JURISDICTION	**:**	CORONER'S COURT OF WESTERN AUSTRALIA
ACT	**:**	CORONERS ACT 1996
CORONER	**:**	Michael Andrew Gliddon Jenkin, Coroner
HEARD	**:**	9 MARCH 2022
DELIVERED	**:**	13 APRIL 2022
FILE NO/S	**:**	CORC 669 of 2019
DECEASED	**:**	DRLESKI, BORIS

Catchwords:

Nil

Legislation:

Nil

Counsel Appearing:

Counsel Assisting	:	Will STOPS
Counsel	:	Brendyn Dean Nelson
Counsel	:	Esther Dyer

Counsel Appearing:

Mr W Stops appeared to assist the coroner.

Mr B Nelson (State Solicitor's Office) appeared for the North Metropolitan Health Service, the Office of the Chief Psychiatrist and the Mental Health Commission.

Coroners Act 1996
(Section 26(1))

RECORD OF INVESTIGATION INTO DEATH

I, Michael Andrew Gliddon Jenkin, Coroner, having investigated the death of ***Boris DRLESKI*** *with an inquest held at Perth Coroners Court, Central Law Courts, Court 85, 501 Hay Street, Perth on 9 March 2022, find that the identity of the deceased person was* ***Boris DRLESKI*** *and that death occurred on 22 May 2019 at 18A Kenwick Way, Balga, from bronchopneumonia and combined drug toxicity in the following circumstances:*

Table of Contents

INTRODUCTION

1. Boris Drleski (Mr Drleski) died on 22 May 2019 in Balga from bronchopneumonia and combined drug toxicity.[1,2] At the time of his death, Mr Drleski was the subject of a community treatment order (CTO)[3] made under the *Mental Health Act 2014* (WA) (the MHA).[4] Accordingly, immediately before his death Mr Drleski was an "*involuntary patient*" and thereby a "*person held in care*"[5] and his death was therefore a "*reportable death*".[6]

2. In such circumstances, a coronial inquest is mandatory[7] and 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.[8] On 9 March 2022, I held an inquest into Mr Drleski's death that was attended by members of his family.

3. The Brief of evidence tendered at the inquest consisted of three volumes and included a report on the police investigation into Mr Drleski's death, expert psychiatric reports, reports relating to mental health facilities and Mr Drleski's medical records and clinical notes. The following witnesses gave evidence during the inquest:

a. Dr Jasna Stepanovic (Consultant Psychiatrist, Mirrabooka CMHS);[9]
b. Dr Chris Hodgson (Consultant Psychiatrist, Graylands Hospital);
c. Mr Jonathan Carruthers (Case Manager, Mirrabooka CMHS);
d. Dr Nathan Gibson (Chief Psychiatrist);
e. Ms Jennifer McGrath (Mental Health Commissioner); and
f. Dr Adam Brett (Independent Consultant Psychiatrist).

4. The inquest focused on the circumstances of Mr Drleski's death and the supervision, treatment and care he received while he was the subject of a CTO.

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[1] Exhibit 1, Vol. 1, Tab 4, Life Extinct Form (22.05.19)
[2] Exhibit 1, Vol. 1, Tab 5A, Supplementary Post Mortem Report (21.11.19)
[3] An order made under the MHA that a person receive treatment on an involuntary basis in the community.
[4] Exhibit 1, Vol. 1, Tab 7, Mental Health Tribunal Order (09.05.19)
[5] Section 3, *Coroners Act 1996* (WA)
[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] CMHS is the common abbreviation for Community Mental Health Service

MR DRLESKI

Background[10,11,12,13]

5. Mr Drleski was born in Macedonia on 17 February 1974 and he had one sister. He and his family came to Australia in 1984 and settled in Port Hedland. Mr Drleski attended the local high school and is said to have enjoyed woodwork, soccer and fishing.

6. After finishing school, Mr Drleski worked in a furniture factory in Port Hedland before coming to Perth in 1991. He was then employed in a furniture factory in Balcatta and in about 2003, he began working in the crayfishing industry and as a commercial cleaner.

7. In about 2001, Mr Drleski began a relationship with a woman who had a child from a previous relationship, although Mr Drleski believed the child was his. In about 2003, Mr Drleski began a relationship with a new partner, who he was with for about two years.

8. Mr Drleski received ongoing support from his family, especially his sister. He is said to have had few friends or acquaintances, and those he did have were mostly polysubstance users. Mr Drleski was known to be a heavy smoker of cigarettes and to drink alcohol and he was also a regular user of illicit substances including methylamphetamine, cocaine, heroin and cannabis.

9. Mr Drleski was imprisoned on several occasions following convictions for drug-related offences, theft, unlawful damage and assault occasioning bodily harm. Mr Drleski was 45-years of age when he died at his home in Balga on 22 May 2019.[14,15,16,17,18,19]

[10] Exhibit 1, Vol. 1, Tab 9, Report - FC Const. N Anastasiadis (12.01.20), pp2-3
[11] Exhibit 1, Vol. 1, Tab 10A, Memorandum - Sen. Const. JP D'Souza (22.05.19), p2
[12] Exhibit 1, Vol. 1, Tab 10B, Memorandum – Det. FC Const. L Brigden (23.05.19), p3
[13] Exhibit 1, Vol. 1, Tab 11, File Note - Sen. Const. N Brown (13.08.19)
[14] Mr B Drleski - History for Court: Criminal & Traffic (20.05.92 -16.07.18)
[15] Exhibit 1, Vol.1, Tab 13B, Report - Dr A Brett (18.11.20), p11 para 81
[16] Exhibit 1, Vol. 1, Tab 1, P100 - Report of Death (12.01.20)
[17] Exhibit 1, Vol. 1, Tab 2, P98 - Mortuary Admission Form (22.05.19)
[18] Exhibit 1, Vol. 1, Tab 3, P92 - Identification of Deceased Person - Visual Means (22.05.19)
[19] Exhibit 1, Vol. 1, Tab 12, Report of Death Associated with the use of Drugs (22.05.19)

Mental health diagnoses

10. Mr Drleski's first contact with mental health services appears to have been on 20 September 2000, when a private psychiatrist diagnosed him with schizophreniform psychosis[20] and chronic drug use. At that time, Mr Drleski said he had been using cannabis daily since 17-years of age.[21]

11. Mr Drleski was a patient with complex needs. He was eventually diagnosed with treatment resistant chronic paranoid schizophrenia and anti-social personality disorder. His mental health conditions were complicated by non-compliance with his prescription medication and persistent polysubstance use, including heroin, methylamphetamine, cocaine and cannabis. Although Mr Drleski was often managed in the community, on numerous occasions, especially when he became floridly psychotic, he was admitted to Graylands Hospital (GH).[22,23]

