JURISDICTION	**:**	CORONER'S COURT OF WESTERN AUSTRALIA
ACT	**:**	CORONERS ACT 1996
CORONER	**:**	MICHAEL ANDREW GLIDDON JENKIN
HEARD	**:**	4 MARCH 2021
DELIVERED	**:**	8 MARCH 2021
FILE NO/S	**:**	CORC 279 of 2018
DECEASED	**:**	SOLLY, STEPHEN CRAIG

Catchwords:

Nil

Legislation:

Nil

Counsel Appearing:

Ms S Tyler appeared to assist the coroner.

Mr G Stockton (State Solicitor's Office) appeared for North Metropolitan Health Service.

Coroners Act 1996
(Section 26(1))

RECORD OF INVESTIGATION INTO DEATH

I, Michael Andrew Gliddon Jenkin, Coroner, having investigated the death of ***Stephen Craig SOLLY*** *with an inquest held at Perth Coroners Court, Central Law Courts, Court 85, 501 Hay Street, Perth, on 4 March 2021, find that the identity of the deceased person was* ***Stephen Craig SOLLY*** *and that death occurred on 11 March 2018 at Graylands Hospital from respiratory failure in a man with lung cancer, chronic obstructive pulmonary disease and pulmonary fibrosis in the following circumstances:*

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INTRODUCTION

1. Stephen Craig Solly (Mr Solly) died from respiratory failure on 11 March 2018 at Graylands Hospital. He was 63 years of age. At the time of his death, Mr Solly was the subject to an inpatient treatment order[1] made under the *Mental Health Act 2014* (WA) (MHA).[2,3,4,5]

2. Accordingly, immediately before his death Mr Solly was an "*involuntary patient*" and thereby a "*person held in care*". As a consequence, his death was a "*reportable death*" and in such circumstances, an inquest is mandatory.[6,7]

3. I held an inquest into Mr Solly's death on 4 March 2021. Where, as in Mr Solly's case, the death relates to a person being held in care, I am required to comment on the quality of the supervision, treatment and care the person received while in that care.[8]

4. The documentary evidence at the inquest included a report prepared by the Western Australia Police Force[9] and medical notes and reports. Together, the Brief comprised one volume.

5. Two witnesses gave evidence at the inquest, namely:

    a. Dr Mihaela Iliescu (Consultant psychiatrist); and

    b. Clinical Professor Fiona Lake, (Respiratory physician).

6. The inquest focused on the supervision, treatment and care that Mr Solly received while he was being held in care as well as the circumstances of his death.

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[1] An order requiring a person to receive treatment as an involuntary patient at an authorised hospital.
[2] Exhibit 1, Vol. 1, Tab 18, Continuation of inpatient treatment order (09.03.18)
[3] Exhibit 1, Vol. 1, Tab 1, Report of death (P100)
[4] Exhibit 1, Vol. 1, Tab 3, Identification of deceased person (P92)
[5] Exhibit 1, Vol. 1, Tab 4, Death in hospital form
[6] Section 3, *Coroners Act 1996* (WA)
[7] Section 22(1)(a), *Coroners Act 1996* (WA)
[8] Section 25(3), *Coroners Act 1996* (WA)
[9] Exhibit 1, Vol. 1, Tab 2, Report - Sen. Const. J Robinson (04.07.18)

MR SOLLY

Background[10,11]

7. Mr Solly was the second eldest of seven children and was born in Kalgoorlie. He was a boxing champion in that area for about three years and would compete in the travelling tents that were common at the time.

8. Mr Solly had worked in the gold mining industry and at the Post Office and had a long-term partner but no children. His sister described him as "*highly intelligent*" but noted that even as a young child, Mr Solly's mother felt he had some form of mental illness.

