JURISDICTION	:	CORONER'S COURT OF WESTERN AUSTRALIA
ACT	:	CORONERS ACT 1996
CORONER	:	MICHAEL ANDREW GLIDDON JENKIN
HEARD	:	18 - 20 JANUARY 2022
DELIVERED	:	25 FEBRUARY 2022
FILE NO/S	:	CORC 39 of 2018
DECEASED	:	WILLIAMS, JORDAN JAMES

Catchwords:

Nil

Legislation:

Coroners Act 1996 (WA)
Mental Health Act 2014 (WA)

Counsel Appearing:

Ms S Tyler appeared to assist the Coroner.

Ms P Femia and Ms M Farrar (State Solicitor's Office) appeared for the Western Australian Country Health Service and the Western Australian Police Force.

Ms B Burke (ANF Legal Services) appeared for Ms Ngatama-Mathews and Ms Retimana Te Whatu.

Mr C Beetham (of counsel) appeared for MCM Protection Proprietary Limited.

Mr S Denman (Denman Legal) appeared for Dr Hope.

Coroners Act 1996
(Section 26(1))

RECORD OF INVESTIGATION INTO DEATH

*I, Michael Andrew Gliddon Jenkin, Coroner, having investigated the death of **Jordan James WILLIAMS** with an inquest held at Kalgoorlie Courthouse, 208 Hannan Street, Kalgoorlie, on 18 - 19 January 2022, find that the identity of the deceased person was **Jordan James WILLIAMS** and that death occurred on 24 August 2018, on railway tracks 200 metres north of the Maritana Street Bridge, Kalgoorlie, from head and neck injuries in the following circumstances:*

Table of Contents

INTRODUCTION **4**
MR WILLIAMS **5**
Background 5
Mental health history 6
KALGOORLIE HEALTH CAMPUS **7**
Kalgoorlie Health Campus 7
The MHU 7
Courtyard fence 8
Railway fence 9
MHU staff 10
Code Yellow and admission to D Ward 12
INTERACTIONS WITH POLICE **13**
Welfare check - 17 August 2018 13
Police attendance - 20 August 2018 13
TREATMENT AT KALGOORLIE HEALTH CAMPUS **14**
Presentation - 20 August 2018 14
Treatment - 21 August 2018 16
Treatment - 22 August 2018 16
Treatment - 23 August 2018 18
Treatment - 24 August 2018 22
EVENTS LEADING TO MR WILLIAMS' DEATH **25**
First absconding event - 24 August 2018 25
Second absconding event - 24 August 2018 30
Notification of family 35
Return of Mr Williams' personal belongings 38
CAUSE AND MANNER OF DEATH **39**
Cause of death 39
Manner of death 40
SAC1 REVIEW **42**
Overview 42

SAC1 review findings and recommendations 43
ISSUES RAISED BY EXTERNAL PARTIES **44**
Overview 44
Bed pressure 44
Use of security guards 46
Courtyard fence 48
Retrospective entries 50
Recruiting and retaining staff 51
PURPOSE BUILT MENTAL HEALTH UNIT **53**
QUALITY OF SUPERVISION, TREATMENT AND CARE **54**
Treatment and care 54
Supervision 54
RECOMMENDATIONS **56**
Recommendation 1 56
Recommendation 2 56
Recommendation 3 56
Comments relating to recommendations 57
CONCLUSION **57**

INTRODUCTION

1. Jordan James Williams (Mr Williams) died on 24 August 2018, from head and neck injuries after he absconded from the Kalgoorlie Health Campus (KHC) and lay on nearby railway tracks in the path of an oncoming train. He was 20-years of age.[1,2,3,4,5,6,7]

2. At the time of his death, Mr Williams was an involuntary patient under the *Mental Health Act 2014* (WA).[8] Accordingly, immediately before his death he was a "*person held in care*" and his death was a "*reportable death*". In such circumstances a coronial inquest is mandatory. 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.[9]

3. Members of Mr Williams' family attended the inquest I held into his death on 18 - 19 January 2022, in Kalgoorlie. A Brief containing the documentary evidence tendered at the inquest comprised two volumes and the following witnesses gave oral evidence:

a. Dr Adam Brett (Independent consultant psychiatrist);
b. Dr Judy Hope (Locum psychiatrist, KHC);[10]
c. Ms Piriangatikai Ngatama-Mathews (Mental health nurse, KHC);
d. Ms Karly Retimana Te Whatu (Mental health nurse, KHC);
e. Mr Tonderai Paradza (Mental health nurse, KHC);
f. Mr Robert Truran (Former security guard, MCM Protection Pty Ltd)
g. Mr Steven McNamara (Co-owner, MCM Protection Pty Ltd); and
h. Dr Kavitha Lakshminarayanan (WA Country Health Service).