12. At the time of his death, Mr Drleski was receiving the antipsychotic medication, zuclopenthixol decanoate, which works on the balance of chemical substances in the brain. This medication can be administered in tablet form or by means of long-acting intramuscular injections (depot injection) given weekly, fortnightly or monthly. Mr Drleski received his depot injections monthly, although there is no difference in efficacy between monthly, fortnightly or weekly injections.[24,25]

Community treatment order

13. The MHA provides that a person is not to be placed on a CTO 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 a community treatment order*".[26] It appears that Mr Drleski was first placed on a CTO following his discharge from GH on 19 August 2002. From that time on, Mr Drleski was routinely placed on CTOs after being discharged from GH.[27,28]

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[20] A type of psychotic illness with symptoms similar to schizophrenia but lasting for less than six months.
[21] Exhibit 1, Vol.1, Tab 13B, Report - Dr A Brett (18.11.20), p2, para 4
[22] Exhibit 1, Vol. 2, Tab 24, Statement - Dr C Hodgson (22.02.22), para 14
[23] Exhibit 1, Vol. 2, Tab 25, Statement - Dr J Stepanovic (28.02.22), paras 22-23 and ts 09.03.22 (Stepanovic), p7
[24] See: https://patient.info/medicine/zuclopenthixol-clopixol
[25] ts 09.03.22 (Hodgson), p30
[26] s25(2)(e), *Mental Health Act 2014* (WA)
[27] Exhibit 1, Vol. 2, Tabs 21 & 22, Mr Drleski's Graylands Hospital Inpatient records (E7931499)
[28] ts 09.03.22 (Stepanovic), pp8-10

14. A CTO was required in Mr Drleski's case because he was non-compliant with his medication regime. He also lacked insight into his mental conditions and did not have the capacity to make treatment decisions about his mental health.[29,30] Placing Mr Drleski on a CTO meant that he could be regularly monitored and when he declined his depot medication he could be required to attend an authorised place for an assessment by a psychiatrist. If necessary, his CTO could be also revoked and he could be admitted to hospital on an involuntary basis.[31]

15. Having carefully reviewed the available evidence, I am satisfied that the decision to place Mr Drleski on successive CTOs was justified on the basis that this was the least restrictive way to ensure that he was provided with appropriate treatment for his mental health conditions.

Management at Graylands Hospital[32,33]

16. Mr Drleski's first admission to Graylands Hospital (GH) was as an involuntary patient between 16 - 23 November 2000. He was diagnosed with drug induced psychosis, polysubstance use and antisocial personality traits. Between 2002 and 2019, Mr Drleski was regularly admitted to GH with psychotic symptoms on a background of continuing polysubstance use and non-compliance with his management plans.

17. Mr Drleski's presentation varied during his admissions to GH. Sometimes he was "*pleasant, cooperative and settled*", whilst on other occasions he could be "*extremely delusional and threatening*". Although the majority of Mr Drleski's admissions were for periods of between two and seven days, on one occasion he was admitted for 42 days and on another for 66 days. The duration of Mr Drleski's shorter admissions largely depended on his level of intoxication with illicit substances.

18. Typically, once Mr Drleski's mental state had settled, GH would liaise with Mirrabooka Mental Health Services (MMHS), a community mental health service, and Mr Drleski would be discharged into their care on a CTO.

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[29] Exhibit 1, Vol. 2, Tab 25, Att. JS-1, Report to Mental Health Tribunal - Dr J Stepanovic (17.11.17)
[30] Exhibit 1, Vol. 2, Tab 24, Att. CH1, Report to Mental Health Tribunal - Dr C Hodgson and Dr S Mathews (10.04.19)
[31] See: Division 4, Part 8, *Mental Health Act 2014* (WA)
[32] Exhibit 1, Vol. 2, Tabs 21 & 22, Mr Drleski's Graylands Hospital Inpatient records (E7931499)
[33] Exhibit 1, Vol. 2, Tab 24, Statement - Dr C Hodgson (22.02.22), paras 15-19 & 48

19. In the 12 months before his death Mr Drleski was admitted to GH on six occasions, with the last admission occurring on 10 April 2019, after he declined his depot injection in the community. On that occasion, Mr Drleski was taken to GH with the assistance of four police officers and he reported ongoing delusions. He also said he was using heroin on a regular basis and multiple injection sites were observed on his arms. Mr Drleski accepted his depot injection and was discharged the next day.

Management in the community[34,35,36]

20. Mr Drleski's mental health was clearly extremely difficult to manage, and he presented a number of significant challenges to his treating team. These included the fact that his paranoid schizophrenia was chronic in nature and treatment resistant. Further, despite repeated encouragement and the suggestion he trial the methadone program, Mr Drleski declined to cease his regular use of illicit substances. This adversely affected the management of his mental illness with medication.[37]

21. Mr Drleski was often hostile and abusive towards MMHS staff and his propensity for violence limited the range of staff who could safely interact with him. He also made credible threats of violence towards a number of clinicians, including repeated threats to kill his treating psychiatrist, Dr Jasna Stepanovic.

22. Despite Mr Drleski's threats, Dr Stepanovic continued to advocate for him to be managed in the community on a CTO, because she said this was the least restrictive form of care. With the benefit of hindsight, Dr Stepanovic said that Mr Drleski's threats should have been reported to the Police.[38]

23. Initially, Mr Drleski's sister took him to MMHS for his depot injections. However, as his antisocial behaviour escalated, Mr Drleski's depot injections were administered at his home. Because of Mr Drleski's propensity for violence, it was also determined that female nurses were not to attend his home and that two male nurses would do so instead.

[34] Exhibit 1, Vol. 2, Tab 23, Statement - Mr J Carruthers (10.02.22), paras 15-19
[35] Exhibit 1, Vol. 2, Tab 25, Statement - Dr J Stepanovic (28.02.22), paras 18-50
[36] Exhibit 1, Vol. 2, Tab 25, Att. JS-1, Report to Mental Health Tribunal - Dr J Stepanovic (17.11.17)
[37] ts 09.03.22 (Hodgson), p27
[38] Exhibit 1, Vol. 2, Tab 25, Statement - Dr J Stepanovic (28.02.22), paras 77-79 and ts 09.03.22 (Stepanovic), pp7-8

24. On a number of occasions, clinical staff visiting Mr Drleski's home noticed knives, syringes and drug paraphernalia lying around. Eventually, it was determined that the male nurses attending Mr Drleski's home would be supported by police to ensure that Mr Drleski could be safely assessed and given his monthly depot injections. Mr Drleski's aggressive behaviours continued to escalate and on occasion, he assaulted attending police.

