Coroners Act 1996
[Section 26(1)]

Coroner's Court of Western Australia

RECORD OF INVESTIGATION INTO DEATH

Ref: 21/19

I, Michael Andrew Gliddon Jenkin, Coroner, having investigated the death of ***Mark Quenton FLEURY*** *with an inquest held at the* ***Perth Coroner's Court, Court 85, CLC Building, 501 Hay Street, Perth*** *from* ***20 – 21 May 2019*** *find that the identity of the deceased person was* ***Mark Quenton FLEURY*** *and that death occurred on* ***14 February 2016*** *at* ***1 Dudley Drive, Usher*** *as a result of* ***ligature compression of the neck (hanging)*** *in the following circumstances:*

Counsel Appearing:

Ms A Barter assisted the Coroner.

Ms R Paljetak and Ms Z Bush (State Solicitor's Office) appeared on behalf of WA Country Health Service (WACHS).

Table of Contents

INTRODUCTION

1. Mark Quenton Fleury (the deceased) died on 14 February 2016 at 1 Dudley Drive, Usher, as a result of ligature compression of the neck (hanging).

2. At the time of his death, the deceased was subject to a community treatment order[1] (CTO) made under the *Mental Health Act 2014* (WA) (MHA 2014). Accordingly, immediately before his death he was an "*involuntary patient*"[2] and thereby a "*person held in care*".[3] As a consequence, his death was a "*reportable death*"[4] and in such circumstances, a coronial inquest is mandatory.[5]

3. Where, as here, the death is of a "*person held in care*", I am required to comment on the quality of the supervision, treatment and care the person received while in that care.[6]

4. I held an inquest into the deceased's death on 20 – 21 May 2019. Members of the deceased's family were in attendance during the inquest and his father, Mr Shane Potter, gave oral evidence at the inquest.

5. The following witnesses gave oral evidence at the inquest:

i. Dr E Crampin (Clinical Director, WACHS);
ii. Dr A Brett (consultant psychiatrist);
iii. Ms V Lewis (community mental health nurse);
iv. Dr V Pascu, (consultant forensic psychiatrist);
v. Dr I Soliman (senior medical practitioner, psychiatry); and
vi. Mr S Potter (the deceased's father).

6. The documentary evidence at the inquest included a report into the deceased's death prepared by the Western Australia Police,[7] expert reports, the deceased's medical notes and letters from the deceased's father. Together, the Brief comprised three volumes. The inquest focused on the deceased's supervision, treatment and care while he was the subject of a CTO and the circumstances of his death.

---

[1] Exhibit 1, Vol. 3, Tab 1.8, From 5b: Continuation of Community Treatment Order (05.01.16)
[2] Section 21, *Mental Health Act 2014* (WA)
[3] Section 3, *Coroners Act 1996* (WA)
[4] Section 22(1)(a), *Coroners Act 1996* (WA)
[5] Section 22(1)(a), *Coroners Act 1996* (WA)
[6] Section 25(3) *Coroners Act 1996* (WA)
[7] Exhibit 1, Vol. 1, Tab 2, Report - First Class Constable S Follows

THE DECEASED

Background

7. The deceased was born in Kojonup on 8 February 1978. He had an identical twin brother and was described by his mother as a "*normal healthy child in his upbringing with no sign of learning disabilities or mental issues*".[8]

8. The deceased's father was a farmer and the family eventually settled in Dardanup when the deceased was aged 16-years. When the deceased was 21 years of age, he moved to the north of Western Australia for work, before returning to Bunbury when he was 24 years old.[9]

9. The deceased married on 13 February 2010 and took his wife's surname of Fleury. On 6 February 2011, he and his wife had a daughter, Anaelle Pearl.[10,11]

10. The deceased and his wife separated on 3 February 2012. His former wife and his daughter subsequently relocated to France in November 2015. The deceased's family say that his former wife made it difficult for him to maintain contact with his daughter.[12,13]

11. The deceased was a qualified glazier and was described as a skilled and talented craftsman.[14] He established his own business in 2010.[15]

12. At the time of his death, the deceased was living in a home in Usher (a suburb of Bunbury) which he had purchased when he was about 25-years of age.[16]

---

[8] Exhibit 1, Vol. 1, Tab 8, Statement - Ms S Potter, paras 3-4
[9] Exhibit 1, Vol. 1, Tab 8, Statement - Ms S Potter, paras 5-7
[10] Exhibit 1, Vol. 1, Tab 8, Statement - Ms S Potter, paras 20-21
[11] Exhibit 1, Vol. 1, Tab 9, Report - Dr E Crampin, pp1-2
[12] Exhibit 1, Vol. 1, Tab 8, Statement - Ms S Potter, para 21
[13] Exhibit 1, Vol. 1, Tab 9, Report - Dr E Crampin, pp1-2
[14] ts 21.05.19 (Potter), p127
[15] Exhibit 1, Vol. 1, Tab 8, Statement - Ms S Potter, paras 19-20
[16] Exhibit 1, Vol. 1, Tab 8, Statement - Ms S Potter, paras 34-35

FEATURES OF THE DECEASED'S MENTAL ILLNESS

Diagnosis

13. The deceased's first recorded contact with South West Mental Health Services (SWMHS) was in 2002 when he was said to be experiencing paranoid, persecutory delusions. These delusions were a consistent theme of his illness until his death and responded, but never entirely remitted, to treatment.[17]

14. In a letter to the Mental Health Review Board[18] (MHRB), as it then was, Dr Costello (who had been the deceased's treating psychiatrist at SWMHS until 1 October 2015) stated:

> "*In my view, the best fit diagnosis is one of Paranoid Schizophrenia due to his delusions being varied, extensive and unusual in content*".[19]

15. As noted, the deceased's delusions were often bizarre in nature and sometimes included members of his family, who he would say were making up lies about him. Eventually, his delusional beliefs extended to Dr Costello and the deceased's care was formally transferred to Dr Brett on 1 October 2015.

16. Dr Brett assessed the deceased on 12 November 2015 and stated:

> "*I recorded in the notes that he was surly, difficult to engage, guarded, contradictory and insightless. I noted that his history was consistent with a delusional disorder or psychosis (not otherwise specified).*"[20]

17. It appears that despite his illness, the deceased's personality and day-to-day function were usually preserved. However, at times, his delusions were sufficiently bizarre and all-encompassing for him to be diagnosed with paranoid schizophrenia.[21]

---

[17] Exhibit 1, Vol. 1, Tab 9, Report - Dr E Crampin, p2
[18] The MHRB was replaced by the Mental Health Tribunal on 30 November 2015
[19] Exhibit 1, Vol. 3, Tab 1-6, Letter - Dr M Costello (13.10.15), p1
[20] Exhibit 1, Vol. 1, Tab 10, Statement - Dr A Brett, para 11
[21] Exhibit 1, Vol. 1, Tab 9, Report - Dr E Crampin, p2

Lack of insight

18. In terms of the deceased's understanding of his mental illness and his need for treatment, Dr Costello noted:

> "*He has never shown any independent insight into his condition or understanding of why he needs medicine. His presentations have remained consistent with Mark presenting as guarded, hostile, lacking insight, challenging and demanding the CTO and medications be stopped as we are blocking access to his child and are ruining his life*".[22]

19. Dr Brett, agreed and when asked what his memory of the deceased was, he observed:

> "*That he had chronically poor insight into his mental health. It was very difficult to engage him.*"[23]

Compliance issues

20. An issue closely related to the deceased's lack of insight into his mental health condition was the difficulty in ensuring he complied with his medication regime. As Dr Pascu observed in her report:

> "*Mr Fleury's mental illness was difficult to treat because of his erratic compliance with any prescribed medications and reported side effects from these, possibly in an attempt to cease the prescribed medication given his limited insight into his mental illness. His treatment was maintained under the Mental Health Act in the community on CTOs, which I believe was appropriate given his erratic and superficial, at best, insight into his mental illness.*"[24]

Refusal to allow family to be provided information

21. Another persistent feature of the deceased's mental illness was that he refused to allow his family to be provided with information about his care.

---

[22] Exhibit 1, Vol. 3, Tab 1-6, Letter - Dr M Costello (13.10.15), p3
[23] ts 20.05.19 (Brett), p33
[24] Exhibit 1, Vol. 1, Tab 11, Report - Dr V Pascu, para 61

22. Ms Lewis, (the deceased's case manager at the time of his death) acknowledged that part of her role was to try to engage with family members "*if that is allowed*", but noted that in the deceased's case, this was difficult because:

> "*Mark obviously was very clear that he didn't want his family involved, despite attempts to, I guess, try and work through that with Mark. He…remained very clear that he wouldn't allow any information to be provided to the family. The family did, at times, ring…through, I think, with the previous case manager as well.*"[25]

23. At various times, the deceased made disparaging remarks about members of his family saying they made things up about him and he became angry if information they had disclosed was discussed with him.[26,27,28] Thus, although the deceased's treating clinicians were able to receive information about him from family members[29], clinic staff had to be guarded about what information they could supply in return. Dr Brett explained the limits imposed by the deceased's position:

> "*We can provide information to the family and they can provide information to us, but the information we can provide has to be generic and not confidential. So obviously they knew about his diagnosis, they were given information about his diagnosis. We could give them information about emergency services and how to contact emergency services, but we couldn't give them specific information about Mark's confidential information.*"[30]

24. With respect to advising the deceased's family about changes in his medication, Dr Brett acknowledged this was a controversial area but said in the deceased's case:

> "*I think we did make the decision to inform them that we were changing his medication. And I think they were aware that we had changed it.*"[31]

---

[25] ts 20.05.19 (Lewis), p59
[26] ts 20.05.19 (Brett), p47
[27] Exhibit 1, Vol. 1, Tab 9, Report - Dr E Crampin, p3
[28] Exhibit 1, Vol. 3, Tab 1-6, Letter - Dr M Costello (13.10.15), p1
[29] Letter - Mr Potter (27.05.2016)
[30] ts 20.05.19 (Brett), p48
[31] ts 20.05.19 (Brett), p49

25. One of the difficulties the deceased's treating clinicians faced in trying to encourage him to be more open about information being provided to his family was that family members were often incorporated into the deceased's delusional beliefs.[32]

26. An important part of trying to build a therapeutic relationship with the deceased was to gain his trust. Given that the deceased's decision not to involve his family in his care was considered to be reasonable, this placed clinicians in a difficult position.[33]

27. Dr Brett considered the deceased's decision not to allow his family to be involved in his care was reasonable in the context of his delusional beliefs about his family. Dr Brett agreed that in those circumstances, receiving information about the deceased's condition from family members (who had closer contact with the deceased) was critical, especially where family members were expressing concerns that the deceased might self-harm.[34]

Concerns for safety of family members

28. Clinic staff also had concerns for the safety of family members, given that the deceased was known to behave in a verbally aggressive manner at times. As Dr Brett explained:

> "*We were concerned that if we gave him too much information that we had heard from his family, it may place them at risk and so we were very, very careful about what we could divulge and what we couldn't. Obviously, that doesn't mean we could have given them more information about Mark's mental health and that probably would have made it easier for them to manage Mark, but it may have, if Mark had found out about that, that would have made our relationship even worse.*"[35]

---

[32] ts 20.05.19 (Brett), pp49-50
[33] ts 20.05.19 (Lewis), p63
[34] ts 20.05.19 (Brett), pp50-51
[35] ts 20.05.19 (Brett), p50, see also ts 20.05.19 (Crampin), p30

29. The deceased's periodic hostility towards family members and his intermittent beliefs that they were acting against his interests were features of his paranoid delusional illness that impacted his treatment.[36]

30. Another aspect of the deceased's periodic hostility towards his family was their concerns about him learning that they had provided information to his treating clinicians. As Dr Pascu put it:

> "*There is also evidence in his file of family members contacting the treating team with relevant information about Mr Fleury's compliance with treatment, mental state, behaviour and deteriorations in his mental state specifically requesting that the information they provided not be shared with Mr Fleury which further confirmed the potential for harm towards his family. All these issues, in my opinion, further complicated any communications with his family regarding his overall care and management.*"[37]

Assessment of Risk

31. Assessing the risk that a person with a mental illness will self-harm or take their life by suicide is something that clinicians routinely do in a "*dynamic way*" every time they see their clients.[38]

32. However, Dr Brett drew a sharp distinction between risk assessment and risk prediction. As he pointed out, risk prediction is impossible:

> "*Risk prediction of rare events is mathematically impossible…So suicide is a rare event and so we are not in the business of risk prediction, because we can't do it. What we can do, is we can assess risk and we can manage risk.*"[39]

---

[36] Exhibit 1, Vol. 1, Tab 11, Report - Dr V Pascu, paras 57-58
[37] Exhibit 1, Vol. 1, Tab 11, Report - Dr V Pascu, para 59 and see also ts 20.05.19 (Crampin), p30
[38] ts 20.05.19 (Crampin), p9
[39] ts 20.05.19 (Brett), p38

33. On the issue of predictability of suicide, Dr Crampin noted that:

> "*much as we can identify a group of people who might be at higher risk of suicide due to all the factors that we have described, the ability to accurately predict somebody's risk of suicide on any particular day – my own personal experience is that the suicides I have come across during my career often were not directly predictable or were not directly predicted in a kind of straightforward way prior to them happening.*"[40]

34. Dr Crampin noted that some mental health illnesses carry a greater risk of suicide and gave as an example, psychotic illnesses such as schizophrenia. As she pointed out, treating the underlying illness is the first step in trying to reduce the risk of suicide. In addition, regular monitoring to reassess risk on a "*dynamic basis*" with increased monitoring if the risk seems to be escalating is also important with involuntary admission to hospital being indicated where the assessed risk is very high.[41]