4. The inquest focused on the circumstances of Mr Williams' death and the supervision, treatment, and care he received while he was an inpatient at the KHC.

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[1] Exhibit 1, Vol. 1, Tab 1, P100 - Report of Death (25.08.18)
[2] Exhibit 1, Vol. 1, Tab 4, P92 - Identification by Other Means (25.08.18)
[3] Exhibit 1, Vol. 1, Tab 3, Memo - Const. A McDonald (24.08.18)
[4] Exhibit 1, Vol. 1, Tab 4, P92 -Identification of deceased person other than by visual means (25.08.18)
[5] Exhibit 1, Vol. 1, Tab 4, Coronial Identification Report (25.08.18)
[6] Exhibit 1, Vol. 1, Tab 4, Affidavit - Sgt. G Holden (25.08.18)
[7] Exhibit 1, Vol. 1, Tab 5, Life extinct form (24.08.18)
[8] Exhibit 1, Vol. 1, Tab 29.7, Form 6A - Inpatient Treatment Order in Authorised Hospital (23.08.18)
[9] Sections 3, 22(1)(a) & 25(3) *Coroners Act 1996* (WA)
[10] Dr Hope is also known professionally as Associate Professor Hope

MR WILLIAMS

Background[11,12,13]

5. Mr Williams was a fit, healthy young man whose smile "*just lit the whole room up*".[14] He was born in Kalgoorlie and had one sister. He enjoyed a close and loving relationship with his family, including a "*great relationship*" with his father. When he was about 16-years of age, Mr Williams moved to Ravensthorpe to undertake a heavy diesel mechanic apprenticeship with his grandfather.

6. When Mr Williams' mother died from breast cancer in September 2016, he reportedly began using methylamphetamine and cannabis to help him to cope. He moved in with his father and sister, and with help from his father, Mr Williams was able to cease using illicit drugs.

7. Mr Williams reportedly had a son (Riley) with a former partner. Riley was born in August 2017, and Mr Williams last saw him around that time.[15] In 2017, Mr Williams' father met a new partner who had four children of her own. According to Mr Ben Williams (Mr Williams' uncle) the new partner had a negative effect on Mr Williams, and his mental health deteriorated further after Mr Williams' father took his life in February 2018.

8. Following his father's death, Mr Williams moved in with Mr Ben Williams in Kalgoorlie briefly before returning to Ravensthorpe to live with his grandfather. After a few months, Mr Williams returned to Kalgoorlie and in about July 2018, he recommenced his mechanical apprenticeship at a workshop in Kalgoorlie. However, due to his erratic behaviour in the workplace, Mr Williams' employment was terminated on 17 August 2018.

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[11] Exhibit 1, Vol. 1, Tab 9, Statement - Mr B Williams (01.08.19), paras 3-36
[12] Exhibit 1, Vol. 1, Tab 10, Statement - Ms V Mizen (03.09.18), paras 4-35
[13] Exhibit 1, Vol. 1, Tab 2, Report - FC Const. S Cervenak (11.08.19), pp2-3
[14] ts 18.01.22 (Retimana-Te Whatu), p96
[15] Exhibit 1, Vol. 1, Tab 29.11, KHC Integrated Progress Notes (5.30 pm, 20.08.18)

Mental health history[16,17][18][19,20]

9. Mr Williams' saw his GP on 1 June 2016. He was diagnosed with depression and prescribed an antidepressant and referred to a mental health service known as Headspace. On 27 June 2016, Mr Williams' GP prescribed temazepam for poor sleep. Headspace referred Mr Williams to a community mental health team (the Team) on 30 November 2016, after he presented with ongoing symptoms of depression, suicidal ideation, and hallucinations.

10. After his mother's death, Mr Williams reportedly began using amphetamines and moved into a caravan park with his partner. He referred to himself as a "*sinner*" because of his illicit drug use, expressed suicidal ideation and said if he died, he would be "*reborn*". He was referred to a drug and alcohol service but on 5 December 2016 he declined further follow up and denied suicidal ideation or illicit drug use.

