Coroners Act 1996
[Section 26(1)]

Coroner's Court of Western Australia

RECORD OF INVESTIGATION INTO DEATH

Ref: 26/19

I, Michael Andrew Gliddon Jenkin, Coroner, having investigated the death of ***Stephen Thomas OXLEY*** *with an inquest held at the* ***Perth Coroner's Court, Court 85, CLC Building, 501 Hay Street, Perth,*** *on* ***16 July 2019*** *find that the identity of the deceased person was* ***Stephen Thomas OXLEY*** *and that death occurred on or about* ***9 December 2017*** *at* ***82 Monash Avenue, Nedlands,*** *as a result of* ***artherosclerotic and hypertensive heart disease*** *in the following circumstances:*

Counsel Appearing:

Sergeant L Housiaux assisted the Coroner.

Mr E Cade (State Solicitor's Office) appeared on behalf of North Metropolitan Health Service and Dr Mark McAndrew.

Table of Contents

INTRODUCTION

1. Stephen Thomas Oxley (the deceased) died on or about 9 December 2017 at 82 Monash Avenue, Nedlands as a result of artherosclerotic and hypertensive heart disease.

2. At the time of his death, the deceased was subject to a community treatment order (CTO)[1] made under the *Mental Health Act 2014* (WA) (MHA 2014).[2] Accordingly, immediately before his death he was an "*involuntary patient*" and thereby a "*person held in care*".[3] His death was therefore 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 16 July 2019. The deceased's mother and two of his sisters attended the inquest.

5. The documentary evidence at the inquest included a report into the deceased's death prepared by Western Australia Police[7], expert reports and the deceased's medical notes. Together, the Brief comprised one volume. Dr Mark McAndrew (consultant psychiatrist) gave oral evidence at the inquest.

6. I note that a report by Dr John Fletcher which formed part of the Brief was adopted by Dr McAndrew who agreed with its contents and gave evidence at the inquest in accordance with the report.[8]

7. 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.

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[1] A community treatment order made under the *Mental Health Act 2014* (WA) is an order that a person receive treatment as an involuntary patient in the community
[2] Exhibit 1, Vol. 1, Tab 16A, Community Treatment Order (26.07.17)
[3] Section 3, *Coroners Act 1996* (WA)
[4] Section 3, *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 - Senior Constable A Van Andel
[8] Exhibit 1, Vol. 1, Tab 12, Report - Dr J Fletcher

THE DECEASED

Background

8. The deceased was born in Northam on 5 January 1965 and was 52-years of age when he died on or about 9 December 2017.[9] He had three older sisters and was described by his mother as being "*generally healthy and fit*" with no major medical issues whilst he was growing up.[10]

9. The deceased was reportedly a very active child with a keen interest in sport, especially cricket. Indeed, cricket was his major passion and he played for many years and was a life member of his local cricket club. He was also a keen follower of AFL football.[11,12]

10. After completing Year 11 at secondary school, the deceased began apprenticeships as a chef and a carpenter but did not complete them. He held a number of casual and handyman type jobs and also worked at Rottnest Island. At the time of his death, the deceased was in receipt of the disability pension and had not worked for many years.[13,14]

11. The deceased never married and had no children. He led a quiet and apparently contented life, living independently in rented premises in Nedlands. He regularly visited his parents until his father's death in 2014 and thereafter, his mother visited weekly and helped him with shopping.[15,16]

12. The deceased maintained an interest in the activities of family members and participated in family occasions from time to time. He was said to enjoy visits from people and to have some close friends who he kept in touch with. Nevertheless, according to his mental health treating team, the deceased was socially isolated.[17,18]