35. The risk assessment process involves an assessment of factors that make risk events (such as self-harm and/or suicide) more likely. Risk factors might include: the person's diagnosis, any previous history of suicide attempts, their current mood state and any thoughts of self-harm or of harming others.[42]

36. According to Dr Brett, the deceased's main risk factor was his diagnosis, which was mitigated by the fact that the deceased received his anti-psychotic medication by way of a regular depot injection. Other risk factors Dr Brett considered relevant included the deceased's relationship with his ex-wife in France and:

> "*things which were happening in his life which we had no knowledge or control over.*"[43]

---

[40] ts 20.05.19 (Crampin), p10
[41] ts 20.05.19 (Crampin), p10
[42] ts 20.05.19 (Crampin), pp9-10
[43] ts 20.05.19 (Brett), p39

37. Given that the deceased took his life on 14 February 2016, it may or may not be significant that his daughter's birthday was on 6 February, his birthday was on 8 February and his wedding anniversary was on 13 February.[44]

38. Dr Crampin pointed out that risk assessments can never be 100% accurate and the assessment is always done on a "*balance of probabilities basis*".[45] Dr Brett also made the relevant point that risk is dynamic and can change rapidly, observing:

> "*you can see someone in your office and assess them as being at no acute risk, they walk out of your office, something changes and their risk status changes quickly.*"[46]

39. Dr Pascu also reinforced the point that psychiatrists cannot predict risk:

> "*risk assessment is about assessing what is there at the time of the assessment, and managing the risk at the time of the assessment. That risk is very dynamic. It's very fluid. We don't know what that person will do in three hours, especially if there is a significant social stressor – intoxication, or something happens in their lives. What I keep telling my trainees, I don't know what I will be doing tomorrow. How can I know what another person will be doing tomorrow?*"[47]

40. Before touching on the criteria for making an involuntary treatment order under the MHA 2014, I note Dr Brett's observation that:

> "*The evidence of the efficacy of CTOs to reducing risk is scant and the evidence for admission into hospital to reduce risk in the long term is also scant.*" [48]

[44] ts 21.05.19, p131
[45] ts 20.05.19 (Crampin), p10
[46] ts 20.05.19 (Brett), p39
[47] ts 21.05.19 (Pascu), p86
[48] ts 20.05.19 (Brett), p39

Involuntary Patient Status

41. During the course of the deceased's contact with the SWMHS, the legislation relating to mental health changed and the *Mental Health Act 1996* (WA) was replaced by the MHA 2014 on 30 November 2015.

42. Section 25(2)(e) of the MHA 2014 provides that a person shall not be placed on a CTO unless:

> "*the person cannot be adequately provided with treatment in a way that would involve less restriction on the person's freedom of choice and movement than making an inpatient treatment order.*"

43. Dr Brett explained in broad terms, the basis on which a person may, under the MHA 2014, be placed on a CTO:

> "*The first issue is that they have to have a mental illness that requires treatment. And so in Mark's case this was the case. Second, they need to be at significant risk to themselves or others and thirdly, they need to lack capacity to make decisions about their treatment.*
>
> *The principles of the Mental Health Act are that you should try and use the least restrictive option and so that is usually a CTO, rather than hospital. And the criteria for an inpatient treatment order are identical to those of the community treatment order. The differences being that if you thought someone's risk isn't manageable in the community, you would put them into hospital to manage their risk better.*"[49]

44. The MHA 2014 also introduced the concept of a "nominated person" to be the mental health consumer's support person, and the individual they wanted the relevant mental health service to communicate with about their care.[50]

---

[49] ts 20.05.19 (Brett), p39
[50] ts 20.05.19 (Crampin), p15

45. Section 263 of the MHA 2014 describes the role of a "*nominated person*" in these terms:

> "*to assist the person who made the nomination by ensuring that, in performing a function under this Act in relation to that person, a person or body:*
> *(a) observes that person's rights under this Act; and*
> *(b) takes that person's interests and wishes into account.*"

46. Consistent with his views on family involvement in his care, the deceased declined to have a "*nominated person*".[51]

CONTACT WITH SWMHS

Contact in the period 2002 – 2008

47. When seen at SWMHS in 2002, the deceased presented with low mood and paranoid ideation. No history of suicide attempts or thoughts were noted and a CT scan of his head was normal. The deceased was treated with risperidone (an anti-psychotic) and anti-depressant medication.[52,53]

48. Although the deceased's mood improved, his residual paranoid symptoms remained. The deceased was discharged from SWMHS in 2003, mainly due to erratic compliance with follow up.[54,55]

49. In 2006, the deceased made contact with SWMHS expressing concerns that people were following him. However, he failed to engage with the service.[56] A similar situation occurred in 2008 when the deceased presented to SWMHS concerned that people were stalking him. He reported he was still taking risperidone, but at a smaller dose. However, again, he chose not to engage with the SWMHS.[57,58]

---

[51] Exhibit 1, Vol. 1, Tab 11, Report - Dr V Pascu, para 32
[52] Exhibit 1, Vol. 1, Tab 9, Report - Dr E Crampin, pp2-3
[53] Exhibit 1, Vol. 1, Tab 11, Report - Dr V Pascu, para 14
[54] Exhibit 1, Vol. 1, Tab 9, Report - Dr E Crampin, pp2-3
[55] Exhibit 1, Vol. 1, Tab 11, Report - Dr V Pascu, para 14
[56] Exhibit 1, Vol. 1, Tab 9, Report - Dr E Crampin, p3
[57] Exhibit 1, Vol. 1, Tab 9, Report - Dr E Crampin, p3
[58] Exhibit 1, Vol. 1, Tab 11, Report - Dr V Pascu, para 16

Contact in 2013

50. In June 2013, the deceased's family contacted SWMHS with concerns about his welfare after he reportedly stopped taking his risperidone. The deceased said he'd been gassed in his car, that tenants in his house were trying to harm him with chemicals and that he'd been raped.[59]

51. On 5 July 2013, the deceased and his mother were seen by Dr Costello. The deceased was described as very guarded about his symptoms. The deceased was "*enraged*" at his family and expressed hostility towards his mother saying that his family "*were making everything up*".[60,61]

52. On 8 July 2013, the deceased was admitted to the acute psychiatric unit at Bunbury Hospital (APU) as an involuntary patient. The deceased was found to have "*absolutely no insight into his illness*" and "*refused any form of involvement with the mental health team*". His inpatient diagnosis was paranoid psychosis and he remained in the psychiatric unit until he was discharged on 30 July 2013.[62]

53. As a result of his lack of insight into the fact that he required treatment, he was placed on a depot injection of the anti-psychotic paliperidone[63] and placed on a CTO under the care of Dr Costello at the SWMHS. After the deceased was discharged, his family are said to have reported "*a great improvement*".[64]

54. The deceased continued to ask SWMHS to stop his medication and although according to Dr Costello, the deceased: "*regularly became angry and irritable with his family and the mental health team*", his level of functioning was considered much better on prescribed medication. At around this time, the deceased was noted, on occasion, to be rude and verbally aggressive to staff.[65]

---

[59] Exhibit 1, Vol. 1, Tab 9, Report - Dr E Crampin, p3
[60] Exhibit 1, Vol. 1, Tab 9, Report - Dr E Crampin, p3
[61] Exhibit 1, Vol. 3, Tab 1-6, Letter - Dr M Costello (13.10.15), p1
[62] Exhibit 1, Vol. 3, Tab 1-6, Letter - Dr M Costello (13.10.15), pp1-2
[63] This is a slow release, slow acting form of paliperidone, an atypical anti-psychotic delivered by way of regular injections, in circumstances where compliance with oral medication is thought to be problematic, see: Exhibit 1, Vol. 1, Tab 9, Report - Dr E Crampin, p3
[64] Exhibit 1, Vol. 3, Tab 1-6, Letter - Dr M Costello (13.10.15), p2
[65] Exhibit 1, Vol. 3, Tab 1-6, Letter - Dr M Costello (13.10.15), p2

55. Initially, it appears that the deceased was compliant with the terms of his CTO although he consistently challenged his diagnosis and need for treatment. However, Dr Costello noted that the deceased's compliance and engagement with SWMHS became erratic and he needed to be reminded to attend for depot injections. The deceased had also missed several reviews with his psychiatrist and when his CTO expired in January 2014, it was decided to trial him off it.[66]

Contact in 2014

56. It is noteworthy that when the deceased's CTO expired in January 2014, the deceased's family expressed concerns that he would disengage from the SWMHS and stop taking his medication.[67]

57. On 8 October 2014, the deceased's family contacted SWMHS expressing what Dr Costello described as "*extreme concerns*" that the deceased was at risk due to his paranoid delusions. The deceased had been expressing fears he was being gassed and his father reported that the deceased had been "*stalking women*". The deceased's family noted how aggressive the deceased had become and suggested that SWMHS workers seek police assistance when approaching him.[68]

58. Dr Costello assessed the deceased at the family home with police on 9 October 2014 and found him to be acutely psychotic and lacking insight into his mental illness.[69] He was admitted to the APU as an involuntary patient under the *Mental Health Act 1996* (WA) which was then in force.[70]

59. At this time, the deceased's family expressed their "*absolute frustration*" that the deceased's CTO had been allowed to expire in January 2014. Dr Costello explained the legal criteria for keeping someone on a CTO and noted that the deceased had always refuted the stalking allegations.[71]

---

[66] Exhibit 1, Vol. 3, Tab 1-6, Letter - Dr M Costello (13.10.15), p2
[67] Exhibit 1, Vol. 3, Tab 1-6, Letter - Dr M Costello (13.10.15), p2
[68] Exhibit 1, Vol. 3, Tab 1-6, Letter - Dr M Costello (13.10.15), p2
[69] Exhibit 1, Vol. 1, Tab 11, Report - Dr V Pascu, para 23
[70] Exhibit 1, Vol. 3, Tab 1-6, Letter - Dr M Costello (13.10.15), p2
[71] Exhibit 1, Vol. 3, Tab 1-6, Letter - Dr M Costello (13.10.15), p2

60. The deceased was diagnosed with psychosis (not otherwise specified) and re-commenced on monthly depot injections of paliperidone. He remained an inpatient until his discharge on a CTO under the care of Dr Costello on 24 October 2014. The inpatient team had noted that because the deceased had "*absolutely no insight into his condition*", it was likely that he would need to remain on a CTO indefinitely.[72,73]

61. It seems unfortunate that the deceased's CTO had been allowed to expire in January 2014, however, one of the objects of the *Mental Health Act 1996* (WA), which was in force at the time, was:

> "*to ensure that persons having a mental illness receive the best care and treatment with the least restriction of their freedom and the least interference with their rights and dignity*".[74]

62. Given Dr Costello's explanation to the family when the CTO expired in January 2014, it appears that clinicians did not feel that the deceased satisfied the criteria to extend the CTO at that time, although this is not entirely clear.[75]

63. In his letter to the MHRB on 29 October 2014, Dr Sketcher (consultant psychiatrist, APU, Bunbury Hospital) noted the importance of obtaining information about the deceased's condition from his family before any decision was made about his CTO.[76]

64. The relevant portion of Dr Sketcher's letter is as follows:

> "*It is strongly recommended that if the Board considers discharging Mark from involuntary treatment at any stage, that input from his family be sought and carefully considered prior to this decision being taken, as in Mark's case collateral history is very informative and the risks to the community are substantial*".[77]

---

[72] Exhibit 1, Vol. 3, Tab 1-6, Letter - Dr M Costello (13.10.15), p2
[73] Exhibit 1, Vol. 1, Tab 11, Report - Dr V Pascu, para 23
[74] Section 5(a), *Mental Health Act 1996 (WA)* see also section 10(1)(a) of the MHA 2014
[75] Exhibit 1, Vol. 3, Tab 1-6, Letter - Dr M Costello (13.10.15), p2
[76] Exhibit 1, Vol. 1, Tab 13-3, Letter - Dr B Sketcher (29.10.14), p2
[77] Exhibit 1, Vol. 1, Tab 13-3, Letter - Dr B Sketcher (29.10.14), p2

65. The deceased was followed up in the community after his discharge from hospital but he was noted to be: "*dismissive, hostile, with limited rapport*". He was fixated on ceasing his depot and complained of aches and tiredness and said he needed an over-the-counter stimulant in order to function.[78]

66. As a result of the deceased's persistent complaints about side-effects, he was started on an alternative antipsychotic depot medication, namely Risperdal Consta. His family were apparently informed of the change and remained supportive.[79]

67. The deceased's situation at around this time was compounded by ongoing Family Court proceedings relating to the breakdown of his marriage and access to his daughter.[80]

Contact in 2015

68. On 3 February 2015, the deceased's parents and his brother attended a family meeting. They were provided with basic feedback about the deceased's condition and compliance. The family's views about the deceased's treatment were canvassed and risks to family members were discussed, although no acute risks were apparently identified at that time.[81]

69. When reviewed by Dr Costello on 25 February 2015, the deceased presented as unwell and agitated. He complained that his medication was causing erectile issues and he was having testosterone therapy. The deceased disputed the concerns that SWMHS and his family had about his mental health and made disparaging comments about each member of his family in turn. The session had to be terminated because of the deceased's agitation and he appears to have incorporated Dr Costello into his delusional system by this stage. Dr Costello felt that the deceased was able to conceal many of his symptoms but remained psychotic and lacked insight.[82,83]