25. Mr Drleski's last documented face-to-face review by Dr Stepanovic occurred on 22 August 2018. On that occasion, Mr Drleski presented as loud, agitated, threatening and demanding. He again made threats to kill MMHS staff, including Dr Stepanovic, and was placed on a CTO. Dr Stepanovic said she believed she had examined Mr Drleski at least once after this date, although if that assessment did occur, it was not documented in the MMHS notes.[39]

26. Following Dr Stepanovic's review, Mr Drleski's sister advised MMHS staff that her brother had disclosed he was using heroin. She also said Mr Drleski had asked her to take him to a GP, but that two doctors had declined to prescribe any medication. MMHS advised her that Mr Drleski should be taken to Next Step, a drug rehabilitation service. I will return to the options now available for patients with chronic mental health and polysubstance issues (such as Mr Drleski) later in this finding.[40]

27. The evidence before me makes it clear Mr Drleski routinely declined to accept his depot medication and had to be admitted to GH for this purpose. From November 2018, Mr Drleski's management plan included a proviso that if he declined his depot medication in the community, it would be given at GH. On 8 February 2019, Mr Jonathan Carruthers (who took over as Mr Drleski's case manager in early 2019) called the Office of the Chief Psychiatrist (OCP) after Mr Drleski's mental health advocate raised concerns that the MHA was being applied incorrectly in his case. The advocate suggested that Mr Drleski should be granted a two-week period within which to accept his monthly depot injections, in accordance with the breach process set out in the MHA.[41]

[39] Exhibit 1, Vol. 2, Tab 25, Statement - Dr J Stepanovic (28.02.22), para 53
[40] Exhibit 1, Vol. 2, Tab 25, Att. JS-8, MMHS Outpatient Notes (Dr J Stepanovic, 22.08.18)
[41] Exhibit 1, Vol. 2, Tab 23, Statement - Mr J Carruthers (10.02.22), paras 20-23 and ts 09.03.22 (Carruthers), pp35-36

28. After investigating the matter, Ms Kay Pak (a clinical consultant with the OCP) emailed Mr Carruthers on 8 February 2019, and confirmed Mr Drleski's management plan was acceptable, noting that:

> In light of the significant risks (both current and historical) to the well-being and safety of the client, mental health staff, the police and others the Chief Psychiatrist concurs with the current management plan whereby if the client refuses his depot then, if he meets the criteria for a Form 1A,[42] he should be taken to an authorised hospital to have his depot medication as per his current management plan.[43,44]

29. Ms Pak said she was aware that MMHS had already advised Mr Drleski's mental health advocate that she should not visit his home. Nevertheless, Ms Pak also recommended that MMHS write to the Chief Advocate of the Mental Health Advocacy Service to alert her to the situation so that further arrangements to ensure the safety of Mr Drleski's advocate could be put in place.[45]

30. Ms Pak also suggested that Mr Drleski's supervising psychiatrist ask the State Forensic Mental Health Service to assess Mr Drleski "*Due to* [his] *longstanding forensic and current risk issues*".[46] Following Ms Pak's email, Mr Carruthers updated Mr Drleski's management plan, although it is unclear whether the suggested forensic referral was ever actioned.

31. In relation to forensic assessments, I note that Mr Drleski had been referred to the Community Forensic Mental Health Service on 16 May 2018 for a risk assessment. That assessment was deferred several times and it appears it never eventuated.

32. On 14 February 2019, Mr Carruthers visited Mr Drleski's home, accompanied by police. Mr Drleski declined his monthly depot injection and was taken to GH by ambulance, where the injection was subsequently given.

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[42] A Form 1A under the MHA is an order for a person to be examined by a psychiatrist.
[43] Exhibit 1, Vol. 2, Tab 23, Att. JDC2, Email Ms K Pak (Office of the Chief Psychiatrist) to Mr J Carruthers (08.02.19), p2
[44] See also: Exhibit 1, Vol.3, Tab 27, Report - Chief Psychiatrist, Dr N Gibson (04.03.22), pp9-10, paras 60-68
[45] Exhibit 1, Vol. 2, Tab 23, Att. JDC2, Email Ms K Pak (Office of the Chief Psychiatrist) to Mr J Carruthers (08.02.19), p2
[46] Exhibit 1, Vol. 2, Tab 23, Att. JDC2, Email Ms K Pak (Office of the Chief Psychiatrist) to Mr J Carruthers (08.02.19), p2

33. Before being taken to GH, Mr Drleski complained about the automated text messages he had been receiving from MMHS on his mobile phone. These text messages were reminders about Mr Drleski's depot injection and assessment appointments, but Mr Carruthers felt they were "*triggering*" to Mr Drleski and asked MMHS administrative staff to stop sending them.[47]

34. From that point onwards, Mr Drleski received reminder phone calls in the week prior to his monthly depot injections and attempts were made to conduct mental state examinations during these calls. MMHS staff would then liaise with staff at GH and four police officers would be arranged to help transfer Mr Drleski to GH so that his depot medication could be administered in a safe, controlled environment.[48]

35. On 19 March 2019, Mr Carruthers emailed his colleagues and noted that Mr Drleski's management did not have a "*recovery based focus*".[49] In his statement to the Court, Mr Carruthers noted that: "*Mr Drleski's refusal to interact with staff and his consistent threats and abuse meant it was very difficult to initiate support for his recovery*".[50]

36. On 10 April 2019, Mr Carruthers visited Mr Drleski's home, accompanied by four police officers, to conduct an assessment. Mr Drleski attempted to assault the officers and had to be restrained with handcuffs. After refusing his depot medication, Mr Drleski was taken to GH in the rear passenger pod of a police vehicle. On arrival at GH, Mr Drleski's handcuffs were removed and he was admitted to Smith Ward.

