST ADMISSION

29. In late April 2011 Dr Fletcher had a discussion with Graylands psychiatrist Dr Ancy John about the deceased. They noted that, despite the use of reasonably powerful depot medications, for some time the deceased's symptoms could not be controlled. He neglected his self-care and his unit, was constantly agitated, had auditory hallucinations, was extremely thought disordered, and had profound delusions of a paranoid and religious nature.[20]

30. With the agreement of the deceased's family, Dr Fletcher and Dr John agreed to admit him to Graylands for a six-week trial of the latest depot olanzapine, an anti-psychotic medication that had not been prescribed to the deceased previously.[21] During that time, the owner of the deceased's unit, Uniting Care West, would take the opportunity to clean and renovate the unit.[22]

31. On 12 May 2011, the deceased was admitted to a secure ward in Graylands under the care of Dr John in an acute service team and was started on olanzapine. According to Mark Passmore, the deceased was not consulted about this admission and was angry about it.[23]

32. Over the following weeks the deceased did not show much improvement despite increased doses of olanzapine and augmentation with another anti-psychotic medication, amisulpride. In July 2011 the deceased assaulted a staff member while under the delusional belief that he would be killed.[24]

33. Graylands staff considered that the deceased would require a prolonged admission, so on 7 September 2011 he was transferred to the Rehabilitation Service at

[20] Exhibit 1, Tab 12
[21] Exhibit 1, Tab 12
[22] Exhibit 1, Tab 8
[23] Exhibit 1, Tab 8
[24] Exhibit 1, Tab 13

Graylands, under the care of Dr Mathew.[25] The Rehabilitation Service was a relatively new service at Graylands that was set up to attempt to control the symptoms of the 30 per cent of very difficult schizophrenic patients who do not respond to traditional measures.[26]

34. Dr Mathew explained that there were three aims of the deceased's admission in the Rehabilitation Service. The first aim was to continue with the olanzapine for a bit longer. The second aim was, if the olanzapine was not effective, to persuade the deceased to try clozapine again since it had provided some improvement in 1996. The third aim was to teach the deceased daily living skills and to put supports in place so that he could live more independently with his disability.[27]

35. The first two aims of the rehabilitation, the medication treatment aims, were unsuccessful; the deceased remained unwell. As to the third aim, the deceased was unwilling to engage with the occupational therapist, so could not be taught daily living skills. Attempts to implement these aims took a considerable amount of time.[28]

36. The deceased and his family were unhappy and distressed by the deceased's long admission to Graylands. The deceased repeatedly insisted that he be allowed to return to live in his unit where he had managed to get by with the support of his family in the past. His parents, quite reasonably, told Dr Mathew that there was no point in keeping the deceased in hospital if he did not improve further.[29]

37. In addition, Uniting Care West indicated that the deceased would not be able to keep his unit if his

[25] Exhibit 1, Tab 13
[26] ts 23 per Mathew, B
[27] ts 23-24 per Mathew, B
[28] ts 24 per Mathew, B
[29] ts 24 per Mathew, B

admission extended for much longer.[30] Loss of his unit would have meant the deceased would have had to stay in Graylands indeterminably longer because it would have been difficult to find alternative accommodation for him due to his history and symptoms.[31]

38. Dr Mathew and his team faced the dilemma of either keeping the deceased at Graylands where he was not improving and was clearly distressed or placing him into the community where he would not be able to look after himself.[32]

39. An important factor in deciding what to do for the deceased was that, while he had a history of purported suicide attempts in 2006, no suicidal behaviour had been seen since, including during this last admission to Graylands.[33]

THE DECEASED IS DISCHARGED

40. After a discussion between Dr Mathew and Dr Fletcher, a decision was made to discharge the deceased home and to try to support him there. As a result, the rehabilitation team focused on putting supports in place to allow the deceased to live in the community.[34]

41. On 6 December 2011 the deceased was moved to an open ward, where he remained for three months. His medication was changed from depot olanzapine to depot zuclopenthixol for ease of use in the community, and support arrangements were put in place for a period of trial leave before he was to be discharged. Due to the difficulty of arranging for suitable employees within support agencies, this process took longer than expected. During that time the deceased took advantage of

[30] Exhibit 1, Tab 13
[31] Exhibit 1, Tab 21
[32] ts 22 per Mathew, B
[33] Exhibit 1, Tab 21
[34] ts 24 per Mathew, B

unescorted leave on the hospital grounds without any problem.[35]

42. The deceased was given trial leave on 6 March 2012. Dr Mathew had initially wanted the deceased to return after one week for review, but when this was raised in advance, the deceased became anxious, thinking that it was a plan to re-admit him and keep him in Graylands. After some negotiation, the deceased agreed to return in two weeks' time on 20 March 2012 for review. Arrangements were made for staff from the Subiaco Clinic to conduct home visits during that time.[36]

43. On 20 March 2012 the deceased returned to Graylands and was reviewed by Dr Mathew and his registrar. The deceased's mental state did not appear to have deteriorated; he presented as usual with the same delusions and thought disorder. He said that he was not anxious and that he was getting on well with his support workers.