---

[78] Exhibit 1, Vol. 3, Tab 1-6, Letter - Dr M Costello (13.10.15), p2
[79] Exhibit 1, Vol. 1, Tab 11, Report - Dr V Pascu, para 24
[80] Exhibit 1, Vol. 2, Tab 1.5, Documents relating to Family Court proceedings
[81] Exhibit 1, Vol. 1, Tab 9, Report - Dr E Crampin, p4
[82] Exhibit 1, Vol. 1, Tab 11, Report - Dr V Pascu, para 26
[83] Exhibit 1, Vol. 1, Tab 9, Report - Dr E Crampin, p4

70. The deceased's CTO was reviewed by the MHRB on 12 March 2015 and extended. Dr Costello had provided the Board with a letter asking that information obtained from the deceased's family not be disclosed to the deceased because of potential risks to family members. The letter also said it was thought that the deceased had followed Dr Costello home.[84]

71. The deceased's mother, Ms Potter, was informed of this outcome by phone and she said that she and the deceased had generally been getting on well, although on one occasion he had been verbally aggressive and had spat in her face. She also reported some bizarre comments he had made about having been in prison and having another family elsewhere.[85]

72. Dr Costello reviewed the deceased on 24 March, 7 April and 5 May 2015. The deceased remained concerned about his depot medication and claimed it was affecting his blood pressure, but he declined to consider an alternative depot if oral medication was not a possibility.[86]

73. On 17 July 2015, the deceased's mother advised SWMHS about an email the deceased had sent in which he made serious allegations about his father and said he wished his mother would die. The deceased's mother was told the deceased was still subject to a CTO and she said that he appeared to be managing the day to day requirements related to working and socialising.[87]

74. When reviewed by Dr Costello on 4 August 2015, the deceased appeared sullen, angry and dismissive. He refused to acknowledge any need for medication or follow up by the mental health team. He complained of numerous side effects from his medication (e.g.: blurred vision, sedation and impotence) but despite having been given written information about alternative depot medications, the deceased refused to consider them and wanted oral medication. No change was made to his medication because Dr Costello did not believe he would be compliant with oral medication.[88]

---

[84] Exhibit 1, Vol. 1, Tab 9, Report - Dr E Crampin, p4
[85] Exhibit 1, Vol. 1, Tab 9, Report - Dr E Crampin, p4
[86] Exhibit 1, Vol. 1, Tab 9, Report - Dr E Crampin, pp4-5
[87] Exhibit 1, Vol. 1, Tab 9, Report - Dr E Crampin, p5
[88] Exhibit 1, Vol. 3, Tab 1-6, Letter - Dr M Costello (13.10.15), p3

75. The family's ongoing concerns were noted and it was recorded that the deceased had not previously acted in a violent manner but: "*an ongoing risk of aggression in response to his frustration with his interaction with the mental health service had to be considered".* [89]

76. On 24 August 2015, the deceased's mother called the Clinic to advise that she believed the deceased had stopped drinking and that his mental health and interactions with her had improved considerably. On 27 August 2015, the deceased's CTO was again extended by the MHRB.[90]

77. Dr Costello next reviewed the deceased on 15 September 2015. On this occasion, the deceased was reported to be hostile, argumentative and verbally abusive. He told Dr Costello he wanted another doctor to oversee his care because Dr Costello was "*incompetent*" and "*insightless*", didn't listen to him and punished him for things that he (the deceased) had done in the past.[91]

78. The deceased also expressed anger at Dr Costello for listening to his family, who he said made things up about him and he made insulting remarks about them.[92] On the basis that the therapeutic relationship between the deceased and Dr Costello had completely broken down, and with agreement from the deceased, his care was transferred to Dr Brett, who was then attending the Bunbury clinic two days per month.[93]

79. As Dr Pascu observed:

> "*Due to Mr Fleury's ongoing focus on the various clinicians who over time he included in his delusional system, his personal anger towards Dr Costello and more so following Dr Costello being summonsed to court in the family matter, it was decided to transfer his care to the visiting Forensic Psychiatrist Dr Brett.*"[94]

---

[89] Exhibit 1, Vol. 1, Tab 9, Report - Dr E Crampin, p5
[90] Exhibit 1, Vol. 1, Tab 9, Report - Dr E Crampin, p5
[91] Exhibit 1, Vol. 3, Tab 1-6, Letter - Dr M Costello (13.10.15), p3
[92] Exhibit 1, Vol. 1, Tab 9, Report - Dr E Crampin, p6
[93] Exhibit 1, Vol. 3, Tab 1-6, Letter - Dr M Costello (13.10.15), p3
[94] Exhibit 1, Vol. 1, Tab 11, Report - Dr V Pascu, para 30

80. Dr Costello last reviewed the deceased on 1 October 2015, pending Dr Brett's review later that month. The deceased continued to lack any insight into his condition and also requested a different case manager.[95]

81. Dr Brett's first contact with the deceased occurred on 15 October 2015 in the context of a hearing in the MHRB.[96] The deceased and Dr Brett appeared together from Bunbury by video link and as Dr Brett explained:

> "*It was a difficult hearing. He didn't think he had a mental illness. Dr Costello had written the report so it wasn't my report.*
>
> *The Mental Health Review Board hearing was by video link, so the tribunal was sitting in Perth, I was sitting in an office with Mark.*
>
> *He heard a lot of things he didn't want to hear, particularly that he had a mental illness and…he needed to be on a Community Treatment Order*".[97]

82. The deceased was clearly unhappy and became more agitated as the hearing progressed, but the CTO was extended.[98]

83. Dr Brett's first comprehensive assessment of the deceased occurred on 12 November 2015. The deceased presented as surly, difficult to engage and guarded as well as contradictory and chronically insightless. The deceased complained of side effects on his depot medication and said he wanted to change to oral medication.[99]

84. Dr Brett reduced the deceased's dose of depot medication in an effort to help improve the reported adverse effects and said he would consider oral medication if compliance could be guaranteed.[100]

---

[95] Exhibit 1, Vol. 3, Tab 1-6, Letter - Dr M Costello (13.10.15), p3
[96] Exhibit 1, Vol. 1, Tab 10, Statement - Dr A Brett, para 6
[97] ts 20.05.19 (Brett), p34
[98] Exhibit 1, Vol. 1, Tab 10, Statement - Dr A Brett, para 6
[99] Exhibit 1, Vol. 1, Tab 10, Statement - Dr A Brett, paras 6-11 and ts 20.05.19 (Brett), p35
[100] Exhibit 1, Vol. 1, Tab 10, Statement - Dr A Brett, paras 12 and ts 20.05.19 (Brett), p35

85. At this review, the deceased claimed he had anxiety not schizophrenia. He denied reports of stalking behaviour and said he had conflict with his father. He described significant Family Court issues and said that although he was seeing his daughter weekly, his ex-wife planned to take her to France. He said his main support was his brother.[101]

86. The deceased's refusal to appoint a nominated person was problematic, as Dr Pascu observed:

> "*Mr Fleury declined to have a nominated person involved in his care. This further complicated communications between the treating team and his family. Under the provisions of the Act, as Mr Fleury's family were very supportive of him, the treating team continued to provide brief updates regarding his progress including changes in treatment*".[102]

87. On 12 November 2015, the deceased signed a form authorising his caseworker to seek collateral information from his brother, Stuart. On 8 December 2015, Ms Lewis spoke to Mr Stuart Potter who said that the deceased was better when he was on medication but that the family would not be happy if the deceased was put onto tablets instead of depot medication.[103]

88. According to Ms Lewis, the deceased's brother did not raise any particular concerns about the deceased's mental health at this time.[104]

Medication Change – Abilify Depot

89. On 9 December 2015, when Dr Brett and Ms Lewis reviewed him, the deceased complained of side effects of his risperidone depot. Dr Brett discussed changing to another depot medication, namely aripiprazole (Abilify) after a trial of oral aripiprazole to assess side effects.[105] The deceased had said he wanted to stop all medications although he would agree to take oral medication. Dr Brett did not believe that the deceased had the capacity to make this decision.[106]

---

[101] Exhibit 1, Vol. 1, Tab 10, Statement - Dr A Brett, paras 6-11
[102] Exhibit 1, Vol. 1, Tab 11, Report - Dr V Pascu, para 32
[103] Exhibit 1, Vol. 1, Tab 14, Statement - Ms V Lewis, paras 7-8
[104] Exhibit 1, Vol. 1, Tab 14, Statement - Ms V Lewis, paras 7-8
[105] Exhibit 1, Vol. 1, Tab 14, Statement - Ms V Lewis, para 9
[106] Exhibit 1, Vol. 1, Tab 10, Statement - Dr A Brett, para 13

90. One of the benefits of Abilify, apart from its lower side effects profile was that it was administered via a monthly injection, reducing the number of times the deceased would have to attend the Clinic.[107]

91. Because of the deceased's complaints about the side effects of risperidone, Dr Brett rang the pharmacological help-line at Graylands Hospital and asked about an Abilify trial. The pharmacist advised that oral Abilify should be prescribed first to check for side effects, and then a depot form of Abilify could be used monthly.[108] Dr Brett considered that the deceased would need a long term medication but that it was appropriate to switch to a medication that had fewer side effects.[109]

92. On 10 December 2015, Ms Potter spoke to Ms Lewis and acknowledged that Ms Lewis was not able to disclose anything about the deceased's treatment. Ms Potter reported that the deceased was drinking less than he had in the previous two to three months and was also visiting her. She said he was "*chugging along quite well*". Ms Potter also said that the deceased was not reporting bizarre memories as he had been before.[110,111,112]

93. On 14 December 2015, Ms Lewis returned a call from the deceased who was querying the dose of his Abilify tablets. She reminded him that the trial of oral tablets was to check for side effects. On 21 and 22 December 2015, Ms Lewis made unsuccessful attempts to contact the deceased to see how he was finding the Abilify tablets and if he wanted to switch to Abilify depot. The deceased's next injection was due on 23 December 2015, but he didn't attend his appointment.[113]

94. On 29 December 2015, Ms Lewis sent the deceased a further text message reminding him that his depot injection was due and he attended the clinic that day.[114]

---

[107] ts 20.05.19 (Brett), p36
[108] ts 20.05.19 (Brett), p36
[109] Exhibit 1, Vol. 1, Tab 10, Statement - Dr A Brett, paras 14-16
[110] Exhibit 1, Vol. 1, Tab 9, Report - Dr E Crampin, p7
[111] Exhibit 1, Vol. 1, Tab 14, Statement - Ms V Lewis, para 11
[112] Exhibit 1, Vol. 3, Tab 1.2, Service Events Details (10.12.16: 10.45 am)
[113] Exhibit 1, Vol. 1, Tab 14, Statement - Ms V Lewis, paras 12-15
[114] Exhibit 1, Vol. 1, Tab 14, Statement - Ms V Lewis, paras 16

95. The deceased appeared well and was pleasant to Ms Lewis. He said he was happy he had spoken to his daughter on Christmas Day by Skype. He confirmed he had been taking his Abilify tablets and said he was happy to switch to Abilify depot. After contacting Dr Khoja (in Dr Brett's absence), Ms Lewis gave the deceased his Abilify depot injection and conveyed Dr Brett's instructions that the deceased should continue taking the Abilify tablets for a further two weeks.[115]

96. Ms Lewis planned to contact the deceased on 12 January 2016 to remind him to cease the Abilify tablets.[116] His management plan was updated and his risk of suicide and violence was assessed as low.[117,118]

97. In December 2015, the deceased's family expressed concerns about this medication change. However, the overall dose of antipsychotic medication the deceased was receiving remained unchanged because although Abilify tablets had been introduced prior to introduction of depot Abilify, the deceased was still receiving his depot dose of risperidone.[119]

Contact in 2015

98. On 12 January 2016, Ms Lewis sent the deceased a text reminding him to cease his oral Abilify.[120] On 14 January 2016, the deceased and Dr Brett attended a MHRB hearing at which the deceased's CTO was further extended. Dr Brett recalled that the hearing was "*very difficult*" and that the deceased became upset with him during the hearing. Dr Brett recorded in his notes that: "*it was impossible to establish a therapeutic relationship with* [the deceased]."[121]

99. The deceased attended the Clinic at around lunchtime on 1 February 2016 for his depot medication, having been sent reminders to do so by Ms Lewis on 25 January 2016 and 27 January 2016.[122]

---

[115] Exhibit 1, Vol. 1, Tab 14, Statement - Ms V Lewis, paras 16-19
[116] Exhibit 1, Vol. 1, Tab 14, Statement - Ms V Lewis, para 19
[117] Exhibit 1, Vol. 1, Tab 9, Report - Dr E Crampin, p7
[118] Exhibit 1, Vol. 3, Tab 1-3, Risk Assessment (29.12.15)
[119] Exhibit 1, Vol. 1, Tab 11, Report - Dr V Pascu, para 34
[120] Exhibit 1, Vol. 1, Tab 14, Statement - Ms V Lewis, para 20
[121] Exhibit 1, Vol. 1, Tab 10, Statement - Dr A Brett, para 18
[122] Exhibit 1, Vol. 1, Tab 14, Statement - Ms V Lewis, paras 21-23

100. The deceased was apologetic for missing his appointment and Ms Lewis thought he looked fitter,[123] noting:

> "*I remember thinking that this was the most well I had ever seen him. His mood was good and he seemed much happier. He did not identify any side effect issues with the aripiprazole depot*".[124]

101. The deceased mentioned a recent Skype conversation he had with his daughter and demonstrated an understanding that his daughter's lack of interest in talking was quite common for a young child. Ms Lewis gave the deceased his second Abilify depot and reminded him of his appointment with Dr Brett on 3 February 2016.[125]

102. As it happened, the deceased did not attend his appointment with Dr Brett on 3 February 2016, but on the basis of the overall improvement reported by Ms Lewis, Dr Brett agreed to the appointment being rebooked for one month's time.[126,127]