9. In 1974, Mr Solly was sentenced to life imprisonment for murder. He was released on parole in 1984, but returned to prison over the next few years as a result of assault charges. In 1994, Mr Solly was transferred from Casuarina Prison to Graylands Hospital to engage in a pre-release rehabilitation program. He was finally released from prison in 1995.[12]

Medical and mental health diagnoses[13,14]

10. Mr Solly had a number of medical issues including: combined chronic obstructive pulmonary disease related to severe pulmonary fibrosis and emphysema. He was also diagnosed with pulmonary hypertension, gastro-oesophageal reflux and peripheral vascular disease. Mr Solly was blind in his left eye and had a long-standing history of heavy smoking (cigarettes) although he did not drink alcohol or use illicit drugs.

11. In terms of his mental health, it appears that Mr Solly was diagnosed with paranoid schizophrenia while he was in prison, although exactly when this diagnosis was made is unclear. In any case, his mental health issues were recognised as early 1974, when he was sentenced to life imprisonment.[15]

[10] Exhibit 1, Vol. 1, Tab 2, Report - Sen. Const. J Robinson (04.07.18), pp3-4
[11] Exhibit 1, Vol. 1, Tab 7, Memo of conversation with Ms N Everix (12.03.18)
[12] Graylands Hospital Discharge summary (26.05.95), p2
[13] Exhibit 1, Vol. 1, Tab 8, Medical report - Dr M Iliescu (21.06.18)
[14] Exhibit 1, Vol. 1, Tab 25G, Medical report - Dr I Moore (20.02.17)
[15] Exhibit 1, Vol. 1, Tab 9, Sentencing remarks, Justice Wickham (12.12.74), pp278-279

12. In addition to being diagnosed with paranoid schizophrenia, Mr Solly was diagnosed with organic personality disorder, and later with cognitive impairment which was assessed as early onset dementia. He was prescribed medications for his mental health conditions and a puffer for his respiratory issues, which he often refused. As I will discuss, oxygen therapy was not a viable option.

Hospital admissions relating to psychiatric care[16,17]

13. Mr Solly was admitted to Graylands Hospital in 2000 and 2004 following psychotic episodes which were thought to be related to non-compliance with medication. After 2004, his mental state appears to have stabilised and he was managed primarily in the community until 2012.

14. On 21 September 2012, Mr Solly presented to Sir Charles Gairdner Hospital (SCGH) with agitation, pressured speech and physical aggression. He was transferred to Swan District Hospital (as it then was) on 26 September 2012 and received treatment as an involuntary patient under the MHA until he was discharged on 22 November 2012.

15. During this period, Mr Solly was diagnosed with early onset dementia and on 18 June 2012, the State Administrative Tribunal ordered that the Public Advocate be appointed as Mr Solly's limited guardian for the purposes of making treatment decisions and determining where and with whom he should live. Mr Solly's guardianship order was subsequently extended until 2 April 2019.[18]

16. Mr Solly was admitted to Graylands Hospital as an involuntary patient in September and November 2012 following further psychotic episodes. On 5 August 2013, Mr Solly was admitted to Graylands Hospital for the last time. On that occasion, he was described as grossly thought disordered with incoherent, rambling speech. He displayed threatening behaviour towards staff and required periods of restraint and seclusion.[19]

[16] Exhibit 1, Vol. 1, Tab 8, Medical report - Dr M Iliescu (21.06.18)
[17] Exhibit 1, Vol. 1, Tab 17, Medical report - Dr M Iliescu & Dr A Saranga (19.02.18)
[18] Exhibit 1, Vol. 1, Tab 28, Orders made by State Administrative Tribunal
[19] Exhibit 1, Vol. 1, Tab 13, Medical report - Dr M Schineanu & Dr B Zawadski (16.02.17), p2

17. Mr Solly was treated with depot antipsychotic medication at an increased dose and a mood stabiliser (sodium valproate) and then transferred to the Extended Care Service at Graylands Hospital (HECS), a state-wide inpatient facility that manages people with chronic, treatment resistant psychiatric illnesses and challenging behaviours. On 11 March 2018, the HECS had 67 beds, 57 of which were occupied. The day shift roster at that time was 24 staff. I am advised that the patient capacity and staff roster at HECS has not changed significantly since.[20]