44. However, the deceased said that he did not like Mr Bishop, who he understood to be his case manager, and did not want him to be his case manager.[37] In fact, Mr Bishop had not been the deceased's allocated case manager since 2007 but had continued to see him regularly to support the deceased's subsequent case managers at the Subiaco Clinic.[38]

45. Overall, Dr Mathew and his registrar felt that the deceased was coping well at home. They sent him home for additional leave and assured him that they would tell the Subiaco Clinic that he wanted a different case manager.[39]

46. On 20 March 2012 Mr Bishop returned from leave. He was asked to visit the deceased at home to see how he

[35] Exhibit 1, Tab 13
[36] Exhibit 1, Tab 21
[37] Exhibit 1, Tab 13
[38] ts 17 per Bishop, D P
[39] Exhibit 1, Tab 13

was settling into being back at home. Mr Bishop decided to try to visit the deceased later that week.[40]

47. On 22 March 2012 Mr Bishop attempted to visit the deceased, but he was unable to go to the door of the deceased's unit because he required a security code for a door or gate and did not have it with him.

48. On 24 March 2012 the deceased's niece and nephew, Pauline Sookloll and Michael Hack, visited the deceased at his unit. The deceased was talkative and showed no signs of suicidal ideation.[41]

49. Mr Bishop returned to the deceased's unit on the morning of 26 March 2012 at about 10.00 am. He could smell cigarette smoke through the locked flywire door, so he assumed that the deceased was home. He called out to the deceased who responded by telling Mr Bishop to go away and that he had told the doctors that he did not want anything to do with him. Mr Bishop told him that he would arrange for a colleague, Gary Warren to come to see him and to be his case manager.[42] The deceased indicated his agreement.[43]

50. Mr Bishop did not consider the deceased's behaviour unusual and did not get any sense that the deceased was considering suicide.[44] He returned to the Subiaco Clinic and, after a discussion with Dr Fletcher and Mr Warren, rang Graylands to say that the deceased would not engage with him so that he could not confirm that the planned support networks were in place, but that the Subiaco Clinic was happy for Graylands to discharge the deceased.[45]

51. The Subiaco Clinic made an appointment for the deceased to see Dr Fletcher on 2 April 2012.[46]

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[40] Exhibit 1, Tab 11
[41] Exhibit 1, Tab 9
[42] Exhibit 1, Tab 11
[43] ts 15 per Bishop, D P
[44] Exhibit 1, Tab 11; ts 14 per Bishop, D P
[45] Exhibit 1, Tab 11
[46] Exhibit 1, Tab 12

THE DECEASED IS FOUND DEAD

52. At some stage during the day on 29 March 2012 a Silver Chain representative attended the deceased's unit but the deceased did not answer the door. The representative contacted the deceased's mother.

53. At about 4.00 pm on 29 March 2012 the deceased's mother called the Subiaco Clinic with concerns about the deceased. She was unable to be more specific. An arrangement was made for Mr Warren and Mr Bishop to visit the deceased at home the next morning.[47]

54. At about 7.50 pm on the evening of 29 March 2012, Ms Sookloll and Mr Hack went to the deceased's unit at the request of the deceased's mother. He did not answer their knocks on the door and all the doors were locked.[48]

55. Ms Sookloll looked through the bedroom window and saw the deceased apparently hanging. She smashed a glass door to enter the unit and found him hanging by the neck with a rope tied to the wardrobe. He was clearly dead. She called police while Mr Hack obtained a knife in the kitchen and cut the deceased down.[49]

56. Ambulance paramedics arrived and confirmed that the deceased was dead.[50]

57. Police investigators did not identify any evidence that indicated the involvement of another person in the deceased's death.

CAUSE OF DEATH

58. On 30 March 2012 forensic pathologist Dr D. M. Moss conducted an external post mortem examination of the

[47] Exhibit 1, Tab 12
[48] Exhibit 1, Tab 9
[49] Exhibit 1, Tabs 9 and 10
[50] Exhibit 1, Tab 4

deceased's body and found a ligature and a ligature mark around the neck.[51]

59. There was marked hypostasis to the legs consistent with a period of suspension.[52]

60. Dr Moss formed the opinion that the cause of death was consistent with ligature compression of the neck (hanging).[53]

61. I find that the cause of death was ligature compression of the neck (hanging).

HOW DEATH OCCURRED

62. Hanging in the circumstances in which the deceased was found indicates that the deceased caused his own death with an intention to do so.