[123] Exhibit 1, Vol. 1, Tab 14, Statement - Ms V Lewis, paras 23
[124] Exhibit 1, Vol. 1, Tab 14, Statement - Ms V Lewis, paras 24
[125] Exhibit 1, Vol. 1, Tab 14, Statement - Ms V Lewis, paras 25-26
[126] Exhibit 1, Vol. 1, Tab 10, Statement - Dr A Brett, para 19 and ts 20.05.19 (Brett), pp37-38
[127] Exhibit 1, Vol. 3, Tab 1.2, Integrated Progress Notes - Dr A Brett (03.02.16)

THE FINAL WEEK OF THE DECEASED'S LIFE

Contact with MHERL – 7 February 2016

103. At 1.05 pm on Sunday 7 February 2016, Ms Potter contacted RuralLink, an after-hours emergency mental health service, to report that the deceased had become unwell and irritable and was accusing family members of being involved in a conspiracy.[128] The RuralLink triage form records Ms Potter saying she suspected that: "*a medication change some weeks ago may be responsible for his behaviour change*".[129]

104. Ms Potter also told the RuralLink worker that she: "*does not feel at risk from* [the deceased] *or believe he is a risk to others*" and was "*confident that calling* [the deceased's] *team tomorrow is the appropriate course of action*". The RuralLink triage form records the fact that the deceased was not currently at Ms Potter's home and that she would: "*call the police if he presents a risk in any way in order to have him assessed*". The form concludes with the notation: "*Inform local team tomorrow if nil further contact in the interim*".[130]

Attendance at Bunbury Hospital – 7 February 2016

105. At about 5.45 pm on 7 February 2016, the deceased attended the emergency department at Bunbury Hospital with his mother. Ms Potter told the psychiatric liaison nurse (PLN) who reviewed the deceased that he was becoming more paranoid and that she believed the deceased's mental health had worsened since his depot medication had been changed "*around 8 weeks ago*". The reason for the presentation at the emergency department was said to be that the deceased had been increasingly irritable and rude.[131]

106. When reviewed by the PLN, the deceased was "*pleasant and co-operative*" but: "*was probably guarded and not fully forthcoming*". The deceased did however disclose that he was not sleeping well and was feeling more anxious.[132,133]

---

[128] Exhibit 1, Vol. 1, Tab 9, Report - Dr E Crampin, p7
[129] Exhibit 1, Vol. 3, Tab 1.2, Triage Form - RuralLink (07.02.16: 1.05 pm)
[130] Exhibit 1, Vol. 3, Tab 1.2, Triage Form - RuralLink (07.02.16: 1.05 pm)
[131] Exhibit 1, Vol. 3, Tab 1.2, Triage Form (07.02.16)
[132] Exhibit 1, Vol. 3, Tab 1.2, Triage Form (07.02.16)
[133] Exhibit 1, Vol. 1, Tab 9, Report - Dr E Crampin, p7

107. The PLN discussed the deceased's case with Dr Khoja who recommended that he be given 3 mg of paliperidone in the emergency department and a further 3 mg to take the next morning. The deceased was discharged to be followed up by the SWMHS the following day and both the deceased and Ms Potter are recorded as being "*OK with this plan*".[134]

Contact with SWMHS – 8 February 2016

108. At 9.05 am on Monday, 8 February 2016, Ms Lewis contacted the deceased by phone. There was no answer and she left a message asking him to call back and arrange a review.[135]

109. At 9.40 am, Ms Potter called the clinic and voiced "*some dissatisfaction*" she wasn't informed about the deceased's change of treatment although she acknowledged she understood the requirement to maintain confidentiality. Ms Potter reported "*some decompensation*" with the deceased over the weekend. On the Saturday (06.02.16), the deceased was said to be extremely anxious and worried someone was going to hurt him. He was also said to have some insight and be apologising for past wrongs.[136]

110. Ms Potter reported that by the Sunday (07.02.16), the deceased was: "*back to blaming me for all that's gone wrong in his life".* He said he had wanted to come inside her home on the weekend, but she would not let him in. She agreed to follow him to the emergency department at Bunbury Hospital and felt he had: "*put on a good show for the nurse there*". Ms Potter said she thought the deceased may have gone to work and Ms Lewis told her that she had contacted him and left a message.[137]

111. In a letter dated 27 May 2016, Mr Potter says that in fact, Ms Potter attended the Clinic and told Ms Lewis that the deceased had not been going to work. Mr Potter says that Ms Potter requested that the deceased be: "*taken into care so that the volatility of his moods could be stabilised.*[138]

---

[134] Exhibit 1, Vol. 3, Tab 1.2, Triage Form (07.02.16)
[135] Exhibit 1, Vol. 3, Tab 1.2, Service Event Details (08.02.16: 9.05 am)
[136] Exhibit 1, Vol. 3, Tab 1.2, Service Event Details (08.02.16: 9.20 am)
[137] Exhibit 1, Vol. 3, Tab 1.2, Service Event Details (08.02.16: 9.20 am)
[138] Letter - Mr S Potter (27.05.16)

112. In attempting to resolve these competing versions, I note that Ms Lewis created her file note of these events on 8 February 2016,[139] whereas Mr Potter's letter is dated 27 May 2016. It is therefore possible that Mr Potter's description of the events on this day (which is second hand in any event) may be mistaken.

Contact with SWMHS – 9 February 2016

113. At 8.10 am on Tuesday, 9 February 2016, Ms Lewis called the deceased but there was no answer and she left a message.[140]

114. It appears that the deceased had called the Clinic on 8 February 2016, but that the receptionist had sent the wrong patient details to Ms Lewis and his call had therefore not been returned.[141,142]

115. At 9.20 am on 9 February 2016, Ms Potter went to the clinic to speak with Ms Lewis about her concerns. She reported that the deceased had been at his brother's house the previous night and was "*very anxious and paranoid*" and believed someone was going to harm him.[143]

116. Ms Potter told Ms Lewis that the deceased had been getting very angry and stayed with his brother overnight because he was too scared to go to his own home. She said that in the past when he became unwell he had thrown out his possessions and can be: "*very menacing and scary*".[144]

117. Ms Potter said she had phoned the deceased that morning and he claimed he was at Bunbury Hospital and that he had not been attending work, which was typical of his behaviour when he was unwell. Ms Potter told Ms Lewis she would contact the Clinic if she was able to locate him. Ms Lewis contacted the hospital but they had no record of the deceased's attendance.[145]

---

[139][139] Exhibit 1, Vol 3, Tab 1.2, Service Event Details (08.02.16: 9.20 am)
[140] Exhibit 1, Vol 3, Tab 1.2, Service Event Details (09.02.16: 8.05 am)
[141] Exhibit 1, Vol 3, Tab 1.2, Service Event Details (09.02.16: 8.10 am)
[142] Exhibit 1, Vol. 1, Tab 14, Statement - Ms V Lewis, para 31
[143] Exhibit 1, Vol 3, Tab 1.2, Service Event Details (09.02.16: 9.20 am)
[144] Exhibit 1, Vol 3, Tab 1.2, Service Event Details (09.02.16: 9.20 am) & ts 20.05.19 (Lewis), p65
[145] Exhibit 1, Vol 3, Tab 1.2, Service Event Details (09.02.16: 9.20 am) & ts 20.05.19 (Lewis), p65

118. Again, Mr Potter's description of the events on this day is markedly different from the version recorded by Ms Lewis. Mr Potter says that the deceased's brother attended the Clinic on 9 February 2016 and spoke with the deceased's caseworker (presumably Ms Lewis). The deceased's brother explained that the deceased had come to his house the night before at about 11.00 pm and had been hiding on the patio. The deceased was said to be terrified and said that people were after him. He begged his brother to take him in and hide him.[146]

119. Mr Potter says that the deceased's brother asked the caseworker to take the deceased into care so that: *his moods could be monitored and stabilised*" but that the caseworker refused to consider this request and said she would leave a message for the deceased to contact her.[147]

120. I was unable to find any record of this interaction in the Clinic files and when asked about it at the inquest, Ms Lewis said that she could not recall this incident.[148]

121. At 11:25 am, Ms Lewis spoke to Dr Khoja and told him about the information Ms Potter had provided and the deceased's "*decompensation in mental state*". Dr Khoja suggested giving the deceased paliperidone tablets if he attended the clinic.[149]

122. Ms Lewis called the deceased at 11.30 am but there was no reply and she left a message.[150] At 12.15 pm, the deceased phoned the Clinic and asked Ms Lewis to meet him at a coffee shop. She said this was not possible and instead suggested he come to the Clinic and that if he preferred she would sit outside with him.[151]

123. The deceased said he was going home for a shower and would come back to the Clinic at 1.30 pm. Ms Lewis made a notation that there were no beds available on the APU at that time and she contacted Ms Potter to update her on the deceased's contact with the Clinic.[152]

---

[146] Letter - Mr S Potter (27.05.16)
[147] Letter - Mr S Potter (27.05.16)
[148] ts 20.05.19 (Lewis), p66
[149] Exhibit 1, Vol. 3, Tab 1.2, Service Event Details (09.02.16: 11.25 am)
[150] Exhibit 1, Vol. 3, Tab 1.2, Service Event Details (09.02.16: 11.30 am)
[151] Exhibit 1, Vol. 3, Tab 1.2, Service Event Details (09.02.16: 12.15 pm)
[152] Exhibit 1, Vol. 3, Tab 1.2, Service Event Details (09.02.16: 12.15 pm)

124. At 1.30 pm, the deceased presented at the Clinic and was seen by Ms Lewis. They discussed his attendance at the emergency department over the weekend and he said he had been feeling more anxious but denied feelings of paranoia. The deceased confirmed he had not been at work for a few days but declined a medical certificate.[153]

125. The deceased told Ms Lewis that the Abilify was not helping and in fact, was making his anxiety worse. He asked for risperidone tablets as they had been helpful in the past. He denied thoughts of harming himself or others and agreed to be followed up by Ms Lewis in two days. Ms Lewis had no concerns about his safety at this time.[154]

126. Ms Lewis contacted Dr Brett who agreed to the deceased's request for risperidone tablets. The tablets were subsequently collected from the hospital pharmacy by the deceased and Ms Lewis. Dr Brett told Ms Lewis he would review the deceased's depot medication at his next appointment and probably change it back to risperidone or paliperidone.[155,156]

127. After the assessment, Ms Lewis called Ms Potter's landline to update her, but there was no reply and she left a message.[157] At 3.00 pm, Ms Potter called in at the Clinic to see Ms Lewis who had already left for the day. Ms Potter spoke to another caseworker (and later to Dr Khoja in consultation with Dr Costello).[158]

128. Ms Potter told the caseworker that she was concerned that the deceased's condition had recently deteriorated and he had not been detained when he presented to the emergency department on 7 February 2016.[159] Ms Potter said the deceased was able to "*put on a good act*" and "*mask his symptoms*".[160]

---

[153] Exhibit 1, Vol 3, Tab 1.2, Service Event Details (09.02.16: 1.30 pm) and ts 20.05.19 (Lewis), p65
[154] Exhibit 1, Vol 3, Tab 1.2, Service Event Details (09.02.16: 1.30 pm) and ts 20.05.19 (Lewis), p65
[155] Exhibit 1, Vol 3, Tab 1.2, Service Event Details (09.02.16: 1.30 pm)
[156] Exhibit 1, Vol. 1, Tab 10, Statement - Dr A Brett, paras 20-21
[157] Exhibit 1, Vol 3, Tab 1.2, Service Event Details (09.02.16: 2.20 pm)
[158] Exhibit 1, Vol 3, Tab 1.2, Service Event Details (09.02.16: 3.00 pm)
[159] This is inconsistent with the triage form of the deceased's presentation at the emergency department on 07.02.16, which records that both the deceased and Ms Potter were "*OK*" with a plan that he be discharged and followed up by the Clinic [see: Exhibit 1, Vol. 3, Tab 1.2, Triage Form (07.02.16)]
[160] Exhibit 1, Vol 3, Tab 1.2, Service Event Details (09.02.16: 3.00 pm)

129. Ms Potter also expressed concern that she had not been advised about the change to the deceased's depot medication. She said that the deceased had deteriorated since Friday (06.02.16) and that if she had known about the medication change earlier, she would have contacted the Clinic to report early signs of concern.[161]

130. Despite this evidence, I note that Ms Potter appears to have been aware of the deceased's medication change by at least 7 February 2016, because she mentioned it in the context of the deceased's behaviour having changed when she contacted RuralLink (07.02.16: 1.05 pm).[162] Ms Potter also mentioned the medication change to the PLN when she accompanied the deceased to the emergency department at Bunbury Hospital on 7 February 2016.[163]

131. Ms Potter asked for confirmation that the deceased had attended the Clinic and expressed concern that he had not been admitted to the APU. She was told that the deceased had attended the Clinic requesting oral medication. Ms Potter said she was unhappy about this and that it was unlikely that the deceased would comply with oral medication.[164]

132. The caseworker reminded Ms Potter that the deceased did not want his care discussed with family members and outlined the limitations of confidentiality. Ms Potter said she was frustrated that the deceased was "*pulling the wool over everyone's eyes*" and was "*allowed to walk away*". Ms Potter asked about how she could be more involved in the deceased's care and the role of the MHRB was discussed with her.[165]

133. The caseworker explained that because the deceased had sought additional treatment voluntarily he needed to be given the opportunity to comply, before being admitted as an involuntary patient under the MHA. Ms Potter is recorded to have said that she would contact police if she had any further concerns about the deceased or his whereabouts.[166]