37. In an email to colleagues on 10 April 2019, Mr Carruthers noted "*a senior police officer*" had suggested that in future, clinical staff should liaise with Mirrabooka Police station and have four officers attend Mr Drleski's home to ensure his safe transfer to GH in a police vehicle in the event that he refused his depot medication.[51,52]

[47] Exhibit 1, Vol. 2, Tab 23, Att. JDC5, Service Event Details - Mr J Carruthers (14.02.19)
[48] Exhibit 1, Vol. 2, Tab 23, Att. JDC5, Service Event Details - Mr J Carruthers (14.02.19)
[49] Exhibit 1, Vol. 2, Tab 23, Att. JDC6, Email Mr J Carruthers to colleagues (19.03.19)
[50] Exhibit 1, Vol. 2, Tab 23, Statement - Mr J Carruthers (10.02.22), para 38
[51] Exhibit 1, Vol. 2, Tab 23, Att. JDC7, Service Event Details - Mr J Carruthers (10.04.19)
[52] Exhibit 1, Vol. 2, Tab 23, Att. JDC8, Email Mr J Carruthers to colleagues (10.04.19)

38. In his email to colleagues, Mr Carruthers also noted that the senior police officer had suggested that the ambulance (which had been usually requested for the monthly depot injection and assessment visits) be dispensed with and only be called if Mr Drleski or attending staff sustained a physical injury during the journey to GH.[53,54]

39. On 8 May 2019, Mr Carruthers attended a peer review meeting along with the head of MMHS, members of Mr Drleski's community and inpatient clinical teams, and staff from the OCP. The purpose of the meeting was to discuss Mr Drleski's case and to confer about the mechanism being used to bring him to GH when he refused his depot injection in the community.

40. Following the meeting, Mr Carruthers drafted an updated management plan for Mr Drleski. That plan noted that four police officers were required to attend monthly visits by MMHS staff and that if Mr Drleski refused his depot injection, he would be taken to GH in a police vehicle for this purpose.[55,56]

41. On 13 May 2019, Mr Carruthers called Mr Drleski to remind him about his monthly depot injection the following day and Mr Drleski said he would attend MMHS. Given Mr Drleski's previous non-compliance and his abusive and combative behaviour, Mr Carruthers was surprised when Mr Drleski attended MMHS on 14 May 2019, on his own volition.[57]

42. Mr Carruthers said he had arranged for police officers to attend MMHS in case Mr Drleski became abusive or violent, but that as it happened, they were not required. Although Mr Drleski was delusional and made threats towards police, Mr Carruthers saw him alone and Mr Drleski accepted his depot injection. During the appointment, Mr Drleski confirmed that he had recently been using more heroin than methamphetamine and was noted to have bruises and track marks "*all over his arms*".[58]

[53] Exhibit 1, Vol. 2, Tab 23, Att. JDC7, Service Event Details - Mr J Carruthers (10.04.19)
[54] Exhibit 1, Vol. 2, Tab 23, Att. JDC8, Email Mr J Carruthers to colleagues (10.04.19)
[55] Exhibit 1, Vol. 2, Tab 23, Att. JDC9, MMHS Outpatient Notes (08.05.19)
[56] Exhibit 1, Vol. 2, Tab 23, Att. JDC10, Updated Client Management Plan (08.05.19)
[57] Exhibit 1, Vol. 2, Tab 23, Att. JDC11 MMHS Outpatient Notes (13.05.19) & Att. JDC12 MMHS Outpatient Notes (14.05.19)
[58] Exhibit 1, Vol. 2, Tab 23, Att. JDC12, MMHS Outpatient Notes (14.05.19)

43. Mr Carruthers said that during the time he had been his case manager, he could not recall Mr Drleski ever having attended MMHS and that this was "*extremely out of character*" for Mr Drleski. At the inquest, Mr Carruthers said he felt he was developing some rapport with Mr Drleski and was pleasantly surprised when Mr Drleski agreed to come to the clinic again for his June 2019 depot injection.[59]

44. In light of Mr Drleski's previous refusal to engage with mental health staff along with his abusive behaviour and threats of violence, this change of attitude towards his depot injections offers a tantalising glimpse of what might have been. Sadly, Mr Drleski died before his June 2019 appointment, and so it will never be known if his recent change of attitude would have persisted. In passing, I note that Mr Carruthers' efforts to develop a therapeutic relationship with Mr Drleski were applauded by Dr Adam Brett, the consultant psychiatrist who provided the Court with an independent assessment of Mr Drleski's care.[60]

Mental Health Tribunal hearings[61,62,63]

45. Mr Drleski's care and management was the subject of periodic review by the Mental Health Tribunal (Tribunal) and hearings were usually conducted when Mr Drleski was an inpatient at GH. At these hearings, the Tribunal reviewed Mr Drleski's CTOs and Inpatient Treatment Orders (which were the orders that enabled him to be given his depot medication at GH). The Brief contains reports prepared by clinicians for Tribunal hearings in 2017, 2018 and 2019.

46. A Tribunal hearing was conducted on 11 April 2019. Mr Drleski's treating psychiatrist at GH (Dr Chris Hodgson) co-authored a report for that hearing which set out Mr Drleski's management plan. That plan was directed at trying to get Mr Drleski to accept his depot injection in the community rather than having to come to GH to receive it. At the hearing, the Tribunal raised concerns about the method being used to bring Mr Drleski to GH when he refused his depot medication.

[59] ts 09.03.22 (Carruthers), pp35 & 40-41
[60] ts 09.03.22 (Brett), pp74 & 80 and see also: ts 09.03.22 (Brett), pp78-79
[61] Exhibit 1, Vol. 2, Tab 24, Statement - Dr C Hodgson (22.02.22), paras 20-31
[62] Exhibit 1, Vol. 2, Tab 24, Att. CH1, Report to Mental Health Tribunal - Dr C Hodgson and Dr S Mathews (10.04.19)
[63] Exhibit 1, Vol. 2, Tab 24, Att. CH2, Report to Mental Health Tribunal - Dr C Hodgson and Dr S Mathews (08.05.19)

47. The hearing was adjourned to enable Mr Drleski's community and inpatient clinical teams to confer about the propriety of those arrangements. In short, the Tribunal was concerned that Mr Drleski was being brought to GH by means of a Form 1A (Referral for Examination by a Psychiatrist) and a Form 4A (Transport Order), both issued under the MHA. The Tribunal queried whether the breach process under the MHA should be used instead.