18. Although efforts were made to transfer Mr Solly to supported accommodation, there were no suitable options and he remained an inpatient in HECS until his death. By mid-2017, Mr Solly was no longer able to be managed during weekend leave placements with either his partner or his sister and instead, his family regularly visited him at HECS.[21]

19. Mr Solly's mood and mental state fluctuated but clinical staff were unable to identify any particular triggers that caused a deterioration in his behaviour. Mr Solly spent much of his time walking alone around the grounds of the hospital whilst smoking.[22]

20. The management of Mr Solly's mental illness was particularly difficult because, as Dr Iliescu, explained Mr Solly:

> [Had] a long established diagnosis of paranoid schizophrenia characterised by gross thought disorder, fragmented delusional beliefs and occasional perceptual disturbances. He has limited insight into his illness and its consequences on his daily functioning.[23]

21. Mr Solly's poor judgment and lack of insight meant that his disinhibited behaviour was often perceived as "*challenging*" by other patients and he could easily be the subject of counter-aggression. In addition, Mr Solly was known to behave aggressively towards staff on occasion, and was often non-compliant with medication for his physical conditions.

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[20] Email - Mr G Stockton to Ms S Tyler (05.03.21) and ts 04.03.21 (Iliescu), p7
[21] Exhibit 1, Vol. 1, Tab 11, Client management plan (11.02.18)
[22] ts 04.03.21 (Iliescu), p8
[23] Exhibit 1, Vol. 1, Tab 17, Medical report - Dr M Iliescu & Dr A Saranga (19.02.18), p3

22. Mr Solly was the subject of a series of inpatient treatment orders (TO) under the MHA, the last of which was made on 9 March 2018.[24] The MHA provides that a person shall not be placed on a TO unless:

> [T]he 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.[25]

23. In Mr Solly's case, a TO was required because he had impaired judgement and very little insight into his mental illness. In a letter to the Mental Health Tribunal seeking to extend Mr Solly's TO, Dr Iliescu observed:

> Due to the impacts of organic brain changes and long standing psychiatric illness, Mr Solly's capacity to make informed decisions about his treatment is severely compromised. He does not fully comprehend the implications of his psychiatric illness and cannot weigh the factors that would have an impact on his health, and safety of himself and others. Mr Solly does not have the capacity to take rational decisions regarding his treatment and accommodation aspects. Mr Solly has no insight into his illness and is unlikely to adhere to prescribed medications outside the hospital setting.[26]

24. On the basis of the available evidence, I find that the decision to maintain Mr Solly on a TO was clearly justified on the basis that it was the least restrictive way to ensure that he was provided with appropriate treatment for his mental illness.

Respiratory issues[27]

25. Mr Solly was first reviewed by the Respiratory Clinic at SCGH (the Clinic) in 2015. At that time he was diagnosed with emphysema and pulmonary fibrosis related to smoking. He was noted to have pulmonary nodules and enlarged mediastinal nodes, which were subsequently monitored by the Clinic. Mr Solly reported smoking 30 cigarettes daily and despite being advised to quit smoking, he declined to do so.

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[24] Exhibit 1, Vol. 1, Tab 18, Continuation of inpatient treatment order (09.03.18)
[25] s25(1)(e), *Mental Health Act 2014* (WA)
[26] Exhibit 1, Vol. 1, Tab 17, Medical report - Dr M Iliescu & Dr A Saranga (19.02.18), p3
[27] Exhibit 1, Vol. 1, Tab 29, Medical report - Clinical Professor F Lake (21.01.21)