63. Dr Mathew said that studies have shown that suicide in patients with schizophrenia is often illness-related rather than a response to external events. The precipitating factors are likely to be hallucinations urging the patients to kill themselves or delusions which may lead the patients to harm themselves.

64. Dr Mathew provided a guess, which he emphasised was speculative, that the deceased acted on his frequently mentioned belief that he was brought to Earth by aliens and that he was waiting for UFO's to take him back. The deceased may have decided that the way to leave this earth was to end his life. Dr Mathew said that this conclusion explains why the deceased was not distressed when he was seen on the last occasion. He said that these unpredictable impulsive suicides are known in schizophrenia.[54]

[51] Exhibit 1, Tab 6
[52] Exhibit 1, Tab 6
[53] Exhibit 1, Tab 6
[54] ts 24 per Mathew, B

65. Dr Brett noted that suicide is a high risk for people with schizophrenia, with the World Health Organisation calculating the lifetime risk of suicide globally for people with schizophrenia to be 10-13%, which is 12 times the population risk. A study of individuals with schizophrenia who had made serious suicide attempts reported that 81% of those people had positive psychotic symptoms at the time of attempting suicide.[55]

66. Dr Brett also stated that the high risk of suicide in people with schizophrenia does not mean that all people with psychotic symptoms need to be in hospital. The vast majority of them are managed in the community and a significant proportion of them with have active symptoms that fluctuate over time.[56]

67. I am satisfied that, while the deceased's mind was disturbed, he formed an intention to end his life and hanged himself with a ligature and compressed his neck, which caused his death.

68. I find that death occurred by way of suicide.

COMMENTS ON THE TREATMENT, SUPERVISION AND CARE OF THE DECEASED

69. The deceased was within the four or five per cent of people with schizophrenia who are extremely severely impaired by their mental illness, and which illness is extremely resistant to currently available treatment.[57]

70. After several years during which his ability to look after himself deteriorated to the point where he could no longer do so, the deceased was admitted into Graylands to attempt to treat his illness. When that attempt failed, further treatment and therapy was provided in order to allow him to live independently in the community with the help of his family and support agencies.

[55] Exhibit 1, Tab 20
[56] Exhibit 1, Tab 20
[57] ts 22 per Mathew, B

71. The decision to release the deceased to live in his unit was entirely justified given the deceased's history, his ongoing condition, the level of support put in place, and the legislative requirement under s26(1)(d) of the *Mental Health Act 1996* to use the least restrictive option.[58] In my view, the evidence makes clear that the decision was the only realistic humane option available.

72. To the extent that Dr Brett offered any criticism about the deceased's management, the bulk of that criticism related to his view that the current system of mental health care in Western Australia is fragmented and should be changed to a more flexible service in which every patient had a single case co-ordinator throughout the patient's involvement with all aspects of the mental health service. That service would result in a single management plan for each patient with clearer lines of responsibility.[59]

73. Dr Brett said that the system he describes has been implemented in other jurisdictions, and he cites a recent paper which proposes implementing such a system in the Perth south metropolitan region. He said that the system has not been implemented there due to resourcing issues.[60]

74. Dr Brett thought that it was possible that the deceased may not have ended his life when he did had that system been in place at the time because he would have received better care in the community.[61]

[58] ts 22 per Mathew, B
[59] ts 47 per Brett, A D
[60] ts 47 per Brett, A D
[61] ts 47 per Brett, A D

75. Dr Brett considered that the deceased's management could have been better if resources were better, but he thought that the medication approach was sensible and that the management was good enough given the constraints on the treating team.[62]

76. In my view, the evidence establishes that the standard of supervision, treatment and care of the deceased while an involuntary patient at Graylands prior to his release on leave was reasonable and appropriate.

77. Likewise, the deceased was receiving support and care while he was on trial leave and living in his unit in March 2012. He was receiving his depot medication and was visited by the Subiaco Clinic staff; Meals on Wheels was attending once a day; a person attended regularly to help with cleaning; and the deceased's family were very supportive. On his review with Dr Mathew on 20 March 2012, he seemed to have been 'all right' during that time at home.[63]

78. I am satisfied that the standard of supervision, treatment and care of the deceased while he was an involuntary patient was reasonable and appropriate in all of the circumstances.

CONCLUSION

79. The deceased spent most of his adult life a direct victim of the terrible spectrum of mental illness that includes chronic treatment-resistant paranoid schizophrenia. In his case, the severity was extreme.

80. Despite the best efforts of mental health professionals with the resources available to them, the deceased's illness could not be cured and his symptoms could not be

[62] ts 49 per Brett, A D
[63] ts 34 per Mathew, B

reduced. In the end, that illness caused his death as surely as would a potentially fatal physical disease.

B P King
Coroner
15 February 2016