48. Dr Hodgson was an attendee at the meeting on 8 May 2019, I referred to earlier. After discussion, attendees agreed that Mr Drleski's management plan (including the use of Forms 1A and 4A when he refused his depot injection) was appropriate. Following the meeting, Dr Hodgson's registrar prepared an addendum report (which Dr Hodgson subsequently countersigned) for the Tribunal hearing scheduled for 9 May 2019. In part, that report states:

> Mr Drleski is likely to require ongoing treatment under a community treatment order to maintain medication management and facilitate recovery. Mirrabooka clinicians will continue to review and attempt to engage Mr Drleski in the community with 4 police officers due to significant risk to others. The breach of CTO process may be considered if Mr Drleski is of stable mental state, with intact capacity and low immediate risk. A Form 1A and transfer to Smith ward at Graylands Hospital will need to be considered if, at the time of assessment in the community, Mr Drleski presents with a deterioration in mental state with risk of harm to self or others and impaired capacity requiring treatment. The appropriate ongoing care will be determined at the time of admission in collaboration with the community team and will include administration of depot medication.[64]

49. At the hearing on 9 May 2019, the Tribunal ordered that the CTO made in respect of Mr Drleski on 11 April 2019, remain in force. It also appears that the Tribunal accepted the appropriateness of using Forms 1A and 4A to transport Mr Drleski to GH when he refused his depot injection in the community.[65,66]

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[64] Exhibit 1, Vol. 2, Tab 24, Att. CH2, Report to Mental Health Tribunal - Dr C Hodgson and Dr S Mathews (08.05.19), p1
[65] Exhibit 1, Vol. 1, Tab 7, Order - Mental Health Tribunal (09.05.19)
[66] See: s395, *Mental Health Act 2014* (WA)

EVENTS LEADING TO MR DRLESKI'S DEATH[67,68,69,70,71,72,73]

50. Mr Drleski had reportedly been experiencing flu-like symptoms in the three days before his death. Over that same period he is said to have taken a number of overdoses of heroin and his friends said that he needed to be given Narcan (i.e.: naloxone), an intramuscular medication that reverses the effects of opioids, including heroin.[74]

51. During the evening of 21 May 2019, Mr Drleski and his housemate had some friends over. Mr Drleski was reported to have consumed "*three or four shots of heroin and speed* [methylamphetamine] *throughout the day*". One of Mr Drleski's friends said he went to bed at 8.00 pm whilst another thought Mr Drleski had retired between 9.30 pm and 10.00 pm. Either way, Mr Drleski did not have dinner as he was not feeling well. One of the friends said he checked on Mr Drleski several times during the night.

52. Sometime before 9.00 am on 22 May 2019, Mr Drleski was discovered unresponsive in his bedroom. He was on his knees beside the bed, with his arms resting on the bed. He was given Narcan by one of his friends whilst others started CPR and called emergency services. When ambulance officers arrived, Mr Drleski was near his bed and CPR was being performed. Ambulance officers noted syringes in a bucket and on a bedside table, and there was an uncapped needle near Mr Drleski's body.

53. Ambulance officers were unable to gain intravenous access and so a needle was inserted into Mr Drleski's left tibia. Although he was given repeated doses of adrenaline, there was no response, and Mr Drleski was declared deceased at 9.17 am.[75] Police arrived and noted blood splatter on the bedroom carpet and near Mr Drleski's head and neck area. It was assumed that Mr Drleski had been coughing up blood and a police investigation found no evidence of criminality with respect to his death.

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[67] Exhibit 1, Vol. 1, Tab 15, Statement - OT (22.05.19)
[68] Exhibit 1, Vol. 1, Tab 16, Statement - JH (22.05.19)
[69] Exhibit 1, Vol. 1, Tab 17, Statement - MB (22.05.19)
[70] Exhibit 1, Vol. 1, Tab 18, Statement - JD (22.05.19)
[71] Exhibit 1, Vol. 1, Tab 19, SJA Patient Record (Crews OPK21D2 & WNG27D2, 19.05.19)
[72] Exhibit 1, Vol. 1, Tab 9, Report - FC Const. N Anastasiadis (12.01.20), pp3-4
[73] Exhibit 1, Vol. 1, Tab 10A, Memorandum - Sen. Const. JP D'Souza (22.05.19), pp2-3
[74] See: https://adf.org.au/drug-facts/naloxone
[75] Exhibit 1, Vol. 1, Tab 4, Life Extinct Form (22.05.19)

CAUSE AND MANNER OF DEATH

54. Dr Clive Cooke (a forensic pathologist) conducted a post mortem examination of Mr Drleski's body on 24 May 2019. Dr Cooke found evidence of recent resuscitation attempts and numerous bruises and small spots and depressions (punctate marks) on the skin of Mr Drleski's hands and arms. With the exception of congested lungs and cirrhosis of the liver, Mr Drleski's internal organs appeared otherwise healthy.[76]

55. Microscopic examination of tissues showed changes in Mr Drleski's lungs that indicated bronchopneumonia. Bronchopneumonia is a type of infection affecting the large tubes (bronchi) that carry air from the windpipe (trachea) to the lungs. Although virological testing was negative for viral respiratory infections, microbiological testing "*showed bacterial organisms associated with pneumonia*".[77]

56. Toxicological analysis found diazepam, temazepam and oxazepam (all benzodiazepines) in Mr Drleski's system along with zuclopenthixol, tramadol (opioid pain medication), mirtazapine (anti-depressant) and pseudoephedrine (a decongestant). Methylamphetamine and its metabolite amphetamine were also detected along with morphine and codeine, a common impurity found in heroin. The substance, monoacetylmorphine, was detected in Mr Drleski's urine, and indicates recent heroin use.[78]

57. At the conclusion of the post mortem examination, Dr Cooke expressed the opinion that the cause of Mr Drleski's death was bronchopneumonia and combined drug toxicity.[79] I accept and adopt Dr Cooke's conclusion as my finding as to the cause of Mr Drleski's death.

58. Further, on the basis that there is no evidence that Mr Drleski consumed illicit drugs or medication with the intention of taking his life, I find that his death occurred by way of accident.

[76] Exhibit 1, Vol. 1, Tab 5B, Post Mortem Report (24.05.19), p5
[77] Exhibit 1, Vol. 1, Tab 5A, Supplementary Post Mortem Report (21.11.19), p1
[78] Exhibit 1, Vol. 1, Tab 6, Toxicology report (13.11.19)
[79] Exhibit 1, Vol. 1, Tab 5A, Supplementary Post Mortem Report (21.11.19)

INDEPENDENT ASSESSMENT OF MR DRLESKI'S CARE

Overview

59. Dr Brett (an experienced consultant psychiatrist) was asked to conduct an independent assessment of Mr Drleski's care. Dr Brett provided two reports to the Court and gave evidence at the inquest.[80,81] Before I outline the concerns Dr Brett expressed about Mr Drleski's care, it is worth noting the concluding comments in his first report:

> I would conclude by stating that the information shows that Mr Drleski's management was very difficult. I believe the clinicians were trying their best in a very difficult situation. There are a number of systemic issues that this case illustrates. These are reflected in the Chief Psychiatrist's targeted review. The issue remains that there is a large discrepancy between policy, planners and coalface clinicians.[82]