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[9] Exhibit 1, Vol. 1, Tab 9, Email from deceased's family (23.07.18), paras 1 & 3
[10] Exhibit 1, Vol. 1, Tab 10, Statement - Ms M Oxley, para 5
[11] Exhibit 1, Vol. 1, Tab 9, Email from deceased's family (23.07.18), para 8
[12] Exhibit 1, Vol. 1, Tab 10, Statement - Ms M Oxley, para 4
[13] Exhibit 1, Vol. 1, Tab 9, Email from deceased's family (23.07.18), paras 5 & 9
[14] Exhibit 1, Vol. 1, Tab 12, Report - Dr J Fletcher, p2
[15] Exhibit 1, Vol. 1, Tab 9, Email from deceased's family (23.07.18), para 16
[16] Exhibit 1, Vol. 1, Tab 10, Statement - Ms M Oxley, para 17
[17] Exhibit 1, Vol. 1, Tab 9, Email from deceased's family (23.07.18), para 16
[18] Exhibit 1, Vol. 1, Tab 12, Report - Dr J Fletcher, p1

Medical Issues

13. The deceased had limited contact with his general practitioner and refused to have blood tests to check his cholesterol, lipids and/or blood sugar levels. He would not allow his blood pressure to be taken although begrudgingly, he would allow himself to be weighed from time to time.[19]

14. The deceased also refused routine electrocardiograms (ECG), to check his propensity for arrhythmias, a rare side effect of some anti-psychotic medication.[20] However, I note that Dr McAndrew confirmed that the deceased's depot medication (flupenthixol) was associated with a considerably lower risk of arrhythmias when compared to some other anti-psychotic medication.[21]

15. The deceased's mental health treating team considered that he had the capacity to make decisions about his physical health and it seems he was fully aware of why blood tests were required and the advantages and disadvantages of the proposed tests.[22]

16. The deceased led a largely sedentary lifestyle and took little regular exercise. He was a heavy smoker and was thought to consume at least two packets of cigarettes daily.[23,24] The deceased was known to occasionally drink alcohol but he had no recent history of illicit drug use. There is evidence of historical illicit drug use and he had admissions to Graylands Hospital in 1993[25] and 2004,[26,27] related, at least in part, to marijuana and alcohol abuse.

17. In March 2015, the deceased's weight was 107 kg and he was reportedly drinking 4 litres of milk daily. By September 2016, his weight had decreased to 97.5 kg.[28] At the time of his death, he weighed about 105 kg giving him a body mass index of 31.4,[29] which placed him in the "*obese*" category.

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[19] Exhibit 1, Vol. 1, Tab 12, Report - Dr J Fletcher, p2
[20] Exhibit 1, Vol. 1, Tab 12, Report - Dr J Fletcher, p2
[21] ts 16.07.19 (McAndrew), p13
[22] Exhibit 1, Vol. 1, Tab 12, Report - Dr J Fletcher, p2
[23] Exhibit 1, Vol. 1, Tab 9, Email from deceased's family (23.07.18), para 10
[24] Exhibit 1, Vol. 1, Tab 12, Report - Dr J Fletcher, p2
[25] Deceased's Medical Records Discharge Summary (30.06.93): Admission 13.04.93 - 30.06.93
[26] Deceased's Medical Records Discharge Summary (22.06.04): Admission 19.05.04 - 15.06.04
[27] Deceased's Medical Records Discharge Summary (30.11.04): Admission 28.07.04 - 10.11.04
[28] Exhibit 1, Vol. 1, Tab 12, Report - Dr J Fletcher, p2
[29] Exhibit 1, Vol. 1, Tab 7, Post Mortem Report, p2

18. The deceased's obesity, heavy smoking and lack of regular exercise placed him at higher risk of heart related issues and stroke.[30] However, it was not thought that his antipsychotic medication had any impact on his physical health.[31]

Mental Health Issues

19. The deceased's first recorded contact with mental health services was in March 1989. At that time, he was admitted to Graylands Hospital and diagnosed with bipolar affective disorder.[32,33]

20. Subsequently, the deceased was diagnosed with schizoaffective disorder and at times showed definite signs of psychotic illness. At other times, he displayed symptoms of bipolar affective disorder, as evidenced by hypomanic or floridly manic phases.[34]

21. The deceased did express some suicidal ideation (and possibly made a suicide attempt) prior to 2013 and his medical record contains a some reports of risk-taking or dangerous behaviour during periods of psychosis.[35,36] However, the deceased was never assessed as "*majorly depressed*" in terms of his bipolar condition and his treating psychiatrist at Subiaco Adult Community Mental Health Clinic (Subiaco Clinic) had never: "*seen Mr Oxley suicidal in ideation or intent or in planning or to be at high risk of suicide*".[37]