26. Mr Solly was reviewed at the Clinic in late 2016 when a CT scan of his chest showed a new lesion in his lower right lung. The scan also confirmed widespread emphysema, stable interstitial lung disease and nodules in his right and left lungs. Despite his severely limited lung function, he continued to smoke heavily and was frequently in "*type-1 respiratory failure*". Although Mr Solly was considered for oxygen therapy, this was not considered to be viable option for a number of reasons.[28]

27. First and most importantly, Mr Solly steadfastly refused to stop smoking, making it unsafe for him to use oxygen. Second, the presence of an oxygen cylinder on the HECS would, in the context of Mr Solly's often aggressive behaviour, have posed an unacceptable risk to the safety of patients and staff.[29]

28. Further, transferring Mr Solly to a less restrictive part of the hospital where oxygen therapy might have been an option was impossible because of Mr Solly's psychiatric illness. Finally, Mr Solly's lack of insight into his condition and his mild cognitive impairment meant that he was not able to tolerate the mask he would be required to wear whilst receiving oxygen therapy.[30]

29. Mr Solly's refusal to stop smoking was addressed in weekly staff meetings at HECS, where it was noted that Mr Solly did not have the capacity to understand that his heavy smoking was making it harder for him to breath.[31]

30. Mr Solly's smoking was also addressed during his reviews at the Clinic. Clearly it would have been preferable for Mr Solly to have stopped smoking, but his respiratory team recognised that smoking was one of the main ways Mr Solly managed his mental health issues. Also, from Mr Solly's perspective, despite the damage it was doing him, smoking was a pleasurable activity.[32,33]

[28] Exhibit 1, Vol. 1, Tab 25F, Letter - Dr K Lim & Clinical Professor F Lake (19.12.16)
[29] ts 04.03.21 (Iliescu), p11
[30] ts 04.03.21 (Iliescu), pp11-12
[31] ts 04.03.21 (Iliescu), p9
[32] ts 04.03.21 (Lake), pp15-16 & 22-23

31. Even as his illness progressed and he became unable to walk without help, Mr Solly continued to smoke. His respiratory team were therefore obliged to approach his treatment on the basis that Mr Solly would never quit smoking.

32. Mr Solly's diagnosis was primary lung malignancy (lung cancer) and the respiratory team carefully considered the available treatment options and made conclusions about the viability of those options, as follows:

    a. Surgical removal of part of the lung. This was considered impossible because of Mr Solly's severely impaired lung function;

    b. Radiotherapy: this carried a high risk of causing a fatal inflammation of the lung tissues (pneumonitis), even if a precisely targeted approach was adopted using a "*cyber knife*". Further, it was felt that Mr Solly would be unable to tolerate the diagnostic tests required to perform radiotherapy, namely a PET scan and tissue diagnosis using a fine needle aspiration through his chest wall; and

    c. Chemotherapy: is regarded as "*not very effective*" in smoking related cancers and carries with it a lot of side effects which would have impacted on Mr Solly's medical and psychiatric conditions.[34]

33. Because of Mr Solly's psychiatric and cognitive issues, it was extremely difficult for the respiratory team to engage him in discussing his treatments options. Despite their best efforts, the team felt that at best, Mr Solly had only a rudimentary understanding of the seriousness of his lung disease and the viability of possible treatment options.[35]

34. Mr Solly's responses to available treatment options varied depending on his mental state. At times he would ask to be left alone so he could "*die in peace*". Sometimes he would say he wanted treatment and at other times he would say he wanted to "*have his last days in a nice place*".[36]

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[33] Exhibit 1, Vol. 1, Tab 8, Medical report - Dr M Iliescu (21.06.18), p2
[34] ts 04.03.21 (Lake), pp17-18 & 25
[35] ts 04.03.21 (Lake), p19 and ts 04.03.21 (Iliescu), pp10 & 12
[36] ts 04.03.21 (Lake), p19

35. The consideration of Mr Solly's treatment options culminated in a meeting on 26 December 2016 (the Meeting), attended by Mr Solly, his sister, his partner, his guardian, members of the respiratory team, a consultant psychiatrist and registrar, a psychologist, a ward nurse and a social worker.[37]