60. Dr Brett noted that there was good evidence that Mr Drleski was chronically psychotic, even when he was not using illicit substances, noting that when Mr Drleski had been in prison he remained psychotic. Dr Brett acknowledged that Mr Drleski's management in the community was "*clearly difficult*" and that he appeared to be treatment resistant and became acutely unwell when he used illicit substances. Dr Brett also noted that Mr Drleski's management did not appear to have changed significantly over the years "*despite the fact it did not seem to be working*".[83]

Comments on management in the community[84,85]

61. After considering all of the available evidence, Dr Brett said he considered Mr Drleski's management in the community was "*suboptimal*" and noted there was no evidence of Mr Drleski being examined by Dr Stepanovic after 22 August 2019. As I noted, Dr Stepanovic said she believed she had reviewed Mr Drleski after this date, although there is nothing in writing to support this belief.[86]

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[80] Exhibit 1, Vol.1, Tab 13A, Report - Dr A Brett (18.04.21) and Tab 13B, Report - Dr A Brett (18.11.20)
[81] ts 09.03.22 (Brett), pp73-86
[82] Exhibit 1, Vol.1, Tab 13B, Report - Dr A Brett (18.11.20), p14, paras 21-22
[83] Exhibit 1, Vol.1, Tab 13B, Report - Dr A Brett (18.11.20), p11, paras 4-6
[84] Exhibit 1, Vol.1, Tab 13A, Report - Dr A Brett (18.04.21), pp4-5, paras 1-13
[85] Exhibit 1, Vol.1, Tab 13B, Report - Dr A Brett (18.11.20), pp11-13, paras 1-20
[86] Exhibit 1, Vol. 2, Tab 25, Statement - Dr J Stepanovic (28.02.22), para 53

62. In her statement, Dr Stepanovic said that with the benefit of hindsight, she should have made more detailed notes of her interactions with Mr Drleski and his sister, especially with respect to attempts to engage with him, as well as all of the appointments that were booked and not attended by Mr Drleski. Dr Stepanovic also conceded that she should have documented her discussions about Mr Drleski with team members, the Head of Service, the GH inpatient team, the Tribunal and the OCP in more detail.[87]

63. Dr Brett expressed the view that Mr Drleski could not be managed safely in the community, given that four police officers were required to attend Mr Drleski's monthly assessment and depot injection appointments to ensure the safety of clinical staff. Whilst it is true that Mr Drleski made repeated threats towards staff at MMHS and had assaulted police, it is worth noting that his last assault related conviction occurred in 2007. He had certainly been convicted of numerous offences after that time, but those charges mainly related to the possession or cultivation of drugs.[88]

64. Dr Hodgson acknowledged that Mr Drleski could be "*extraordinarily abusive and threatening*" when intoxicated by methylamphetamine, but said that when settled, Mr Drleski "*actually got on quite well with staff*". Dr Hodgson said there was a therapeutic relationship between Mr Drleski and his inpatient and community treating teams and that Mr Drleski was manageable in the community on a CTO. Dr Hodgson also noted that successive hearings of the Tribunal had come to the same conclusion.[89]

65. The Chief Psychiatrist (Dr Nathan Gibson) acknowledged that difficult pragmatic issues arise when there are limited rehabilitation beds and clinicians are considering "*the least worst scenario*". Dr Gibson said that the issue of managing potentially dangerous patients in the community is one which divides psychiatrists, with some taking the view that the "*bottom line is how dangerous the patient is at the particular point of assessment*". Nevertheless, Dr Gibson said there seemed to be little dispute that if a patient is assessed as "*very dangerous*" then they must be managed in an acute inpatient bed, where one is available.[90]

[87] Exhibit 1, Vol. 2, Tab 25, Statement - Dr J Stepanovic (28.02.22), paras 75-76
[88] Mr B Drleski - History for Court: Criminal & Traffic (20.05.92 -16.07.18)
[89] Exhibit 1, Vol. 2, Tab 24, Statement - Dr C Hodgson (22.02.22), paras 38-39
[90] Exhibit 1, Vol.3, Tab 27, Report - Chief Psychiatrist, Dr N Gibson (04.03.22), p10, paras 66-67

66. Dr Brett noted that Mr Drleski had not been managed by the Intensive Community Outreach Team (ICOT), despite this having been recommended. As the name suggests, ICOT offers an intensive multi-disciplinary service aimed at improving the mental health of its consumers. However, Dr Hodgson expressed the view that Mr Drleski "*was not the type of client that ICOT could work with*". This was due in part to the "*unpredictability*" of Mr Drleski's home situation, including the weapons he stored there and the substance use of his regular visitors. Dr Stepanovic also said there was a concern that the frequent contact with clinicians that is part of the ICOT service would probably have caused Mr Drleski's aggressive behaviours to escalate.[91,92]

67. Dr Brett also raised the issue of whether Mr Drleski's management would have been enhanced by engagement with peer support workers and/or services offered by non-government organisations. Whilst this may have been beneficial, Mr Drleski's aggressive attitude towards MMHS staff meant that options in this respect were very limited. As noted, because of safety concerns, female staff were not permitted to attend Mr Drleski's home and his mental health advocate had been warned against doing so.

68. Mr Carruthers said Mr Drleski had "*blatantly and abrasively refused to engage with those who tried to help him*" and that given the safety risks posed by Mr Drleski, it would have been inappropriate to have referred him to the services suggested by Dr Brett. Dr Stepanovic agreed and Dr Hodgson referred to Mr Drleski's lifestyle and home environment as reasons why referrals to these services would not have been possible.[93,94,95]

Long-term hospitalisation[96]

69. Dr Brett said he could find no evidence that long-term hospitalisation (meaning a stay of many months) had been considered and believed this could have been beneficial and may have enabled rapport to have been developed and Mr Drleski's chronic illicit substance use to have been addressed.

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[91] Exhibit 1, Vol. 2, Tab 24, Statement - Dr C Hodgson (22.02.22), paras 33-34 and ts 09.03.22 (Hodgson), pp27-28
[92] ts 09.03.22 (Stepanovic), pp13-14
[93] Exhibit 1, Vol. 2, Tab 23, Statement - Mr J Carruthers (10.02.22), para 52
[94] Exhibit 1, Vol. 2, Tab 24, Statement - Dr C Hodgson (22.02.22), para 40
[95] Exhibit 1, Vol. 2, Tab 25, Statement - Dr J Stepanovic (28.02.22), paras 64-65
[96] Exhibit 1, Vol.1, Tab 13B, Report - Dr A Brett (18.11.20), pp12-13, paras 11-14 and ts 09.03.22 (Brett), pp75-77 & 85-86

70. Dr Brett also said that a long-term inpatient admission might have allowed Mr Drleski to have been trialled on clozapine, an antipsychotic reserved for treatment resistant cases of schizophrenia (see discussion below).