22. At the deceased's last formal risk assessment, his suicide risk and his aggressive risk were "*low*". His protective factors were said to be his "*supportive mother, family and friends*".[38] When reviewed by his treating psychiatrist (on 28.11.17), the deceased was assessed as calm, but still requiring a CTO because of his lack of insight.[39]

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[30] ts 16.07.19 (McAndrew), p11
[31] Exhibit 1, Vol. 1, Tab 12, Report - Dr J Fletcher, p2
[32] Exhibit 1, Vol. 1, Tab 12, Report - Dr J Fletcher, p1
[33] Deceased's Medical Records (A0604263), 08.03.89
[34] Exhibit 1, Vol. 1, Tab 12, Report - Dr J Fletcher, p1
[35] Exhibit 1, Vol. 1, Tab 12, Report - Dr J Fletcher, p2
[36] Exhibit 1, Vol. 1, Tab 17C, Letter - Dr J Fletcher (25.08.17), p2
[37] Exhibit 1, Vol. 1, Tab 12, Report - Dr J Fletcher, p1
[38] Exhibit 1, Vol. 1, Tab 13, Brief Risk Assessment (25.10.17)
[39] Exhibit 1, Vol. 1, Tab 14, Deceased's Integrated Progress Notes (28.11.07)

Admissions to Graylands Hospital

23. The deceased had 10 admissions to Graylands Hospital over the period 1989 - 2014. As noted, his admissions in 1993 and 2004 were at least partly related to excessive marijuana and alcohol use.[40,41,42] The other admissions were related to non-compliance with his anti-psychotic medication.[43]

Last admission to Graylands Hospital

24. The deceased's last admission to Graylands Hospital was on 29 May 2014 and was said to coincide with the recent death of the deceased's father. The deceased was taken to Sir Charles Gairdner Hospital by police after displaying unusual behaviour at a local shopping centre. He was subsequently transferred to Graylands Hospital as an involuntary patient and placed on a secure ward.[44]

25. For most of his admission, the deceased remained severely disorganised and thought disordered and he verbalised numerous delusional beliefs. Two weeks prior to his discharge, his mental state markedly improved and he responded well to a depot injection of the anti-psychotic medication, flupenthixol.[45]

26. The deceased was granted unescorted ground access and then transferred to an open ward without issue. He was compliant with medication and showed more insight into his condition. He was seen by a clinical psychologist for grief counselling regarding unresolved feelings about his father's death.[46]

27. The deceased was discharged home on 3 September 2014 after an admission of 98-days. He was placed on a CTO and his care was transferred to Subiaco Clinic.[47]

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[40] Deceased's Medical Records Discharge Summary (30.06.93): Admission 13.04.93 - 30.06.93
[41] Deceased's Medical Records Discharge Summary (22.06.04): Admission 19.05.04 - 15.06.04
[42] Deceased's Medical Records Discharge Summary (30.11.04): Admission 28.07.04 - 10.11.04
[43] Deceased's Medical Records (A0604263), Volumes 1-6
[44] Exhibit 1, Vol. 1, Tab 18A, Discharge Summary - Graylands Hospital, pp1-2
[45] Exhibit 1, Vol. 1, Tab 18A, Discharge Summary - Graylands Hospital, p2
[46] Exhibit 1, Vol. 1, Tab 18A, Discharge Summary - Graylands Hospital, p2
[47] Exhibit 1, Vol. 1, Tab 18A, Discharge Summary - Graylands Hospital, p2

Community Treatment Order

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

29. 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.*"

30. In the deceased's case, a CTO was required because he had very little insight into, and impaired judgement with respect to, his mental illness. The deceased also lacked capacity to "*make sound treatment decisions*" with respect to his mental health.[48]

31. On 25 October 2017, the deceased's CTO was continued until 24 January 2018 on the basis that his treating psychiatrist was satisfied that the deceased was still in need of an involuntary treatment order and should continue to receive treatment in the community.[49]