36. The consensus at the Meeting was that Mr Solly's respiratory function had declined and that he was likely to die either as a result of the mass in his right lung (thought to be cancer) or from his underlying lung disease. It was noted that Mr Solly had no symptoms related to his lung mass and that his breathlessness was related to his pre-existing pulmonary fibrosis and emphysema.[38]

37. After discussion, the outcome of the Meeting was that further treatment should focus on the quality of Mr Solly's life as opposed to further investigations into his suspected lung cancer. Although there was discussion about an advanced care directive regarding resuscitation at the Meeting no final decision was reached.[39]

38. From Mr Solly's perspective, his quality of life revolved around the regular visits he received from his family and his desire to go outside and smoke cigarettes. Although he had expressed a desire to live somewhere other than Graylands Hospital, this was not possible because of his chronic mental health conditions.[40]

39. At a further review at the Clinic on 20 February 2017, it was decided that the outcome of the Meeting was still appropriate and no further respiratory reviews were scheduled.[41]

40. Having reviewed the available evidence, I am satisfied that reasonable efforts were made to involve Mr Solly in decisions about his care and treatment. I am further satisfied that the outcome of the Meeting, namely that the focus should be on quality of life issues, was appropriate in all of the circumstances.

[37] Exhibit 1, Vol. 1, Tab 25G, Letter - Dr I Moore & Clinical Professor F Lake (20.02.17)
[38] Exhibit 1, Vol. 1, Tab 25G, Letter - Dr I Moore & Clinical Professor F Lake (20.02.17)
[39] Exhibit 1, Vol. 1, Tab 25F, Letter - Dr K Lim & Clinical Professor F Lake (19.12.16) ts 04.03.21 (Lake), p21
[40] ts 04.03.21 (Lake), pp18-19 & 25-26
[41] Exhibit 1, Vol. 1, Tab 25G, Letter - Dr I Moore & Clinical Professor F Lake (20.02.17)

41. In 2017, Mr Solly was admitted to SCGH on two occasions with pneumonia and exacerbation of his lung disease. During the admission in September 2017, he became agitated and absconded from the hospital.[42,43,44,45]

42. Mr Solly's last presentation to SCGH was on 2 February 2018 when, during a visit from his partner, he developed severe breathlessness. He was taken to SCGH by ambulance and was found to be hypoxic. His emphysema and fibrosis were noted to have progressed and although a CT scan ruled out pleural effusion and pulmonary embolism, it showed Mr Solly's lung mass had increased in size, suggesting a malignancy.[46]

43. Mr Solly declined any active treatment although he did accept medications, including prednisolone, antibiotics and puffers. In accordance with the decision taken at the Meeting, the suspected malignancy was not further investigated. Mr Solly accepted oxygen therapy intermittently and was able to walk to a garden area and back to smoke cigarettes. After his symptoms had stabilised, he was transferred back to the HECS.[47]

44. In late February 2018, Mr Solly developed a fever which was suggestive of pneumonia and he was treated with antibiotics. It was noted that as Mr Solly was becoming increasingly frailer, his challenging behaviours were becoming worse. In February and March 2018, he assaulted patients and staff and he also threw milk over a consultant psychiatrist during a review. As a result of these behaviours, his antipsychotic medication and analgesia were reviewed.