11. On 25 December 2016, Mr Williams presented to the emergency department (ED) at KHC. He was intoxicated with methylamphetamine, amphetamine, and cannabis and was diagnosed with amphetamine-induced psychotic disorder with delusions and admitted for observation. His symptoms appeared to resolve and he was discharged home the following day. Although Mr Williams was referred to the Team, attempts to contact him were unsuccessful.

12. On 15 February 2017, Mr Williams (who reportedly had access to firearms) presented to the ED after threatening to shoot himself. He tested positive for cannabis, but no self-harm risks or psychotic symptoms were identified. Mr Williams left the ED before being seen by the psychiatric liaison nurse, and although he was referred to the Team, that referral was closed on 20 February 2017, for unknown reasons. Mr Williams had no further contact with mental health services until his admission to KHC on 20 August 2018, although on 9 October 2017, his GP restarted Mr Williams' citalopram, the antidepressant he had reportedly ceased taking two months before.

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[16] Exhibit 1, Vol. 1, Tab 21, PSOLIS Records (30.11.16 - 03.01.17), pp2-5
[17] Exhibit 1, Vol. 1, Tab 22, Medical records, Boulder Medical & Occupational Health
[18] Exhibit 1, Vol. 1, Tab 30, Report - Dr A Brett (17.05.21), pp2-5
[19] Exhibit 1, Vol. 1, Tab 34, Kalgoorlie Headspace Records
[20] Exhibit 1, Vol. 1, Tab 35, Kalgoorlie Community Mental Health Medical Records

KALGOORLIE HEALTH CAMPUS

Kalgoorlie Health Campus[21,22,23]

13. KHC is a 106-bed inpatient facility servicing the Goldfields region of Western Australia. It offers a range of specialty services to inpatients and outpatients and is located on Piccadilly Street, Kalgoorlie. There is a railway line (with two sets of tracks, one in each direction) situated on KHC's south-eastern boundary at the so-called "*back*" of hospital. A chain link fence runs part of the way along that railway line.[24,25]

The MHU[26,27]

14. KHC's mental health unit (the MHU), also known as A Ward, is a six bed inpatient unit that was originally part of a medical ward. The structure was built in the 1970's and was first authorised as a mental health facility in 2002. Precisely because it was not purpose-built, the MHU has various structural and design issues, including blind spots. A secure room to isolate patients needing additional care is now available, but this was not in place in 2018.

15. Each of the six rooms in the MHU is approximately four metres square and has a small adjoining bathroom. Bedframes and tables in each room are bolted to the floor and ligature minimisation devices (i.e.: specialised tap, shower, and toilet fittings) have been installed and the shower curtains have quick release brackets. Flooring in the ward has been updated, and efforts have been made to improve the overall environment. In January 2019 an airlock was fitted to the front entrance of the MHU and the gate to the laundry was modified.[28,29]

16. Notwithstanding these improvements, the physical environment of the MHU has a run-down appearance and patient amenities are rudimentary. There are also limited spaces where patients can sit outside their rooms with any privacy.

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21 Exhibit 1, Vol. 2, Tab 36, Statement - Dr K Lakshminarayanan (26.11.21), paras 25-28
22 Exhibit 1, Vol. 1, Tab 27, KHC site plans and Exhibit 1, Vol. 2, Tab 36, Attachment 1 - KHC site plan
23 Exhibit 1, Vol. 2, Tab 47, Statement - Mr C Crabtree (12.01.22), paras 13-23
24 See: www.wacountry.health.wa.gov.au/Our-services/Goldfields/Goldfields-health-services/Kalgoorlie-Health-Campus
25 Exhibit 1, Vol. 2, Tab 47, Attachments 1-4, Photos of MHU
26 Exhibit 1, Vol. 2, Tab 36, Statement - Dr K Lakshminarayanan (26.11.21), paras 29-46
27 Exhibit 1, Vol. 2, Tab 47, Statement - Mr C Crabtree (12.01.22), paras 15-xx
28 Exhibit 1, Vol. 2, Tab 47.1 - 47.4, Photos of MHU's interior
29 Exhibit 1, Vol. 2, Tab 38, KVL1 - Service review of the MHU (Oct 2018), Appendix 8, Photos of MHU's interior & Courtyard