32. The continuation of the deceased's CTO was reviewed by the Mental Health Tribunal (MHT) on 29 November 2017. In a report to the MHT, Dr Fletcher noted that the deceased had:

> "*no major problems with being on a CTO but he does not feel it is necessary, and has repeatedly indicated that if it were to stop, he would immediately stop coming for the Depot injection.*
>
> *He is also adamant that he will never go on or take tablets of any sort.*"[50]

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[48] Exhibit 1, Vol. 1, Tab 17A, Letter Dr J Fletcher (07.07.16), p1
[49] Exhibit 1, Vol. 1, Tab 16B, Form 5B: Continuation of Community Treatment Order (25.10.17)
[50] Exhibit 1, Vol. 1, Tab 17D, Letter Dr J Fletcher (24.11.17), p1

33. Dr Fletcher confirmed that if the deceased's CTO was not continued, the deceased's mental health would relapse "*quite rapidly*". By way of example, Dr Fletcher referred to the deceased's 98-day admission to Graylands Hospital in 2014 which he said was due to the deceased's non-compliance with his depot medication.[51,52]

34. Dr Fletcher reiterated that the deceased lacked the capacity to make mental health treatment decisions because of his poor insight and poor judgement in relation to his mental illness.[53]

35. I find that the decision to maintain the deceased on a CTO was justified on the basis that it was the least restrictive way to ensure that the deceased was provided with appropriate treatment for his mental illness.[54]

36. In my view, the appropriateness of maintaining the deceased on a CTO is demonstrated by the fact that from the time of his discharge from hospital in September 2014 until his death, he was compliant with his depot medication. As a result, his mental health remained stable during that period.

37. I note in passing that the terms of the deceased's CTO did not authorise staff at Subiaco Clinic to compel him to undergo physical investigations (e.g.: blood tests, ECG etc.) that might have detected any deterioration in his cardio-vascular health.[55] As Dr Fletcher observed:

> "*While Mr Oxley did not have capacity to make decisions regarding his mental health treatment, he retained capacity to make some decisions about his medical care. For example, he was fully aware of why blood tests would be indicated, but stated his refusal when he was not psychotic and he understood the advantages and disadvantages of the proposed blood tests*".[56]

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[51] Exhibit 1, Vol. 1, Tab 17D, Letter Dr J Fletcher (24.11.17), p2
[52] Tts 16.07.19 (McAndrew), p14 & pp15-16
[53] Exhibit 1, Vol. 1, Tab 17D, Letter Dr J Fletcher (24.11.17), p2
[54] Exhibit 1, Vol. 1, Tab 17D, Letter Dr J Fletcher (24.11.17), p1
[55] ts 16.07.19 (McAndrew), p12
[56] Exhibit 1, Vol. 1, Tab 12, Report - Dr J Fletcher, p2

MANAGEMENT BY SUBIACO CLINIC

38. After his discharge from Graylands Hospital on 3 September 2017, the deceased's care was transferred to Subiaco Clinic, part of the North Metropolitan Health Service.[57] As noted, Subiaco Clinic had managed the deceased's care since at least 1993.

39. The deceased was seen by his treating psychiatrist every four to six weeks and by his case manager, (a community mental health nurse), every two weeks. The deceased's case manager had been involved in his care for many years and administered his flupenthixol injection during his fortnightly visits to the Clinic. Although the deceased was generally compliant with attending the Clinic, from time to time he needed to be reminded to do so.[58]

40. The Clinic's records[59] for the five months prior to the deceased's death show that he regularly received his depot injection. Entries in the notes demonstrate the deceased's mental state was stable and did not identify any risks with respect to suicide or self-harm. Typical entries include:

i. 25 July 2017: "*Stephen remains stable in mood and mental state. Denies any risks towards self and others. Nil psychotic symptoms observed or reported. Good personal hygiene. Nil FTD…*[formal thought disorder]*…orientated, speech normal. No concerns verbalised by Stephen.*"

ii. 19 September 2017: "*Stephen seen in clinic reports stable mood and mental state. Nil psychotic symptoms observed or reported. Denies any acute risk issues towards self and others. Reports sleeping well, maintains adequate diet. No further complaints from neighbours. Read discussed and signed management plan…Remains on CTO. Fully orientated, speech normal in rate, tone, volume and quantity."*