71. Dr Hodgson (with whom Dr Stepanovic agreed) said he was confident Mr Drleski would not have been accepted by GH's Extended Care Service (HECS). For a start, Dr Hodgson noted there were only 60 HECS beds that were "*constantly full*" and the focus of HECS was now on patients "*who can be rehabilitated*". Dr Hodgson said that Mr Drleski's chronic polysubstance use and his treatment resistant mental health conditions meant that his prospects of rehabilitation were "*low*" and therefore, he was unlikely to have benefitted from a referral to HECS.[97,98]

72. At the inquest, Dr Stepanovic said that with the benefit of hindsight, she should have advocated for a lengthy hospital admission in Mr Drleski's case.[99] I will touch on the facilities which are now available (or which are about to be made available) to mental health consumers like Mr Drleski who have long-term polysubstance use and chronic mental health issues.

Potential trial on clozapine[100,101,102,103]

73. Dr Brett considered that Mr Drleski would have benefitted from a trial of clozapine, in the context of a long-term inpatient admission. Clozapine is a "*novel antipsychotic that is used in treatment resistant schizophrenia*",[104] and is regarded as "*the gold standard*" for treatment resistant schizophrenia.[105]

74. Although clozapine has been shown to have very good results in some patients, weekly blood tests are required for the first 18 weeks with monthly blood tests thereafter. This is required to monitor clozapine levels because the medication can cause serious side-effects including heart issues, seizures and a decrease in an individual's white blood cells count.[106]

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[97] Exhibit 1, Vol. 2, Tab 24, Statement - Dr C Hodgson (22.02.22), paras 44-46 and ts 09.03.22 (Hodgson), pp27-27
[98] Exhibit 1, Vol. 2, Tab 25, Statement - Dr J Stepanovic (28.02.22), paras 61-62
[99] ts 09.03.22 (Stepanovic), pp15-17 & 22 and see also ts 09.03.22 (Carruthers), pp41-44
[100] Exhibit 1, Vol.1, Tab 13B, Report - Dr A Brett (18.11.20), pp12-13, paras 11-14 and ts 09.03.22 (Brett), p80
[101] Exhibit 1, Vol. 2, Tab 24, Statement - Dr C Hodgson (22.02.22), para 42 and ts 09.03.22 (Hodgson), pp29-30
[102] Exhibit 1, Vol. 2, Tab 25, Statement - Dr J Stepanovic (28.02.22), paras 66-73 ts 09.03.22 (Stepanovic), pp19-21
[103] ts 09.03.22 (Gibson), pp55-56
[104] Exhibit 1, Vol.1, Tab 13B, Report - Dr A Brett (18.11.20), p12, para12 and ts 09.03.22 (Brett), p77
[105] Exhibit 1, Vol. 2, Tab 25, Statement - Dr J Stepanovic (28.02.22), para 67
[106] See: https://www.nps.org.au/australian-prescriber/articles/clozapine-in-primary-care

75. Dr Hodgson did not consider that treatment with clozapine was an option in Mr Drleski's case. Although Mr Drleski might have agreed to an inpatient trial, in Dr Hodgson's view Mr Drleski's lack of insight into his mental health conditions meant there was no prospect he would have agreed to continue with the treatment after being discharged home. Clozapine treatment requires a high level of cooperation and if the daily dose is missed for more than a few days, the initiation protocol must be repeated.

76. Mr Drleski's lack of insight into his mental health conditions was the precise reason he was managed on a CTO and received depot injections. For that reason, and given Mr Drleski's disorganised lifestyle, it does seem it would have been almost impossible for MMHS staff to have ensured his compliance with a clozapine regime. Nevertheless, there is no way of knowing whether Mr Drleski might have been convinced to take clozapine after discharge, given that long-term hospitalisation was never attempted.

TREATMENT OPTIONS SINCE MR DRLESKI'S DEATH

Review by Office of Chief Psychiatrist[107]

77. In 2020, the OCP conducted a review of the services available to mental health consumers with complex needs (the Review), including those with "*co-occurring severe mental illness and substance abuse issues*" (like Mr Drleski). The Chief Psychiatrist (Dr Nathan Gibson) noted the following issues identified by the Review were of particular relevance in Mr Drleski's case:

1. The availability of long-term complex care or extended care units for patients like Mr Drleski…[noting]…it is very difficult to gain admission into the long-stay ward at Graylands;
2. The issue of patients with Mr Drleski's co-occurring mental health and substance abuse issues being rejected by available services as a potential consequence of being too difficult or not meeting the entry criteria; and
3. The capacity of mental health clinicians to provide substance use treatment for patients like Mr Drleski with substance use issues which severely affected his mental health.[108]

[107] Exhibit 1, Vol.3, Tab 27, Report - Chief Psychiatrist, Dr N Gibson (04.03.22) and ts 09.03.22 (Gibson), pp47-60

78. In his report to the Court, Dr Gibson referred to analysis by the Auditor General that had determined that about 10% of adult mental health consumers used up approximately 90% of available mental health inpatient resources; 50% of specialist clinical community mental health service time and 50% of emergency department mental health time. Dr Gibson also noted that the "*lack of long-term complex care units contributes to this high repeated use*" and Mr Drleski had been a "*high, if reticent, service user*".[109]

79. Dr Gibson noted that the Review had also identified that mental health consumers who had co-occurring severe mental illness and substance abuse issues were commonly rejected by available services "*as a potential consequence of being too difficult or not meeting the entry criteria*".[110]

Response by the Mental Health Commission[111]

80. The Mental Health Commission (the Commission) was established in March 2010, and works closely with the Department of Health and service providers to "*lead mental health reform throughout the State and work towards a modern effective mental health system that places the individual and their recovery at the centre of its focus*".[112]

81. In a report to the Court, the Mental Health Commissioner (Ms Jennifer McGrath) outlined the Commission's response to the issues raised in the Review. Before turning to some of the Commission's initiatives, I note that in late 2020, the Government established the Graylands Reconfiguration and Forensic Taskforce (GRAFT), which is comprised of departmental representatives and others (including the Commissioner). GRAFT is responsible for the oversight and planning for the decommissioning of GH and other mental health facilities.

82. In addition, the Commission is leading the Community Treatment and Emergency Response Roadmap, which is planning the future of community mental health services "*that will meet the needs of the people of WA, including those with complex and multiple needs*".