17. The lack of patient amenities was addressed by the Chief Psychiatrist, in his letter to WACHS dated 9 November 2018, in these terms:

> In a previous well-meaning attempt to reduce ligature risk, there is now a significant paucity of physical therapeutic fixtures, eg basketball court, exercise equipment. There must be access to basic activities and relevant therapy with appropriate facilities for this. I would request this be embedded as a priority.[30]

18. Perhaps the most eloquent reflection on the environment in the MHU came during the following exchange between Nurse Karly Retimana Te Whatu and Ms Sarah Tyler (Counsel Assisting):

> *Nurse Retimana Te Whatu:* I think I get a bit emotional about that because this is reiterated over and over again about the safety of the staff, the safety of patients within the inpatient unit. I mean, a really good indicator would be would you want your family in that unit?
>
> *Ms Tyler:* And when you think about that is your opinion…that the unit is not good enough? You wouldn't want your loved one there?
>
> *Nurse Retimana Te Whatu:* No…and not because of the nursing staff or even the medical officers…a mental health inpatient unit was made by chopping a medical ward in half. There were blind spots. There (were) all sorts of different things…I just about turned on my heel and walked out the first day I walked into that unit. I couldn't believe it.[31]

Courtyard fence[32,33,34]

19. MHU patients have access to a 12-square metre courtyard (the Courtyard), which was originally surrounded by pool type fencing. Subsequently a metal panel fence (with panels attached to metal or brick columns) was installed. There is a vacant area on the other side of the rear fence of the Courtyard which leads to other parts of the KHC grounds, including a carpark adjacent to the previously mentioned railway line. Overall, the Courtyard is a dreary affair with mismatched fencing panels, patchy grass and a generally dilapidated appearance.

[30] Exhibit 1, Vol. 1, Tab 32, Letter from Chief Psychiatrist to WACHS (09.11.18), p2
[31] ts 18.01.22 (Retimana Te Whatu), pp94-95
[32] Exhibit 1, Vol. 2, Tab 36, Statement - Dr K Lakshminarayanan (26.11.21), paras 190-227
[33] Exhibit 1, Vol. 2, Tab 47, Statement - Mr C Crabtree (12.01.22), paras 24-55
[34] Exhibit 1, Vol. 2, Tab 36.22, Plan and photos of the MHU Courtyard

20. The "fence" on the right-hand of the Courtyard (seen by an observer looking into the Courtyard with their back to the MHU) consists of the common wall with the adjacent dialysis unit. A garden bed against this wall conceals essential plumbing and electrical services and means that on the right-hand side, the effective fence height is lower. The fencing on the left-hand and rear sides of the Courtyard consists of the metal panels referred to earlier.

Railway fence

21. For historical reasons, KHC is located adjacent to a railway line. A chain link fence runs part way along the railway tracks, but there are gaps in the fence that allow access onto the tracks. Obviously the fact that patients from the MHU can and have accessed the railway tracks is of enormous concern and is clearly unsatisfactory. This is especially so because the MHU is not a secure facility.[35,36]

22. Following the inquest, Ms Femia (counsel for WACHS) advised that her enquiries had identified that the railway line is currently leased from the Commonwealth by a transport and infrastructure company. Ms Femia also advised that the Office of National Rail Safety Regulator (established in 2015) was the body responsible for facilitating rail safety and would be the body with authority to require upgrades to be made to fencing along the railway line.[37]

23. I accept that WACHS does not own the land on which the railway is situated and that it cannot exercise any control over the nature and safety of the railway fence. Nevertheless, WACHS has a legitimate interest in the security and maintenance of the railway fence, given that the fence abuts KHC and that two patients who absconded from the MHU have been killed by passing trains. I would therefore urge WACHS to raise urgent safety concerns with the lessee of the land on which the railway is situated, and strongly advocate for the section of fence adjacent to KHC to be examined and where necessary, upgraded.

[35] Exhibit 1, Vol. 1, Tab 31, MHAS Inquiry into conditions at Kalgoorlie Hospital (Nov. 2018), para 41 and photos 6 & 7
[36] ts 19.01.22 (Paradza), p114 and ts 19.02.22 (Lakshminarayanan), p197
[37] Emails from Ms P Femia to Ms S Tyler (21.01.22 & 18.02.22) and ts 19.01.22 (Femia), pp219-220

MHU staff

24. On 18 January 2022, I visited KHC with counsel and was shown the MHU, part of the KHC grounds and the carpark at the rear of the hospital. During my visit, I spoke to nursing staff, the MHU social worker, and senior managers. I was impressed by the dedication and passion of these staff members, all of whom seemed genuinely committed to optimising patient care.