[57] Exhibit 1, Vol. 1, Tab 18A, Discharge summary - Graylands Hospital, p2
[58] Exhibit 1, Vol. 1, Tab 12, Report - Dr J Fletcher, pp1-2
[59] Exhibit 1, Vol. 1, Tab 14, Deceased's Integrated Progress Notes (11.07.17 – 12.12.07)

iii. 31 October 2017: "*Stephen was seen in the clinic. Mood stable. Nil psychotic symptoms or symptoms observed or reported. Euthymic…*[i.e.: calm]*…in mood. Affect restricted. Denies suicidal ideation. No psychiatric risks identified.*"

41. The deceased was the subject of client management plans (CMP) which were regularly reviewed and updated. The CMPs were prepared in collaboration with the deceased and set out his issues and problems, treatment goals and the actions required to achieve those goals.[60]

42. The deceased's last CMP was prepared on 19 September 2017 and would have expired on 19 December 2017. It noted that the deceased understood that he had a diagnosis of schizoaffective disorder and usually presented with mania and/or psychotic symptoms when unwell. It noted that although the deceased had been symptom free since his discharge from hospital in 2014, he admitted that if he was not on a CTO he would not comply with his treatment.[61]

43. The first of the goals set out in the deceased's CMP was to minimise symptoms of his schizoaffective disorder by encouraging ongoing compliance with his medication regime. Other goals included maintaining social functioning and promoting physical health and social inclusion.[62]

44. I note that despite the efforts of his treating team, the deceased persistently refused to engage in any form of rehabilitation or recreational programs provided by government or non-government agencies.[63]

[60] Exhibit 1, Vol. 1, Tab 15, Client Management Plan (19.09.17)
[61] Exhibit 1, Vol. 1, Tab 15, Client Management Plan (19.09.17)
[62] Exhibit 1, Vol. 1, Tab 15, Client Management Plan (19.09.17)
[63] Exhibit 1, Vol. 1, Tab 12, Report - Dr J Fletcher, p1

EVENTS LEADING TO THE DECEASED'S DEATH

45. On 7 December 2017, the deceased's mother Ms Oxley visited him at his home with some shopping and stayed for about 30 minutes. The deceased did not mention any problems or issues and Ms Oxley thought he seemed his normal self.[64]

46. The last person known to have seen the deceased alive was his long-term neighbour. She saw the deceased walking back to his house carrying a bottle of milk at about 12.00 pm on 9 December 2017. She said the deceased was walking slowly but there was nothing out of the ordinary about his appearance.[65,66]

47. At about 8.50 am on 11 December 2017, Ms Oxley received a call from a friend of the deceased. The friend said she had visited the deceased on each of the previous two days but there had been no response when she had knocked on his door. About 10 minutes after that call, Ms Oxley went to the deceased's home to check on him.[67]

48. There was no response when Ms Oxley knocked on the deceased's door and called out to him, so she let herself in using a spare key. Ms Oxley found the deceased on the floor by the side of his bed. His leg was cold to the touch and he was unresponsive. She sought help from passers-by and emergency services were contacted.[68]

49. Ambulance officers arrived and found the deceased face down on the floor next to his bed, obviously deceased.[69] A police investigation found no evidence of criminality with respect to the deceased's death[70] and police concluded that the deceased had probably rolled out of bed onto the floor.[71]

50. The deceased's death was formally declared at 9.41 am on 11 December 2017.[72]

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[64] Exhibit 1, Vol. 1, Tab 10, Statement - Ms M Oxley, paras 16-19
[65] Exhibit 1, Vol. 1, Tab 11, Statement - Ms R Potter, paras 4-6
[66] Exhibit 1, Vol. 1, Tab 2, Report - Senior Constable A Van Andel, p3
[67] Exhibit 1, Vol. 1, Tab 10, Statement - Ms M Oxley, paras 20-23
[68] Exhibit 1, Vol. 1, Tab 10, Statement - Ms M Oxley, paras 24-33
[69] Exhibit 1, Vol. 1, Tab 19, St John Ambulance - Patient Care Record
[70] Exhibit 1, Vol. 1, Tab 2, Report - Senior Constable A Van Andel, p5
[71] Exhibit 1, Vol. 1, Tab 4, Report - Sergeant A Unsworth, p2
[72] Exhibit 1, Vol. 1, Tab 6, Life Extinct Form