---

[161] Exhibit 1, Vol. 3, Tab 1.2, Service Event Details (09.02.16: 3.00 pm)
[162] Exhibit 1, Vol. 3, Tab 1.2, Triage Form – RuralLink (07.02.16: 1.05 pm)
[163] Exhibit 1, Vol. 3, Tab 1.2, Triage Form (07.02.16)
[164] Exhibit 1, Vol. 3, Tab 1.2, Service Event Details (09.02.16: 3.00 pm)
[165] Exhibit 1, Vol. 3, Tab 1.2, Service Event Details (09.02.16: 3.00 pm)
[166] Exhibit 1, Vol. 3, Tab 1.2, Service Event Details (09.02.16: 3.00 pm)

134. The caseworker consulted with Dr Khoja and Dr Costello who both expressed the view that because the deceased had sought additional treatment, he needed to be given the opportunity to comply with the oral medication which he had agreed to take.[167]

135. Nevertheless, Dr Costello clearly recognised the delicate nature of the situation because he asked that if the deceased presented to the emergency department, he be considered as "*a low threshold for admission to the APU*" and this was conveyed to Ms Potter. The caseworker advised the PLN of the situation at 5.30 pm.[168]

Contact with Bunbury Police – 10 February 2016

136. According to Mr Potter, on the morning of Wednesday, 10 February 2016, Ms Potter phoned the Bunbury police station to express her concerns about the deceased's mental state and that he might harm himself. Police apparently contacted the Clinic at about 9.00 am and then called Ms Potter back to say they had been told that the deceased "*was complying with his treatment, presented well and that there were no grounds on which to detain him.*"[169]

137. Whilst I was unable to locate any record of this interaction in the Clinic's records, the advice the police are said to have been given by the Clinic is consistent with the documentation recording the interactions on 9 February 2016 between the Clinic and the deceased and the Clinic and Ms Potter respectively.[170,171]

Contact with SWMHS – 10 February 2016

138. At 11.05 am on 10 February 2016, the deceased called the Clinic asking for another prescription for risperidone as he could not recall where he had left the medication he had been given the previous day. He was asked to come to the Clinic, which he subsequently did.[172]

---

[167] Exhibit 1, Vol. 3, Tab 1.2, Service Event Details (09.02.16: 3.00 pm)
[168] Exhibit 1, Vol. 3, Tab 1.2, Service Event Details (09.02.16: 3.00 pm)
[169] Letter - Mr S Potter (27.05.16)
[170] Exhibit 1, Vol. 3, Tab 1.2, Service Event Details (09.02.16: 1.30 pm) and ts 20.05.19 (Lewis), p65
[171] Letter - Mr S Potter (27.05.16)
[172] Exhibit 1, Vol. 3, Tab 1.1, Service Event Details (10.02.16: 11.05 am)

139. Coincidently, while the deceased was in the waiting room at the Clinic, his father called the Clinic. There had been limited contact between Mr Potter and the deceased for some 18 months but the night before, the deceased had arrived unannounced at Mr Potter's farm, some 200 kilometres from the deceased's home.[173]

140. The Clinic's file note of the conversation records that Mr Potter said the deceased told him that he (the deceased) had been bad and deserved to be punished. Mr Potter said the deceased's visit was unexpected and that the deceased appeared: "*very quiet, suspicious, confused thoughts, morose, sad, couldn't settle and looking very tired".*[174]

141. Mr Potter said that at midnight when he and his wife went to bed, the deceased was still awake in the lounge. When Mr Potter went to check on the deceased at 4.00 am, he had already gone. Mr Potter is recorded as having told the caseworker that the deceased's relationship with his twin brother was the one to keep strong as he was the main person that the deceased trusted.[175]

142. In a letter to the Court dated 27 May 2015, Mr Potter states:

> "*I very clearly told* [the caseworker] *that I believed Mark's depression was so deep that I held grave fears he may kill himself. In particular I mentioned "suicide by gumtree" on at least two occasions in this conversation*".[176]

143. The Clinic's file note of this conversation records Mr Potter expressing concerns that the deceased was "*very unwell*". There is no mention in that file note of any concerns directly relating to suicide and the phrase "*suicide by gumtree*" does not appear.[177]

144. If the phrase "*suicide by gumtree*" was used by Mr Potter as he recalls, it is difficult to understand why it would not have been recorded in the caseworker's notes of their conversation.

---

[173] Exhibit 1, Vol. 3, Tab 1.1, Service Event Details (10.02.16: 11.05 am)
[174] Exhibit 1, Vol. 3, Tab 1.1, Service Event Details (10.02.16: 11.05 am)
[175] Exhibit 1, Vol. 3, Tab 1.1, Service Event Details (10.02.16: 11.05 am)
[176] Letter - Mr S Potter (27.05.16)
[177] Exhibit 1, Vol. 3, Tab 1.1, Service Event Details (10.02.16: 11.05 am)

145. The caseworker was clearly aware that the deceased was in the Clinic reception waiting to see Dr Soliman and information of this nature would obviously have been very important. The file note records the fact that the caseworker had a brief discussion with Dr Soliman and provided him with "*the new information*" gleaned from speaking to Mr Potter.[178]

146. Dr Soliman was adamant that the caseworker did not tell him either that there were concerns that the deceased was at risk of suicide or that Mr Potter had used the phrase "*suicide by gumtree*" with respect to the deceased.[179]

147. In any event, the issue of why the words used by Mr Potter were not recorded (if his recollection of events is correct), was overtaken by the fact that the deceased was the subject of a detailed review by Dr Soliman shortly after Mr Potter's conversation with the caseworker.[180]

148. At the inquest, Dr Soliman was asked whether it would have made any difference to his assessment of the deceased had he been told that Mr Potter had concerns that the deceased was at risk of suicide. Dr Soliman's response was:

> "*We would still have to do a risk assessment relating to suicide risk assessments. It becomes very difficult because I would need to confront him, perhaps, that there were concerns raised by family members about you having suicidal thoughts and perhaps asking about that because when I did ask him about suicidal thoughts, he denied it. And, I guess, I would need to challenge that, perhaps.*"[181]

149. In passing, I note that the Clinic records contain two versions of the file note recording the conversation between Mr Potter and the caseworker on 10 February 2016. The file notes are in identical terms, but one has a footer bearing the date 10 February 2016,[182] whilst the other's footer is dated 17 February 2016.[183]

---

[178] Exhibit 1, Vol. 3, Tab 1.1, Service Event Details (10.02.16: 11.05 am)
[179] ts 21.05.19 (Soliman), p116
[180] Exhibit 1, Vol. 3, Tab 1.2, Integrated Progress Notes - Dr I Soliman (10.02.16: 11.30 am)
[181] ts 21.05.19 (Soliman), p126
[182] Exhibit 1, Vol. 3, Tab 1.1, Service Event Details (10.02.16: 11.05 am)
[183] Exhibit 1, Vol. 3, Tab 1.2, Service Event Details (10.02.16: 11.05 am)

150. I sought an explanation for this discrepancy, and in an email addressed to Counsel Assisting, Ms Paljetak (counsel for WACHS) said that her instructions were:

> "*that the date stamp in the footer of a Service Event Detail document refers to the date that the document was printed from PSOLIS, not when the document was written or created.*"[184]

151. It follows that the two versions of the file note relating to 10 February 2016 were printed on different days. Although it is not clear why two versions of the document were printed, given that they are identical, nothing appears to turn on the fact that the footer dates are one week apart.

Dr Soliman's Assessment – 10 February 2016

152. The deceased was reviewed by Dr Soliman at 11.30 am on 10 February 2016. The reason for the deceased's attendance at the Clinic was that he was asking for an additional prescription for risperidone to help with his anxiety as he said he had misplaced the medication he had received the day before.[185]

153. Dr Soliman's detailed file note of his assessment of the deceased refers to information the caseworker conveyed to him from Mr Potter. Dr Soliman was aware of the deceased's visit to Mr Potter's farm, that he hadn't slept well, appeared anxious and had expressed guilt. Dr Soliman was also aware that the deceased had left Mr Potter's farm early that morning and that Mr Potter had asked that none of this information be divulged to the deceased.[186]

154. The deceased told Dr Soliman he had been feeling anxious for two months since changing his depot medication to Abilify. He said he did not like Abilify and preferred to go onto risperidone tablets. On assessment, the deceased was guarded and minimised his symptoms.[187]

---

[184] Email from Ms Paljetak to Counsel Assisting (22.05.19)
[185] Exhibit 1, Vol. 3, Tab 1.2, Integrated Progress Notes - Dr I Soliman (10.02.16: 11.30 am)
[186] Exhibit 1, Vol. 3, Tab 1.2, Integrated Progress Notes - Dr I Soliman (10.02.16: 11.30 am)
[187] Exhibit 1, Vol. 3, Tab 1.2, Integrated Progress Notes - Dr I Soliman (10.02.16: 11.30 am)

155. When asked to describe his anxiety more fully he gave limited information although he did refer to "*crowds*" and "*tightness in the chest*". The deceased specifically denied feeling paranoid or that someone was trying to harm him and denied feeling fearful.[188]

156. At the inquest, Dr Soliman was asked whether he was aware that the deceased had a history of minimising symptoms and his response was:

> "*Yes. And it's not uncommon for people with a psychotic illness to do so…they can be minimising of symptoms or be guarded about their symptoms and I think in Mark's case, he had a long history of being guarded. However, when Mark is…unwell the paranoid thoughts spontaneously express themselves and I think…when Mark presented there wasn't that level of psychotic symptoms that were evident.*"[189]

157. The deceased reported poor sleep and said he thought risperidone would help in this regard. He said that he had taken time off work because his anxiety had affected his ability to communicate but that he wanted to return to work the following week.[190]

158. The deceased described feeling depressed for years since his divorce but said he "*just got on with it*" and still enjoyed going for walks and swimming. He was asked if he had feelings of guilt and he said he did and that these feelings related to having treated his family badly and that he had "*said things*" about his mother and father which he shouldn't have said, but did not wish to elaborate.[191]

159. Dr Soliman was asked whether, if he had taken the view that the deceased was experiencing a depressive episode at the time of his assessment, involuntary admission as an inpatient would have been warranted. Dr Soliman did not consider this would have been appropriate and in fact, thought it could have been counterproductive.[192]

---

[188] Exhibit 1, Vol. 3, Tab 1.2, Integrated Progress Notes - Dr I Soliman (10.02.16: 11.30 am)
[189] ts 21.05.19 (Soliman), p122
[190] Exhibit 1, Vol. 3, Tab 1.2, Integrated Progress Notes - Dr I Soliman (10.02.16: 11.30 am)
[191] Exhibit 1, Vol. 3, Tab 1.2, Integrated Progress Notes - Dr I Soliman (10.02.16: 11.30 am)
[192] ts 21.05.19 (Soliman), p121

160. The deceased had come into the Clinic of his own volition and was actively seeking treatment. Dr Soliman thought that if the deceased had been admitted to hospital against his will: "*…that could have caused some damage to an already fragile therapeutic relationship.*"[193]

161. Dr Soliman noted that the deceased appeared anxious and apprehensive but had expressed no delusional thoughts and no overt paranoid thoughts. Dr Soliman noted:

> "*Collateral history suggests recent decompensation in mental state since change of depot medication. Mark does not present as psychotic however he is guarded and minimising of symptoms. Mark has initiated contact with the service today and yesterday on his own accord & has asked for medications. Denies thoughts of self-harm or harm to others. There is no previous history of self-harm / harm to others.*
>
> ***At this interview, not able to detain in hospital. He is requesting medications & is attending the clinic on his own accord.***"[194] (emphasis added)

162. Dr Soliman offered the deceased a voluntary admission to hospital, which the deceased declined.[195] With respect to his decision not to admit the deceased to the APU involuntarily, Dr Soliman said:

> "*I considered an admission to hospital, which he declined, and at the same time I considered admitting under the Mental Health Act. And I felt that under the Mental Health Act obligations…I would not be able to detain him because he was asking for medications and he was presenting on his own accord. And the Mental Health Act stipulates that it has to be the least restrictive option, and given the fact that he was happy to attend clinic and return for further reviews, I felt that that was appropriate.*[196]

---

[193] ts 21.05.19 (Soliman), p121
[194] Exhibit 1, Vol. 3, Tab 1.2, Integrated Progress Notes - Dr I Soliman (10.02.16: 11.30 am)
[195] ts 21.05.19 (Soliman), p125
[196] ts 21.05.19 (Soliman), p125

163. Before he left the clinic, the deceased was encouraged to take the risperidone tablets and he said he would speak to Ms Lewis the following day. Mr Potter was informed of the outcome of Dr Soliman's assessment and advised to contact the Clinic again if there was any change or further concerns.[197]

Attempts to contact the deceased: 11-12 February 2016

164. At 12.35 pm on Thursday, 11 February 2016, Ms Lewis rang the deceased but there was no answer. She left a message asking him to either contact her or come into the Clinic.[198]

165. At 11.25 pm on Friday, 12 February 2016, Ms Lewis rang the deceased but again there was no answer. She left a further message asking him to either contact her or come into the Clinic. The file note for this contact also notes that Ms Lewis was told by a PLN from Bunbury Hospital that they were holding a bed for the deceased on the APU.[199]

Contact with the deceased - 12 February 2016

166. At about 1.00 pm on 12 February 2016, Ms Lewis called Ms Potter but there was no reply so she left a message.[200] At 2.15 pm, the deceased called Ms Lewis. She thought his voice sounded croaky and he said he was "*pretty crook*", had stomach cramps and was a "*bit flu like*". He said he had been taking his risperidone tablets and they had made things "*a bit easier*". He told Ms Lewis he had recently visited his father to apologise for things he had said to him in the past.[201]