25. At the time Mr Williams was admitted to KHC, a 2:2:2 roster was in place for the MHU, meaning that two nurses were on duty during each eight-hour shift. Following various reviews, the roster has been increased to 3:3:3, meaning three nurses now work during each eight-hour shift. The increased roster means that psychiatric patients admitted to wards other than the MHU because of bed pressure (outliers) are now allocated a nurse by the MHU and are regularly reviewed by the MHU team. In theory, the increased roster should also mean that it is possible to provide a nurse who is responsible for a single patient (an allocation commonly referred to as a "*1:1 special*") used in circumstances where a particular patient requires additional care and support.[38,39]

26. However, even with the increased roster, it may not be possible to allocate a 1:1 special if the level of seriousness (i.e.: patient acuity) of MHU patients is high and/or the number of outliers is excessive. On several occasions, despite there being a clear need for Mr Williams to be allocated a 1:1 special, a shortage of nursing staff led to the use of security guards in this role, an issue I will deal with later.[40]

27. In 2018, the MHU was not supported by a team of allied health professionals. I accept that these staff are a key part of any mental health team and that their presence considerably enhances outcomes for mental health patients. According to Dr Kavitha Lakshminarayanan, after multiple reviews, funding was obtained for an occupational therapist, an Aboriginal mental health worker, and a social worker for the MHU.[41,42]

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[38] Exhibit 1, Vol. 2, Tab 36, Statement - Dr K Lakshminarayanan (26.11.21), paras 49-56
[39] ts 19.02.22 (Lakshminarayanan), pp178-179
[40] ts 19.02.22 (Lakshminarayanan), pp179-180
[41] Exhibit 1, Vol. 2, Tab 36, Statement - Dr K Lakshminarayanan (26.11.21), paras 57-58
[42] ts 19.02.22 (Lakshminarayanan), pp177-178

28. Various attempts to recruit an occupational therapist on a permanent basis have been unsuccessful, and although the position was filled in 2021 using a fixed-term contract, it is currently vacant. The Aboriginal mental health worker and social worker positions have both been filled, however, the social worker's time is currently split between the MHU and the Team. Pleasingly, Dr Lakshminarayanan said "*plans are underway to secure funding for one full time social worker position for the MHU*". I note an art therapist currently attends the MHU and that these sessions are very positively received.[43,44,45]

29. I acknowledge that WACHS has made considerable efforts to recruit a permanent consultant psychiatrist (clinical director) for the MHU and that until recently, those efforts had been unsuccessful. Recently, a clinical director has been recruited and this person's five-year appointment begins in February 2022. The clinical director will be responsible for the MHU and the Team and have a 0.5 clinical load. The previous recruiting difficulties have meant that KHC has been obliged to rely on a succession of locum appointments.[46] Although locum staff are better than no staff at all, I am deeply concerned about the implications of relying on locum staff as opposed to recruiting and retaining staff that reside in Kalgoorlie on a permanent basis. Clearly continuity and strategic direction are compromised when senior positions are filled by a succession of short-term appointments.[47]

30. Dr Adam Brett (the Court's independent expert psychiatrist) said some of his colleagues who had undertaken locum psychiatrist positions at KHC had vowed never to return because conditions were so poor. Dr Lakshminarayanan' experience was somewhat different and she said that although some staff had said they would not return, others had done so. Either way, the ongoing use of locum staff is clearly unsatisfactory. In the present case, Dr Judy Hope was engaged as a locum psychiatrist for one week. Her posting at KHC was only her second locum placement and she had had never worked in Western Australia before.[48]

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[43] Exhibit 1, Vol. 2, Tab 36, Statement - Dr K Lakshminarayanan (26.11.21), paras 58(a)-(c)
[44] ts 19.01.22 (Lakshminarayanan), p176-178
[45] Discussions between Coroner Jenkin and KHC and MHU staff during visit to KHC (18.01.22)
[46] ts 19.01.22 (Lakshminarayanan), p174
[47] Exhibit 1, Vol. 2, Tab 36, Statement - Dr K Lakshminarayanan (26.11.21), paras 168-181
[48] ts 18.02.22 (Brett), pp17 & 26-27 and ts 19.02.22 (Lakshminarayanan), pp195-196