CAUSE AND MANNER OF DEATH

51. Dr Moss, a forensic pathologist, conducted a post mortem examination of the deceased's body on 14 December 2017 and found early post mortem change.[73]

52. The deceased's heart was enlarged (cardiomegaly) and there was severe hardening and narrowing of the blood vessels over the surface of the heart (coronary artery atherosclerosis). The deceased's kidneys showed granular scarring and his lungs were heavy and fluid-laden.[74]

53. Microscopic examination of the deceased's heart confirmed heart cell enlargement as well as changes consistent with chronic (and possibly acute) ischaemia. The deceased's coronary arteries showed severe coronary artery atherosclerosis and changes in his kidneys were consistent with hypertension (high blood pressure).[75]

54. Toxicological analysis detected the presence of the anti-psychotic medication flupenthixol in the deceased's blood but was negative for common drugs. A small quantity of alcohol (0.013%) was detected in his urine.[76]

55. Dr Moss expressed the opinion that the cause of death was artherosclerotic and hypertensive heart disease.[77]

56. I accept and adopt that conclusion.

57. I find that death occurred by way of natural causes.

[73] Exhibit 1, Vol. 1, Tab 7, Post Mortem Report (14.12.17), pp1 & 5
[74] Exhibit 1, Vol. 1, Tab 7, Post Mortem Report (14.12.17), pp1 & 5
[75] Exhibit 1, Vol. 1, Tab 7, Supplementary Post Mortem Report (05.07.18), p1
[76] Exhibit 1, Vol. 1, Tab 8, Toxicology report
[77] Exhibit 1, Vol. 1, Tab 7, Supplementary Post Mortem Report (05.07.18), p1

QUALITY OF SUPERVISION, TREATMENT AND CARE

58. The deceased's mental health was managed by Subiaco Clinic over many years. His treating psychiatrist and case manager were able to establish a therapeutic relationship with him and this helped to ensure he remained compliant with his medication.

59. The deceased had indicated on a number of occasions that if he was not subject to a CTO he would not voluntarily take medication and he repeatedly refused to take oral medication of any kind.

60. The deceased's management on a CTO was appropriate and helped to ensure he was compliant with his anti-psychotic medication. In turn, this meant that the deceased's mental health remained stable following his discharge from Graylands Hospital in September 2014.

61. As I have already noted, I am satisfied that maintaining the deceased on a CTO was the least intrusive means of maintaining his mental health.

62. With respect to his physical health, the deceased repeatedly refused to undergo medical tests with respect to his blood pressure and cholesterol and continued to smoke heavily despite advice that he should stop. He also appeared to disregard advice relating to his weight and he took very little exercise.

63. Whilst the deceased was entitled to make the lifestyle choices that he did, it seems clear that his smoking, obesity and lack of exercise had a direct impact on his physical health.[78]

64. On the basis of the evidence before me, I find that the supervision, treatment and care the deceased received from Subiaco Clinic whilst he was the subject of a CTO was of a very good standard.

[78] ts 16.07.19 (McAndrew), p11

CONCLUSION

65. The deceased was a much loved son, brother, uncle and friend who was 52 -years of age when he died as a result of artherosclerotic and hypertensive heart disease on or about 9 December 2017.

66. The deceased lived a quiet, independent life with his last admission to Graylands Hospital occurring in May 2014. The deceased's treating team at Subiaco Clinic and his supportive family were able to ensure that he remained compliant with his fortnightly depot injections of anti-psychotic medication. As a result, the deceased's mental health remained stable following his discharge from Graylands Hospital in September 2014.

67. It would appear that the deceased's lifestyle choices played a significant role in his unexpected and premature death.

M A G Jenkin
Coroner
23 July 2019