45. Meanwhile, the issue of an advanced care directive relating to resuscitation was discussed between Mr Solly's treating team, his family and his guardian. In February 2018 and March 2018, a series of "*Not for CPR*" forms were prepared for Mr Solly.[48]

[42] Exhibit 1, Vol. 1, Tab 26B, SCGH Discharge Summary (13.06.17)
[43] Exhibit 1, Vol. 1, Tab 26C, SCGH Discharge Summary (14.06.17)
[44] Exhibit 1, Vol. 1, Tab 26D, SCGH Discharge Summary (01.07.17)
[45] Exhibit 1, Vol. 1, Tab 26E SCGH Discharge Summary (18.09.17)
[46] Exhibit 1, Vol. 1, Tab 26F, SCGH Discharge summary (02.02.18)
[47] Exhibit 1, Vol. 1, Tab 26F, SCGH Discharge summary (02.02.18) and ts 04.03.21 (Lake), p21
[48] Exhibit 1, Vol. 1, Tab 20, Not for resuscitation forms (16.02.18, 26.02.18, 02.03.18 & 09.03.18)

EVENTS LEADING TO MR SOLLY'S DEATH[49]

46. On 9 March 2018, Mr Solly experienced episodes of shortness of breath and respiratory distress. He was reviewed by a hospital doctor and his pain medication was reviewed.[50]

47. On 10 March 2018, Mr Solly was reviewed by a hospital doctor on two occasions when he presented with very low oxygen saturations and shortness of breath. He was given oxygen and nebulisers and his condition eventually stabilised. At 10.20 pm, Mr Solly got up for a cigarette but ended up lying on the floor in front of the nursing station shouting at staff to take him outside. He was placed in a wheelchair and taken outside, where he smoked two cigarettes, before being returned to his room.[51,52]

48. After he was woken up on 11 March 2018, Mr Solly came out of his room shouting and he threw a milk drink at the nursing station. He went back into his room and nursing staff assisted him with toileting. He accepted all of his medications, including a nebuliser, but would only tolerate oxygen therapy for short periods. Although he allowed his vital signs to be taken at 9.00 am, he refused a subsequent request and assaulted a staff member.[53]

49. Mr Solly then lay on the floor and demanded cigarettes, despite repeated requests that he get up. At 10.00 am, Mr Solly was still making demands but he allowed staff to assist him with toileting and consented to being placed back in his wheelchair. Nursing staff noted Mr Solly's laboured breathing and as they were attempting to take his vital signs at 10.14 am, he suddenly lost consciousness. A medical emergency call was activated at 10.15 am and a medical officer declared Mr Solly deceased at 10.20 am on 11 March 2018.[54,55,56]

[49] Exhibit 1, Vol. 1, Tab 8, Medical report - Dr M Iliescu (21.06.18), p2
[50] Exhibit 1, Vol. 1, Tab 12, Graylands Hospital Integrated patient notes (09.03.18)
[51] Exhibit 1, Vol. 1, Tab 22, SCGH Discharge summary (11.03.18)
[52] Exhibit 1, Vol. 1, Tab 12, Graylands Hospital Integrated patient notes (10.03.18)
[53] Exhibit 1, Vol. 1, Tab 12, Graylands Hospital Integrated patient notes (11.03.18)
[54] Exhibit 1, Vol. 1, Tab 22, SCGH Discharge summary (11.03.18)
[55] Exhibit 1, Vol. 1, Tab 12, Graylands Hospital Integrated patient notes (11.03.18)
[56] Exhibit 1, Vol. 1, Tab 4, Death in hospital form (11.03.18)

CAUSE AND MANNER OF DEATH

50. Dr Dan Moss, a forensic pathologist, carried out an external post mortem examination of Mr Solly's body on 12 March 2018. Dr Moss noted occasional bruises and abrasions and fingernail clubbing, a sign of low oxygen saturations.[57]

51. Toxicological analysis found a therapeutic level of duloxetine (antidepressant) and paracetamol along with low levels of zucopenthixol (an antipsychotic depot medication).[58]

52. A slightly "*supra-therapeutic*" level of valproic acid (an anticonvulsant and mood stabiliser), was also detected. Dr Moss noted that the level of valproic acid recorded was significantly below previously reported toxic or fatal ranges. Alcohol and common drugs were not found.[59,60]

53. At the conclusion of his external post mortem examination and after reviewing Mr Solly's medical notes, Dr Moss expressed the opinion that the cause of death was respiratory failure in a man with lung cancer, chronic obstructive pulmonary disease and pulmonary fibrosis.[61]

54. I accept and adopt that Dr Moss' conclusion as to the cause of Mr Solly's death. I find that death occurred by way of natural causes.