167. Ms Lewis offered to do a home visit but the deceased said he wasn't feeling physically well enough and would call back on Monday (15.02.16) if he wasn't any better. However, he said his plan was to return to work on Monday (15.02.16). He told Ms Lewis if he was feeling better on the weekend, he would "*do a bit of shopping*".[202]

---

[197] Exhibit 1, Vol. 3, Tab 1.2, Service Event Details (10.02.16: 11.05 am)
[198] Exhibit 1, Vol. 3, Tab 1.2, Service Event Details (11.02.16: 12.35 pm)
[199] Exhibit 1, Vol. 3, Tab 1.2, Service Event Details (12.02.16: 11.25 am)
[200] Exhibit 1, Vol. 3, Tab 1.2, Service Event Details (12.02.16: 1.00 pm)
[201] Exhibit 1, Vol. 3, Tab 1.2, Service Event Details (12.02.16: 2.15 pm)
[202] Exhibit 1, Vol. 3, Tab 1.2, Service Event Details (12.02.16: 2.15 pm)

168. After speaking to the deceased by phone, Ms Lewis did not feel there was any basis on which the deceased could be admitted the APU as an involuntary patient. She expressed her assessment of the deceased in the following terms:

> "*he spoke to me so he was engaging on the phone. He was forward planning. He said he was taking the tablets. And he was logical on the phone and polite and very engaging.*"[203]

169. At the inquest, Ms Lewis was asked about her assessment of the deceased in the face of concerns which had been raised by the deceased's mother and father.[204] Ms Lewis replied that the deceased had said he was feeling anxious but was not displaying any psychotic symptoms and that:

> "*I was aware of Mum's concerns. I'm aware that Dad had rung and I was aware that Dr Soliman had seen Mark on the Wednesday. So I had all of that information with me. I had the interaction with Mark on the phone and how he was towards me and what he was planning to do on the weekend and Monday.*[205]

170. At the inquest, Ms Lewis confirmed her view, that the deceased's level of engagement on the phone during their conversation "*was sufficient*" for her to make an assessment that he did not require involuntary admission as an inpatient at that time.[206]

171. At 2.30 pm, Ms Lewis discussed the deceased's case with Dr Costello who asked Ms Lewis to contact Ms Potter to obtain "*updated collateral information*".[207] I note that Dr Costello did not ask Ms Lewis to conduct a face to face assessment. In any event, Ms Lewis rang Ms Potter's landline at 2.35 pm. There was no reply and she left a message, saying she had spoken to the deceased and asking Ms Potter to call when she was able to.[208]

---

[203] ts 20.05.19 (Lewis), p69
[204] ts 20.05.19 (Lewis), p69
[205] ts 20.05.19 (Lewis), p69
[206] ts 20.05.19 (Lewis), p70
[207] Exhibit 1, Vol. 3, Tab 1.2, Service Event Details (12.02.16: 2.30 pm)
[208] Exhibit 1, Vol. 3, Tab 1.2, Service Event Details (12.02.16: 2.35 pm)

172. Ms Lewis said she did not attempt to call Ms Potter's mobile because in her assessment: "*it wasn't an urgent situation. So that's why I left a message*".[209] When asked if she gave any further consideration to getting an update from Ms Potter about how the deceased was travelling, Ms Lewis said:

> "*No. Because I was aware that Mum and Dad had the phone number for the clinic. So I thought they would have contacted* [if] *they had further* concerns".[210]

173. Given that Dr Costello had asked Ms Lewis to obtain updated collateral information from Ms Potter, it is unfortunate that Ms Lewis was not able to speak with Ms Potter on that day. It is impossible to know whether any information Ms Potter might have provided about the deceased's condition would have prompted any action on the part of Ms Lewis, but at the very least Ms Potter would have been able to convey her previous concerns about the deceased's mental state.

174. At 2.37 pm, Ms Lewis called the PLN at Bunbury Hospital to cancel the bed being held in the deceased's name.[211] As to the rationale for this decision, Ms Lewis said:

> "*when I first knew that Mark had gone to* (the) *emergency department and there were some concerns from the family, part of my usual practice if there's some concerns about a client is to see what the bed availability is.*
>
> *So I had that as an option if I needed it. So we had held it all that week given that we were having contact with Mark and monitoring what was happening…as I spoke to him on the Friday there wasn't any plans for him to be coming in.*
>
> *I hadn't identified there was a need for him to come in. He was future planning. I rang and said that at this stage we didn't need to keep holding that…bed.*"[212]

---

[209] ts 20.05.19 (Lewis), pp69-70
[210] ts 20.05.19 (Lewis), p78
[211] Exhibit 1, Vol. 3, Tab 1.2, Service Event Details (12.02.16: 2.37 pm)
[212] ts 20.05.19 (Lewis), p70

175. There is evidence that on her return home, Ms Potter called Ms Lewis but no one from the deceased's treating team was available as they had apparently all left for the day. Further, there were no after-hours or mobile numbers which Ms Potter could call. In his letter of 27 May 2016, Mr Potter says that no one at the Clinic was aware of why Ms Lewis had called Ms Potter.[213]

176. Ms Lewis was satisfied that the deceased was engaged with SWMHS, he told her he was taking his risperidone medication as prescribed and he displayed evidence of future planning.[214] Given her positive interaction with the deceased on the phone, the decision by Ms Lewis to relinquish the APU bed is perhaps understandable.

177. However, whether Ms Lewis would have made the same decision had she been able to obtain collateral information from Ms Potter is impossible to know.

Contact with the deceased - 13 February 2016

178. On the morning of 13 February 2016, Mr Potter says that his wife discovered that the deceased had left his oral medication at the farm. Mr Potter called the Clinic but unfortunately, it appears that his call was directed to staff at the APU at Bunbury Hospital, who had no knowledge of the deceased.[215]

179. Mr Potter says he was told by a person called "*Matt*" that there was no one from the deceased's treating team available to speak to him and he would have to call the Clinic on Monday.[216]

180. Mr Potter says he told Matt that he was concerned that the deceased was un-medicated and had confused thinking and wildly fluctuating moods. Mr Potter says he told Matt he was concerned that the deceased would kill himself. Mr Potter says that Matt told him that if he was concerned about the deceased's safety, he (Mr Potter) should call the police.[217]

---

[213] Letter - Mr S Potter (27.05.16)
[214] ts 20.05.19 (Lewis), p70
[215] Letter - Mr S Potter (27.05.16)
[216] Letter - Mr S Potter (27.05.16)
[217] Letter - Mr S Potter (27.05.16)

181. Mr Potter says he knew the police would be unable to do anything on the basis of Ms Potter's interaction with them on 10 February 2016. Mr Potter says that Matt told him he would make a record of their conversation and that a member of the deceased's treating team would call Mr Potter on the Monday (15.02.16).[218]

182. There appears to be no record of this conversation and in any event, the mechanism by which such information would be passed on to the Clinic by staff was not made clear.

183. It is impossible to know whether, had the Police been contacted by Mr Potter, they would have spoken to either the PLN at Bunbury Hospital or a worker at RuralLink. Further, it is impossible to know whether, had either of these things occurred, any action would have been taken with respect to the deceased.

184. It is not clear whether Mr Potter contacted either Ms Potter or the deceased's brother to alert them to the fact that the deceased had left his oral medication at Mr Potter's farm and/or that he (Mr Potter) had called the Clinic and spoken to a staff member who had advised him to call the police if he was concerned about the deceased's mental state.

185. In any event, on the morning of 13 February 2016, the deceased went to his mother's workplace. She thought he was: "*very withdrawn, quiet and appeared depressed*". The deceased left shortly after he bought his mother a coffee and she left work at about Noon. During the rest of the day, the deceased was either at her house or was visiting his brother. The deceased and his mother made plans to go for a drive around Bunbury at 11.00 am the following day and the deceased went home.[219]

The events of 14 February 2016

186. As planned, on the morning of 14 February 2016, the deceased and Ms Potter went for a drive around Bunbury and then walked around the inner estuary area.[220]

---

[218] Letter - Mr S Potter (27.05.16)
[219] Exhibit 1, Vol. 1, Tab 8, Statement - Ms S Potter, paras 53-59
[220] Exhibit 1, Vol. 1, Tab 8, Statement - Ms S Potter, para 60

187. Ms Potter thought the deceased was "*still quiet*" and he invited her to his house for dinner. She said she had dinner cooking and instead invited him to come to her. The deceased left Ms Potter's house at about 4.00 pm but returned at 6.00 pm before leaving again to visit a friend at about 7.00 pm.[221]

188. The deceased arrived back at Ms Potter's house at about 7.30 pm and had some dinner. He said he felt a bit sick and lay down on the lounge at about 8.00 pm. She put a blanket over him and went outside so as not to disturb him.[222]

189. When the deceased woke up, Ms Potter told him he looked really tired and suggested he have a "*proper lay down*" in one of her bedrooms. Although the deceased lay down for a short time he got up and said he felt he would sleep better in his own bed. Before he left, he talked about doing mosaics and he and Ms Potter discussed what they would do the following weekend. They also spoke about a tree the deceased was going to take home, but he said he would collect it the following day. The deceased left Ms Potter's home at about 9.30 pm.[223]

190. I note that other than her earlier observation about the deceased still seeming quiet and her later observation that he looked really tired, Ms Potter's statement to Police dated 18 March 2016 does not refer to any concerns she had on 14 February 2016, that the deceased was at risk of suicide or self-harm. Her statement makes it clear that the deceased was talking about the future and making plans for the following weekend.

191. At about 9.50 pm, Ms Potter received a phone call from the deceased's brother to say that the deceased had sent him a text message saying "*Buy Stu Luv Ya Bro*". Ms Potter drove to the deceased's house and when she arrived, she could hear the deceased's TV and she noticed that the lounge light was on. She knocked on the door but there was no response and she went across to a neighbour she knew the deceased sometimes visited.[224]

---

[221] Exhibit 1, Vol. 1, Tab 8, Statement - Ms S Potter, paras 61-64
[222] Exhibit 1, Vol. 1, Tab 8, Statement - Ms S Potter, paras 64-66
[223] Exhibit 1, Vol. 1, Tab 8, Statement - Ms S Potter, paras 67-72
[224] Exhibit 1, Vol. 1, Tab 8, Statement - Ms S Potter, paras 73-80

192. The deceased wasn't at the neighbour's house and by the time Ms Potter returned to the deceased's house, the deceased's brother had arrived. Ms Potter and the deceased's brother knocked on the deceased's door but again, there was no reply. After smashing a lounge room window, they gained access to the deceased's house.[225]

193. They noticed that a bedroom across from the laundry was locked and they banged on the bedroom door and yelled at the deceased to open it. While standing at the door, Ms Potter heard a soft thud.[226]

194. By this stage, police had arrived at the deceased's home. With the assistance of ambulance officers who had also arrived, they removed the bedroom door from its hinges and went inside. When the door was removed, Ms Potter saw the deceased sitting on the floor. She could only see one foot and noticed that the deceased's toes were blue.[227]

195. Ambulance officers noted that the deceased had used a bed to barricade the door. The deceased was in a seated position with a power cord wrapped around his neck and tied to a bedpost. There were no signs of life, his pupils were fixed and dilated, he had mottled skin and there was no heart activity.[228,229]

196. Police examined the scene and determined that there was no criminality associated with the deceased's death. A photograph of the deceased with his daughter was found lying on the bed close to the deceased.[230]

197. Ambulance officers certified the deceased's death at 10.40 pm on 14 February 2016.[231]

---

[225] Exhibit 1, Vol. 1, Tab 8, Statement - Ms S Potter, paras 80-86
[226] Exhibit 1, Vol. 1, Tab 14, Statement - Ms V Lewis, paras 87-90
[227] Exhibit 1, Vol. 1, Tab 14, Statement - Ms V Lewis, paras 96-97
[228] Exhibit 1, Vol. 1, Tab 7B, St John Ambulance Patient Care Record
[229] Exhibit 1, Vol. 1, Tab 2, Police Report, p2
[230] Exhibit 1, Vol. 1, Tab 2, Police Report, p2
[231] Exhibit 1, Vol. 1, Tab 4, Life Extinct Form

CAUSE AND MANNER OF DEATH

198. Dr Cooke, a forensic pathologist, conducted a post mortem examination of the deceased's body on 16 February 2016. Dr Cooke found a mark to the skin of the deceased's neck consistent with the ligature that was looped around the deceased's neck.[232]

199. The right greater horn of the deceased's hyoid bone was fractured and there was mild hardening and narrowing of one of the arteries supplying blood to the deceased's heart (focal coronary arteriosclerosis). The deceased's lungs were also congested but this is a non-specific finding.[233]

200. Toxicological testing found the medication aripiprazole (Abilify) in the deceased's system but was negative for alcohol, amphetamines, benzodiazepines, cannabinoids, opiates and other common drugs.[234]

201. Significantly, I note that there is no reference in the toxicology report to risperidone, which the deceased had told Clinic staff he was taking, having been detected.[235] This leaves open the inference that contrary to what the deceased had told Clinic staff, at the time of his death he was not in fact taking this medication.

202. Dr Cooke expressed the opinion that the cause of death was ligature compression of the neck (hanging).[236]

203. I accept and adopt that conclusion.

204. I find that death occurred by way of Suicide.

[232] Exhibit 1, Vol. 1, Tab 6, Post Mortem Report
[233] Exhibit 1, Vol. 1, Tab 6, Post Mortem Report
[234] Exhibit 1, Vol. 1, Tab 7A, Toxicology Report
[235] Exhibit 1, Vol. 1, Tab 7A, Toxicology Report
[236] Exhibit 1, Vol. 1, Tab 6, Post Mortem Report

QUALITY OF SUPERVISION, TREATMENT AND CARE

205. After reviewing the evidence, I consider that the supervision, treatment and care provided to the deceased in the period prior to February 2016, was adequate.