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[108] Exhibit 1, Vol.3, Tab 27, Report - Chief Psychiatrist, Dr N Gibson (04.03.22), p3, para 15
[109] Exhibit 1, Vol.3, Tab 27, Report - Chief Psychiatrist, Dr N Gibson (04.03.22), p5, para 30
[110] Exhibit 1, Vol.3, Tab 27, Report - Chief Psychiatrist, Dr N Gibson (04.03.22), p6, para 35
[111] Exhibit 1, Vol.3, Tab 26, Report - Mental Health Commissioner, Ms J McGrath, (03.03.22) and ts 09.03.22 (McGrath), pp61-73
[112] Exhibit 1, Vol.3, Tab 26, Report - Mental Health Commissioner, Ms J McGrath, (03.03.22), p1, paras 6-7

83. As for services that might have been relevant to Mr Drleski's treatment and management, Ms McGrath referred to the following initiatives:[113]

a. *Secure Extended Care Units* (SECU): these facilities are intensive inpatient rehabilitation units. They are designed for individuals admitted on an involuntary basis, who have severe and chronic mental health illnesses with co-occurring conditions and challenging behaviours, who pose a significant risk. The goal of treatment at a SECU is for the patient to be transitioned to community rehabilitation and eventually to either supported, or independent living. A planned 12-bed SECU, to be located on the Bentley Hospital campus is due to open in the next few years.

b. *Community Care Units* (CCU): these facilities provide long-term treatment, rehabilitation and recovery care for individuals transitioning out of inpatient facilities, including SECUs. CCUs provide "*open, home like environments*" and are staffed by a multi-disciplinary team that offers recovery-based psychosocial and clinical care in a residential setting.

Two CCUs are due to open in 2022. One of them is located in Orelia and will offer 20-beds to individuals aged between 18-64 years with severe and persistent mental health issues and complex needs (including alcohol and other drug issues) who require a high level of support. The other CCU, located in St James, will offer 40-beds. Half of these will be allocated to individuals with chronic and enduring mental illnesses and psychosocial disabilities, with an expected stay of six to 12 months. The remaining 20-beds (expected to be available in early 2023) will be for shorter stays and be directed at prevention and rehabilitation.

84. Ms McGrath noted that the CCU in Orelia will partner with Cyrenian House, a specialist alcohol and other drug treatment service, with the intention of ensuring "*the provision of integrated mental health and polysubstance use care, treatment and support*". Residents at the CCU will have access to a range of staff including psychiatrists, recovery support workers, social workers, clinical psychologists, occupational therapists, drug and alcohol counsellors and pharmacists.[114]

[113] Exhibit 1, Vol.3, Tab 26, Report - Mental Health Commissioner, Ms J McGrath, (03.03.22), pp4-6, para 24
[114] Exhibit 1, Vol.3, Tab 26, Report - Mental Health Commissioner, Ms J McGrath, (03.03.22), p8, para 34

85. Ms McGrath also referred to the establishment of the Immediate Drug Assistance Coordination Centre, which will coordinate the delivery of a range of services, including telephone advice lines for clinicians and mental health consumers, an outreach team to provide intervention and harm reduction services, a drop-in hub and a 6-bed short term crisis accommodation facility.[115]

QUALITY OF SUPERVISION, TREATMENT AND CARE

86. The evidence establishes that Mr Drleski had very complex needs including chronic mental health conditions that were treatment resistant, and regular and persistent polysubstance use. At the relevant time, clinical staff managing Mr Drleski's care were hampered by the absence of appropriate facilities that offered suitable long-term inpatient care.

87. In those circumstances, clinical staff interacting with Mr Drleski did their best to manage his complex needs by a combination of community care, (that largely consisted of brief monthly assessments and depot injections) and regular, brief inpatient admissions to GH.[116] Whilst this management approach largely enabled Mr Drleski to remain in his home, it was not "*recovery focussed*" and seemed instead to be aimed at maintaining the status quo.

88. At the relevant time, Mr Drleski's clinical teams did not have access to the SECU or the CCUs which are only now beginning to become available. It is possible that Mr Drleski may have benefitted from being admitted (on a long-term basis) to the SECU, with a view to eventually being transitioned to a CCU and ultimately to supported or independent accommodation.[117,118]

89. Mr Drleski's longstanding polysubstance use was a major impediment to the management of his mental illnesses and was never successfully addressed. At the relevant time, the sort of integrated model soon to be available at the SECU (where polysubstance use and mental health issues are tackled together), was simply unavailable.

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[115] Exhibit 1, Vol.3, Tab 26, Report - Mental Health Commissioner, Ms J McGrath, (03.03.22), pp8-9, para 34
[116] ts 09.03.22 (Stepanovic), p13
[117] ts 09.03.22 (Hodgson), p30
[118] ts 09.03.22 (Gibson), pp58-60

90. Notwithstanding the pressure on beds at GH, Mr Drleski may have benefitted from a long-term admission there, had this been possible. One of the goals of such a long-term admission might have been to wean Mr Drleski off illicit substances and to aggressively pursue rehabilitation options, including the methadone and suboxone programs, which he had previously been resistant to.[119]

91. It may also have been possible to engage Mr Drleski in a long-term trial of clozapine, although I accept this had had limited success. Nevertheless, such a trial might have helped and there is the tantalising prospect that Mr Drleski may have been willing to engage with the trial, especially given his unexpected change of heart in relation to receiving his depot injections at MMHS, albeit shortly before his death.

92. Having carefully considered all of the available evidence, it is my view that Mr Drleski's management whilst he was an involuntary patient at GH and whilst he was the subject of a CTO under the care of MMHS was reasonable, when considered in the context of the resources available to his clinical teams at the relevant time. I accept there were few practical alternatives which would have enabled Mr Drleski to have remained in the community. As it was, although he wasn't getting any better, he was at least able to stay in his own home.

93. However, given that Mr Drleski's supervision, treatment and care during the time he was the subject of a CTO was not recovery focussed, it cannot be said to have been optimal. In essence, Mr Drleski's management plan merely maintained the status quo and there did not appear to be any expectation that Mr Drleski would (or could) get better.

94. It seems obvious that the supervision, treatment and care that Mr Drleski received would have been significantly enhanced had his clinical teams been able to admit him to a SECU as an involuntary patient, where both his polysubstance use and his mental health illnesses could have been addressed in a coordinated fashion.

[119] ts 09.03.22 (Hodgson), pp27 & 31

CONCLUSION

95. Mr Drleski's case demonstrates the practical difficulties faced by clinicians attempting to care for individuals with complex needs whose chronic polysubstance use adversely impacts on their treatment for mental health illnesses. It is to be hoped that the Commission will continue to use its influence to ensure that the innovative facilities referred to in Ms McGrath's report are made available to mental health consumers as quickly as possible.

MAG Jenkin
Coroner
13 April 2022