QUALITY OF SUPERVISION, TREATMENT AND CARE

55. Mr Solly's psychiatric illness and his challenging behaviours, including his verbal and physical aggression were, in my view managed with care and skill by the clinical and allied health staff at Graylands Hospital. I therefore agree with Dr Iliescu's assessment that Mr Solly received the best care possible given his circumstances.[62]

[57] Exhibit 1, Vol. 1, Tab 5, Post Mortem Report (12.03.18), pp1 & 3
[58] Exhibit 1, Vol. 1, Tab 6, ChemCentre toxicology report
[59] Exhibit 1, Vol. 1, Tab 6, ChemCentre toxicology report
[60] Exhibit 1, Vol. 1, Tab 5, Post Mortem Report (12.03.18), pp1 & 3
[61] Exhibit 1, Vol. 1, Tab 5, Supplementary Post Mortem Report (20.06.18), p1
[62] ts 04.03.21 (Iliescu), p12

56. In 2015, Mr Solly was referred to the respiratory clinic at SCGH. The respiratory team's treatment of Mr Solly was severely hampered by his steadfast refusal to quit smoking and his limited insight and poor judgement, caused by psychiatric illness and cognitive impairment. Despite those limitations, the respiratory team canvassed all available treatment options and did their best to engage Mr Solly in decisions about his care. Following a meeting of key individuals, including Mr Solly, on 26 December 2016, it was decided that future care would concentrate on improving the quality of Mr Solly's life.

57. In my view, that decision was clearly correct, particularly given the fact that aggressive treatment would have caused Mr Solly significant distress. I therefore agree with Clinical Professor Lake's evidence that Mr Solly received the best possible care given his respiratory and psychiatric conditions.[63]

58. It is significant that Mr Solly's sister specifically requested that her views about Mr Solly's care be put before the Court. In a conversation with Ms Sarah Tyler (counsel assisting), Mr Solly's sister made the following points:

    a. she has no concerns about the care that Mr Solly received while he was an involuntary patient and felt that all of his treating doctors did the best they could do with a difficult situation;

    b. all of the staff involved in Mr Solly's care did a really good job, the doctors were really good and the nurses went above and beyond in the face of really difficult behaviour on Mr Solly's part; and

    c. Clinical Professor Lake is a very good doctor who genuinely cares for her patients.[64,65]

59. On the basis of the evidence before me and for the reasons I have expressed, I find that the supervision, treatment and care that Mr Solly received both at Graylands Hospital and at Sir Charles Gairdner Hospital whilst he was the subject of a TO was of a very good standard.

[63] ts 04.03.21 (Lake), pp23-24
[64] Email from Ms S Tyler, recording conversation with Ms N Everix (04.03.21)
[65] ts 04.03.21 (Iliescu), p12 and ts 04.03.21 (Lake), p24

CONCLUSION

60. Mr Solly was a much loved family member who was 63 years of age when he died from respiratory failure. He led a simple life within the limitations imposed on him by his psychiatric and medical conditions and received very good support from his family.

61. Despite the damage that his heavy smoking was obviously doing to his health, it is clear that Mr Solly did not have the capacity to understand that his health outcomes would have been improved if he gave it up. As it was, he found comfort and pleasure in smoking cigarettes and therefore refused to quit.

62. Mr Solly's complex medical and psychiatric needs and his challenging behaviours were managed sensitively and patiently by the staff at Sir Charles Gairdner Hospital and Graylands Hospital respectively. For the reasons I have expressed, it is my view that in all of the circumstances, Mr Solly received a very good level of care.

MAG Jenkin
Coroner
8 March 2021