206. With respect to the period leading up to the deceased's death, I accept that clinicians at SWMHS were aware that the deceased's mental state was deteriorating. At key stages, the deceased was assessed as not warranting inpatient admission on an involuntary basis.

207. On 10 February 2016 when Dr Soliman conducted a detailed assessment of the deceased. At that time, the basis for not admitting the deceased as an involuntary patient to the APU was that the deceased had presented to the clinic on his own volition, had asked for oral medication and had agreed to be followed up. All of this was viewed in a very positive light.

208. With the benefit of hindsight, the strong reservations held by Ms Potter about the deceased's likely compliance with oral medication, might have been given more weight and led to this development being viewed more cautiously by clinicians.[237]

209. In expressing concern about the deceased's likely non-compliance with oral medication, it seems that Ms Potter considered his request as more likely to be aimed at stopping medication altogether. In other words, if the deceased could establish himself on oral medication, he might then argue to come off depot medication, then stop taking his tablets and thereby be un-medicated.

210. As it happened, at the time of his death, the deceased was "covered" in a medication sense by his last depot injection. However, as if to prove that Ms Potter's concerns about the deceased's non-compliance with oral medication were valid, post mortem toxicological tests failed to detect risperidone in his system at the time of his death.[238]

---

[237] ts 20.05.19 (Brett), p53
[238] Exhibit 1, Vol. 1, Tab 7A, Toxicology Report

211. I note that even if the deceased's request for oral medication had been viewed more cautiously, there is still the fact that the deceased had come into the Clinic and had agreed to be followed up by his case manager, Ms Lewis.

212. Dr Pascu (who at the Court's request, completed a review of the deceased's care) said she: "*would have been accepting of the fact that a community treatment order was continued*". She noted that whilst the deceased's mood was lower on 10 February 2016, he was open to follow up by his case manager, had plans to return to work, was accepting that he required some treatment and specifically denied self-harm ideation.[239]

213. Dr Pascu expressed the opinion that Dr Soliman's decision not to admit the deceased as an involuntary patient was appropriate, saying she was: "*not convinced that being admitted to a secure environment would have been appropriate*"[240] and she further opined that the relevant provisions of the MHA had been complied with.[241]

214. In my view, Dr Soliman's assessment was thorough and detailed and his decision not to arrange for the deceased's involuntary admission following that assessment was, in all the circumstances, reasonable. The deceased had no history of previous suicide attempts and the collateral history from Mr Potter was, taken at its highest, to the effect that he (Mr Potter) had concerns that the deceased was at risk of suicide.

215. I note there is no evidence that any of the deceased's family ever reported that the deceased was expressing thoughts of suicide or self-harm.

216. Although Ms Lewis did attempt to contact the deceased on 11 February 2016, he did not answer her call. The question of whether Ms Lewis should have made further attempts to contact the deceased on that day was overtaken by the fact that when she rang and left a message on 12 February 2016, he called her back.

---

[239] ts 21.05.19 (Pascu), p88
[240] ts 21.05.19 (Pascu), p88
[241] Exhibit 1, Vol. 1, Tab 11, Report - Dr V Pascu, para 81

217. When she spoke to the deceased by phone on 12 February 2016, Ms Lewis found the deceased to be very engaging. He told her he was taking his risperidone tablets and showed evidence of forward planning. On the basis of this interaction, she formed a positive impression of his mental state at that time, and did not consider that an involuntary admission to the APU was warranted. Indeed, after speaking with the deceased and conferring with Dr Costello, Ms Lewis released the APU bed that had been tentatively held for the deceased in case it was required.

218. Ms Lewis did offer to visit the deceased at home, but he declined saying he was physically unwell. On the face of it, the positive assessment that Ms Lewis made after her interaction with the deceased might be considered sufficient justification to have decided not to admit the deceased as an involuntary inpatient. Ms Lewis did discuss the deceased's case with Dr Costello and other than ask her to obtain collateral information from the deceased's mother, Dr Costello does not appear to have considered that further action on the part of Ms Lewis was warranted.

219. I note that on 13 February 2016, Ms Potter considered that the deceased was "*very withdrawn, quiet and depressed*" and that on 14 February 2016, she thought he was "*still quiet*" and "*very tired*". However, there is no evidence that on either 13 or 14 February 2016, Ms Potter considered that the deceased was a self-harm risk, despite the fact that she spent some hours with him on both days.

220. In particular, there is no evidence that during the period 13 - 14 February 2016, Ms Potter contacted RuralLink, the PLN at Bunbury Hospital or the Police to express any concerns about the deceased's mental state. I make that observation not to be critical of Ms Potter, but rather to illustrate the impossibility of predicting whether a person (in this case, the deceased) is more likely to take their life at any particular point in time.

221. Although I accept that Ms Lewis was justified in implementing a plan to follow the deceased up on 15 February 2016, it is unfortunate that she was not able to speak with Ms Potter on 12 February 2016 and therefore factor any concerns into her assessment of the deceased's presentation during her conversation with him on the phone.

222. At the time Ms Lewis made her assessment of the deceased on 12 February 2016, she was aware of the concerns that had been expressed by both Mr Potter and Ms Potter. However, given that there is no record of what Mr Potter says he told clinic staff on 10 February 2016 or "*Matt*" from the APU (i.e.: that the deceased was at risk of suicide) this information, if conveyed in the manner suggested by Mr Potter, was not before Ms Lewis at the time of her phone conversation with the deceased.

223. Had Ms Lewis spoken to Ms Potter on 12 February 2016, Ms Potter's concerns for the deceased's mental state could have been listened to and there is at least the possibility that those concerns may have impacted on the assessment Ms Lewis made of the deceased at that time. Whether this would have been enough to have prompted an involuntary inpatient admission at that time is impossible to know. Objectively, this is perhaps unlikely, given what was assessed by Ms Lewis as a positive interaction with the deceased during their phone conversation on that day.

224. At various stages in her evidence at the inquest, Dr Pascu expressed the opinion that a face to face review of the deceased on 12 February 2016 by a psychiatrist, would have been preferable.[242] However, Dr Pascu also considered that where an initial phone assessment by the patient's caseworker was satisfactory, a face to face assessment may not be necessary,[243] a view with which Dr Crampin concurred.[244]

225. Critically, Dr Pascu observed that the validity of any assessment depended on the strength of the therapeutic relationship that existed between the patient and the worker conducting the assessment.[245] In the face of the concerns being expressed by the deceased's family, Dr Pascu expressed the view that a greater effort should have been made to contact the deceased's family on 12 February 2016 to check the family's assessment of the deceased, in the face of the deceased's positive self-report.[246] In my view, it is difficult to disagree with that assessment.

---

[242] ts 21.05.19 (Pascu), pp91-94
[243] ts 21.05.19 (Pascu), p96
[244] ts 20.05.19 (Crampin), p23
[245] ts 21.05.19 (Pascu), p92
[246] ts 21.05.19 (Pascu), p111 & p113

226. The decision to allow the deceased to continue in the community on a CTO was based partly on the fact that the deceased had approached the Clinic voluntarily to request medication. In order to promote trust and strengthen the therapeutic relationship, it was decided to give the deceased the opportunity to prove that he could be compliant with oral medication, even though this had been an area of significant concern in the past.

227. The family's position is that there is no need to view this case with the benefit of hindsight. From their perspective, the deceased's mental state was deteriorating rapidly and he was in urgent need of involuntary hospitalisation. The deceased's family say that this was obvious to them at the relevant time and should have been obvious to clinicians.[247,248] This is a very understandable perspective, especially considering the fact that the deceased did in fact take his life.

228. With respect to the family's concerns about the deceased's welfare at the relevant time, Mr Potter said:

> "*Mark was not okay and knew he was not okay. We tried to talk to those who had the legally sanctioned responsibility to look after his mental health but they would not listen. After eight days of telling…people that Mark was not okay, he killed himself…Our pain is magnified by the reality that we knew that Mark was extremely unwell and that he was in real danger of committing suicide, yet we could not get anyone to listen to us. We could not prevent his death. We did not know the magic words that would break down the barrier of professional arrogance expressed in a "we know best" attitude that was used to prevent our concerns being treated seriously.*"[249]

229. However, the reality is harder to establish, especially considering the information that clinicians had at relevant times. It follows that the question of whether the family's very understandable position is reasonable in all of the circumstances, is very difficult to evaluate.

---

[247] Letter - Mr S Potter (27.05.16)
[248] ts 21.05.19 (Potter), pp130-131
[249] ts 21.05.19 (Potter), pp130-131

230. With the benefit of hindsight, the concerns being raised with SWMHS by the deceased's mother, father and brother in the period leading up to his death, might, in a different set of circumstances, have led to a more proactive approach on the part of Clinic staff, especially with respect to the issue of whether a face-to-face assessment of the deceased on 12 February 2016 was warranted.

231. The question of whether, had this occurred, the outcome in this tragic case would have been different is impossible to know. As I have already observed, notwithstanding the views being expressed by Mr Potter on 13 February 2016, the deceased had contact with his brother and his mother on that day and with his mother on 14 February 2016. There is no evidence that either the deceased's brother or Ms Potter had the same self-harm concerns for the deceased at that time, that Mr Potter was expressing.

Issues addressed by Dr Pascu - Communication

232. As noted, Dr Pascu was asked to review the deceased's care and provide a report to the Court. She did so by way of a report dated 28 September 2018. After setting out the deceased's treatment history, Dr Pascu helpfully provided her opinion about aspects of the deceased's care.

233. Dr Pascu expressed the view that communication between the family and the Clinic may have been fragmented with different family members at different times. Nevertheless, Dr Pascu considered that:

> "*I am of the opinion that the treating team made significant effort to keep the family informed about Mr Fleury's progress.*"

234. Dr Pascu also considered that a family conference should have been held in early 2016, whether the deceased had agreed to it or not. The benefit of the family conference, (which could have been attended by Mr Potter via video-link), would have been that all family members would be able to pool their information about the deceased at one time and to share their concerns.

235. The family conference would also have offered the opportunity to review any contingency plans that had been created so that all family members were aware of who to call when they felt the deceased's mental state was deteriorating. In addition, members of the deceased's treating team would have been able to consider all of the family's information and the chance of miscommunication would be reduced.[250]

236. Dr Pascu noted that it would be preferable for the deceased to be present at any family conference that was convened.[251] However, given the deceased's persistently expressed views about his family's involvement in his care, this would probably have been unlikely.

237. Dr Pascu said that she did not conduct family conferences in secret and that her practice was to advise the patient that the conference had been convened. Dr Pascu outlined the advice she would give to a patient in these circumstances:

> "*I normally tell them – this is not for you necessarily, it's for me. I'm in the dark here, so I have to…get…things clear in my head, but I understand that you don't want any of your personal information to be discussed with them, and that's fine.*"[252]

238. Dr Brett said that in general terms he greatly valued family conferences. However, in early 2016 a family conference would almost certainly have enraged the deceased and would have been difficult to conduct.[253] He noted that the family conference on 3 February 2015[254] had occurred when the deceased was an inpatient on the APU and that different considerations had applied.[255]

239. Dr Crampin echoed the concerns expressed by Dr Brett about the efficacy of a family conference in the deceased's case. In her view: "*just to bring everyone together in a room could have been an extremely difficult and possibly destructive meeting.*"[256]

---

[250] ts 21.05.19 (Pascu), p100
[251] ts 21.05.19 (Pascu), p100
[252] ts 21.05.19 (Pascu), p100-101
[253] ts 20.05.19 (Brett), p41-42
[254] ts 20.05.19 (Crampin), p16
[255] ts 20.05.19 (Brett), p41-42
[256] ts 20.05.19 (Crampin), p31

240. Whilst I understand the perspectives expressed by Dr Crampin and Dr Brett, there may still have been merit in exploring whether the deceased would have agreed to the Clinic's treating team meeting with family members in the manner suggested by Dr Pascu.

241. I accept that the deceased may well have been hostile to the idea, but perhaps if the family conference had been couched in terms of providing a forum to gather information to support a possible change to the deceased's medication regime, he may have been more receptive to the idea.

242. In the deceased's case, despite attempts by Clinic staff to change his perspective about involving family members in his care, limited progress was made. In that context, a family conference might (and I stress the word might) have provided an opportunity to make further progress, although I acknowledge Dr Brett's concern that this strategy may have been counterproductive.[257]

243. A related issue is whether any further steps could have been taken to encourage the deceased to revisit his decision not to appoint a nominated person under the MHA 2014.

244. In any event, I accept that even if it had been possible to convene a family conference (with or without the deceased), there is no way of knowing whether the outcome in this tragic case would have been different.[258]

Issues addressed by Dr Pascu – Medication Change

245. As to the change in the deceased's medication regime, Dr Pascu considered that in view of the deceased's reported side effects, the change to Abilify was appropriate. Abilify is known to have fewer side effects generally and the fact that the deceased's treating team were willing to listen to his concerns about side effects showed they were trying to engage with him and to involve him in treatment decisions with the hope of strengthening the therapeutic relationship.[259]

---

[257] ts 20.05.19 (Brett), p41-42
[258] ts 20.05.19 (Crampin), p31
[259] Exhibit 1, Vol. 1, Tab 11, Report - Dr V Pascu, paras 82-84

246. It is not entirely clear at what point the deceased's family were made aware of the deceased's changed medication regime. However, as I have pointed out, Ms Potter appears to have been aware of the medication change when she rang the RuralLink emergency line on 7 February 2016 and when she accompanied the deceased to the emergency department at Bunbury Hospital later that day.[260,261]

247. Despite the difficulties in communicating with family members that bedevilled the deceased's management, Dr Brett considered that informing family members of medication changes was appropriate and he believed that this had occurred.[262]

A role for carer support advocates?

248. Dr Brett was asked whether, with the benefit of hindsight, he had any suggestions for improvements in the service offered to the deceased and he said:

> "*I think it would have helped the family a lot if they had had a carer advocate who they knew, who could help advocate on their behalf. And like I say, in the Mental Health Court, that works really well, and I would support that intervention.*"[263]

249. A "*carer support advocate*" is a person who can provide information to the carer and/or family of a mental health patient about the relevant mental health service and what to do in a crisis situation. They may also act as an advocate for the carer/family in MHRB proceedings and more generally.[264]

250. On the other hand, the term "*peer support worker*" refers to a person with a similar or shared experience to the mental health patient who can offer support to that person and help strengthen the therapeutic relationship between the patient and the treating team.[265]

---

[260] Exhibit 1, Vol. 3, Tab 1.2, Triage Form (07.02.16)
[261] Exhibit 1, Vol. 3, Tab 1.2, Triage Form - RuralLink (07.02.16: 1.05 pm)
[262] ts 20.05.19 (Brett), p49
[263] ts 20.05.19 (Brett), p44
[264] Submissions on behalf of WACHS (04.06.19), para 3
[265] Submissions on behalf of WACHS (04.06.19), para 3

251. In written submissions to the Court, the WACHS stated that it: "s*upports the implementation of a peer mental health workforce within the service*".[266]

252. WACHS said it recognises that peer workers can help families feel more included when a family member is receiving treatment for a mental illness. Peer workers can also help families navigate the mental health system and provide a forum for families to express any concerns they have about the treatment being provided to their loved one.[267]

253. WACHS advised that a pilot program to introduce peer workers to the mental health workforce commenced in April 2019 in its South West and Goldfield divisions. Under the program, peer workers fulfil both mental health consumer and carer/family support functions.[268]

254. Relevantly, in cases where a patient refuses to allow their carer and/or family to be involved in their care, WACHS says that separate peer workers would be allocated to the patient and their carer/family.[269]

255. WACHS says it has received funding from the Mental Health Commission for the 2019/2020 financial year, which will enable it to create peer support workers in those regions which have acute psychiatric units, namely Albany, Bunbury, Broome and Kalgoorlie.[270]

256. WACHS says that peer workers do not perform the carer advocacy functions referred to by Dr Brett, although they can support families at Mental Health Tribunal hearings.[271] I note that the Job Description Form for peer workers states that one of their duties is to:

> "*assist consumers and carers* [to] *advocate for their needs and wants.*"[272]

---

[266] Submissions on behalf of WACHS (04.06.19), para 4
[267] Submissions on behalf of WACHS (04.06.19), para 8
[268] Submissions on behalf of WACHS (04.06.19), paras 9-10
[269] Submissions on behalf of WACHS (04.06.19), para 13
[270] Submissions on behalf of WACHS (04.06.19), para 12
[271] Submissions on behalf of WACHS (04.06.19), para 11
[272] Job Description Form attached to Submissions on behalf of WACHS (04.06.19), para 1.11

257. In an email addressed to Counsel Assisting, Ms Paljetak (counsel for WACHS) clarified the role of peer workers with respect to advocacy in the following terms:

> "*peer workers do not take on the role of advocate of a consumer and/or carer in Mental Health Tribunal proceedings and more generally. In essence, the distinction boils down to a person who advocates on behalf of the consumer and/or carer, and a person who assists consumers and/or carers to advocate on their own behalf. Peer workers perform the latter role, but not the former.*"[273]

258. It may be that the reason why it is not the role of peer workers to directly advocate on behalf of mental health consumers and their carers/families is because the qualifications and experience that these workers bring to their roles would not equip them to do so.

259. Nevertheless, I agree with Dr Brett that having a person other than a member of the mental health consumer's treating team available to act as an advocate for the consumer and/or their carer/family is sensible and something that WACHS should give consideration to.

260. Whilst it is a noble goal to have peer workers assist mental health consumers and their carers/families to advocate on their own account, there may be many cases where, for a variety of reasons, this is simply not possible. In those circumstances, the kind of advocacy proposed by Dr Brett could be vital.

261. I accept that the attributes required of a person who would be able to engage in the kind of advocacy proposed by Dr Brett may well be different to the attributes required to be a peer worker. Nevertheless, I urge WACHS to consult with an expert in the field of mental health consumer and carer/family support, to determine whether implementation of the advocacy service proposed by Dr Brett is feasible.

[273] Email from Ms Paljetak to Counsel Assisting (15.07.19)

262. I do see value in the peer worker system being introduced by WACHS, although I note the cautionary tone sounded by Dr Pascu. As she pointed out, the value of this type of service depends largely on the skills and aptitude of the peer workers who are employed:

> "*My experience with the quality of the advocacy services representatives, as I said, it's very diverse, and in some cases they can actually make things worse in the engagement of the treating team and the patient. Look, I think the idea is good. Anything that can improve the engagement with all involved. My experience with the advocacy services, not all of them, but some of the workers… bring in this "them and us" mentality, as in the clinicians are the enemies…the better quality representatives from the advocacy services try to…navigate all these difficulties and try not make them worse. So I would think that the same would apply if there was a carer representative.*"[274]

263. For his part, Mr Potter was unconvinced that a carer advocate would have been useful to his family. In his view, the family already had a good understanding of the deceased's illness and a carer advocate would simply have been:

> "*another layer we needed to push through to get to the people we needed to engage with*".[275]

The SAC 1 review process

264. Dr Crampin confirmed that the SWMHS has a policy of reviewing clinical incidents to identify areas for improvement. The highest category of incident is referred to as a "SAC 1" and this obviously applied to the deceased's case which the SWMHS categorised as the "*unexpected death of a mental health patient*". The SAC 1 review process adopts a "*no blame framework*" and seeks to: "*identify systemic changes that might assist with preventing future incidents*".[276]

---

[274] ts 21.05.16 (Pascu), p106
[275] ts 21.05.16 (Potter), p130
[276] ts 20.05.19 (Crampin), p27

SAC 1 Recommendation 1 – Crisis Management Plan

265. The SAC 1 review made a recommendation relating to a collaborative crisis management plan in the following terms:

> "*The review team considered that a collaborative crisis management plan or personal safety plan shared with the patient, family and service may have emphasised the patient's being able to access voluntary admission when in crisis. It is recommended that further work is undertaken to ensure such a plan is routinely provided as a component of the care of patients*."[277]

266. Dr Crampin described the lengthy process of consultation that followed the SAC 1 review. The process involved seeking input from clinicians and importantly consumers of the service to ensure that the design of the plan: "*would actually be useful for them in these kinds of circumstances*".[278] The upshot of the consultation process was the development of a "*consumer care crisis and relapse plan*" which is to be routinely developed for each mental health consumer in collaboration with their treating team and where applicable, the consumer's carer and/or family.[279]

267. Dr Pascu thought that the contingency plan that had been developed was fairly basic but acknowledged that the emergency contact details would be useful.[280] She agreed that a contingency plan should have been in place in the deceased's case. Ideally, the plan, which would set out what was to occur if the deceased's mental state deteriorated, would have been developed with significant input from the deceased and preferably his family.[281]

268. As Dr Crampin pointed out, in the deceased's case, he had limited insight into his illness and his need for treatment and persistently refused to allow his family to be involved in his care. This would have made the development of a contingency plan very difficult, but at the very least, a clear pathway of who to contact and when could have been identified.[282]

---

[277] Exhibit 1, Vol. 1, Tab 15.1, SAC 1 Review
[278] ts 20.05.19 (Crampin), p19
[279] Exhibit 2, Consumer care crisis and relapse plan
[280] ts 21.05.19 (Potter), p97
[281] ts 21.05.19 (Pascu), pp96-98
[282] ts 20.05.19 (Crampin), p28

269. Through Mr Potter, the deceased's family indicated that they were aware of who to contact in an emergency situation. The problem from their perspective was that nobody seemed to be listening to their concerns.

270. As Dr Pascu pointed out, a contingency plan should have set out a clear communication pathway so that the deceased's family (assuming he had agreed to them being involved in preparing the plan) would have had information about who to contact both during and after office hours.[283]

271. I note that Ms Potter variously contacted the Clinic, WA Police and RuralLink regarding her concerns about the deceased's mental state whereas Mr Potter contacted the Clinic and the APU.

272. One of the consequences of this fragmented communication in the absence of a contingency plan, related to the deceased's assessment by Dr Soliman on 10 February 2016. Although there is evidence that the PLN at Bunbury Hospital and Mr Potter were updated following that assessment, it does not appear that the PLN was formally designated as the after-hours contact person, or alternatively, if this did occur, that this plan was widely shared.[284]

273. Had a contingency plan been in place, there would presumably have been greater clarity about how and to whom, the deceased's family should have been raising their concerns. For example, the plan might have detailed that if the family had concerns about the deceased during business hours, they should contact his caseworker at the Clinic. If they had concerns outside of business hours then they should contact RuralLink or the PLN at Bunbury Hospital.

274. I note that since the deceased's death, the after-hours coverage offered by SWMHS has been improved. On weekdays, the Clinic can now be contacted until 6.00 pm and on Saturdays and Sundays between 9.30 am and 4.30 pm. Outside of those times, the default service is RuralLink, the emergency response line.[285]

---

[283] Exhibit 1, Vol. 1, Tab 11, Report - Dr V Pascu, para 66
[284] Exhibit 1, Vol. 3, Tab 1.2, Service Event Details (10.02.16: 11.05 am)
[285] ts 20.05.19 (Lewis), p62

275. Had this level of service been available in the period immediately prior to the deceased's death, it would have offered a more streamlined pathway for family members to raise their concerns.

276. In submissions to the Court, the WACHS stated that:

> "*WACHS is also in the process of developing a crisis plan for carers and/or family members to be used in circumstances where a consumer refuses the involvement of their carer and/or family members in their care.*
>
> *It is proposed that the crisis plan will contain information on who carers and/or family members can contact and what actions can be taken if they become concerned for their mental health consumer. The crisis plan will contain the Care Call number, which will link carers and/or family members to a member of the executive if they don't believe they are being heard.*"[286]

SAC 1 Recommendation 2 – Directing calls appropriately

277. The SAC 1 review also recommended that a process be developed so that calls received by Bunbury Hospital relating to community mental health patients were appropriately directed.[287]

278. When Mr Potter contacted the Clinic on 13 February 2016 to report his concerns about the deceased, his call was transferred to Bunbury Hospital. Unfortunately, the switchboard operator directed that call to the APU rather than to the PLN. The APU staff member who took Mr Potter's call was unaware of the deceased's case and ultimately suggested that Mr Potter call police if he had concerns.[288]

279. It seems likely that had Mr Potter's call been directed to the PLN, a different response might have been forthcoming. As Dr Crampin observed, the PLN:

---

[286] Submissions on behalf of WACHS (04.06.19), para 14
[287] Exhibit 1, Vol. 1, Tab 15.1, SAC 1 Review
[288] ts 20.05.19 (Crampin), p18

"*would have known about the concerns, because that had all been shared with the psychiatric liaison nurses and they would have known about…the bed having been available and…the daily contact and the daily concerns. And so they…would have seen it in a context…because they would have known what was happening at the time.*[289]

280. Dr Crampin advised that a system was implemented soon after the deceased's death and that calls relating to community mental health patients are now appropriately directed. She said that she was unaware of any further incidents of misdirected calls to Bunbury Hospital up until the time she left the service in 2018.[290]

Improvements to note taking systems

281. Dr Crampin noted that a new electronic medical record system (called BOSSnet) was now being used by the Clinic. The new system was said to be preferable to a paper based system although some issues had been encountered with the new system's search and filing functions.[291]

282. Dr Crampin said that an electronic medical record was preferable and assists in ensuring that entries in a mental health consumer's record are made in a timely manner.[292]

[289] ts 20.05.19 (Crampin), pp18-19
[290] ts 20.05.19 (Crampin), p18
[291] ts 20.05.19 (Crampin), p25
[292] ts 20.05.19 (Crampin), p25

CONCLUSION

283. The deceased was a dearly loved father, son, brother and friend who was 38-years of age when he died from ligature compression of the neck (hanging) on 14 February 2016.

284. This case highlights the difficulties of managing the ever-changing risk of suicide and self-harm associated with some mental health illnesses. Clearly, information from family members who are in close contact with the person with mental illness can be vital to helping clinicians manage that risk.

285. Where, as in this case, the person with the mental illness places severe limits on the information that family members can be given, that person's treatment and care necessarily becomes more complicated. In those circumstances, information from the person's loved ones assumes an even greater significance.

286. The deceased's family raised a number of concerns with various agencies in the week prior to his death. Had it been possible for those concerns to have been considered in a more holistic manner, there is a possibility that the outcome in this tragic case may have taken a different trajectory. However, given that there are so many imponderables in the deceased's case, it is impossible to know whether any particular action at any particular time would have prevented his death.

287. Since the deceased's death, WACHS has made several changes to their clinical practice including: improvements in record keeping systems, the introduction of contingency plans and the employment of peer workers. It is my sincere hope that these changes will help to enhance the services being offered to mental health consumers within the WACHS catchment.

MAG Jenkin
Coroner
17 July 2019