Code Yellow and admission to D Ward[49]

31. The term "*Code Yellow*" is used to describe the situation where, because of extraordinary pressure on beds, a hospital is unable to take any further patients. The decision to call a Code Yellow is taken at senior management level, presumably after input from clinical staff. A Code Yellow was called at KHC at 5.15 pm on 16 August 2018, and was thus in place at the time of Mr Williams' admission. The bed crisis at KHC was exacerbated by an unprecedented State-wide Code Yellow which was called on 21 August 2018.[50][51]

32. When Mr Williams presented to KHC on 20 August 2018, he was one of 11 psychiatric patients. The MHU's six beds were already full, meaning that five patients (including Mr Williams) had to be admitted to general wards. For obvious reasons, staff on medical and surgical wards are not usually experienced in monitoring and treating psychiatric patients and in this case, there are several documented examples of ward staff seeking support from MHU staff and support being provided.

33. The situation during Mr Williams' admission was further exacerbated because of the high acuity of patients admitted to the MHU. One patient was psychotic and behaving in a poorly contained manner, another threatened homicide/suicide if discharged, and two others were experiencing psychotic depression. On 24 August 2018, a patient on the MHU was so unwell they had to be transferred to the high dependency unit, a task that required eight staff members and took most of the day.

34. As if all of this this wasn't enough, Dr Hope was initially responsible for community psychiatric patients as well as those in the MHU and outliers. Dr Hope was also on-call every other night and in order to manage her workload she was obliged to work additional hours each day. During this same period, several MHU nurses had to work additional shifts to cover unforeseen absences;[52] the psychiatric liaison nurse was on unplanned leave between 22 - 24 August 2018 and the senior medical officer, Dr Lynette Foster, was obliged to take leave on 24 August 2018.

[49] Exhibit 1, Vol. 1, Tab 28, Report - Dr J Hope (20.10.20), pp2-3 and ts 18.01.22 (Hope), pp34 & 46-47
[50] Exhibit 1, Vol. 2, Tab 36, Statement - Dr K Lakshminarayanan (26.11.21), paras 61-88
[51] ts 19.01.22 (Lakshminarayanan), p194
[52] ts 18.01.22 (Ngatama-Mathews), p65 and ts 18.01.22(Retimana-Te Whatu), pp85-86

INTERACTIONS WITH POLICE[53,54,55]

Welfare check - 17 August 2018

35. At about 2.00 pm on 17 August 2018, police conducted a welfare check on Mr Williams at his home. Police had been called by his former employer (who was the mother of one of his friends). She told police she was concerned for Mr Williams' welfare after she had been obliged to terminate his employment earlier that day.[56]

36. When police arrived at his home, Mr Williams seemed calm and showed no signs of distress. He said that at the time he was fired from his job he had felt "*like he was physically dying in the inside*", but that since arriving home he had been feeling "*fine*". Mr Williams said he was planning to look for work the following day and denied thoughts of self-harm. He also said he did not want to go to hospital.

37. Police spoke separately to Mr Williams' two housemates, neither of whom had any welfare concerns. Both housemates also said they would be at home that night and would keep an eye on Mr Williams. After speaking to Mr Williams and his housemates, police had no safety concerns and before leaving, officers told Mr Williams that he could always call the Police if he needed help.

38. On the evidence before me, I have concluded that on 17 August 2018, there was no basis for police to have conveyed Mr Williams to KHC against his will and that that their interaction with him was appropriate.

Police attendance - 20 August 2018[57,58,59]

39. At about 9.35 am on 20 August 2018, police received a call from one of Mr Williams' housemates. She said she was concerned about his bizarre behaviour and told police Mr Williams was saying he was trying to hurt himself because "*he feels like he is dead so is trying to feel pain*".[60]

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[53] Exhibit 1, Vol. 1, Tab 12, Const. E Counsel (06.09.18), paras 2-18
[54] Exhibit 1, Vol. 1, Tab 13, Const. E Curtis (06.09.18), paras 2-18
[55] Exhibit 1, Vol. 1, Tab 2, Report - FC Const. S Cervenak (11.08.19), pp5-6
[56] Exhibit 1, Vol. 1, Tab 10, Statement - Ms V Mizen (03.09.18), paras 35-51
[57] Exhibit 1, Vol. 1, Tab 11, Sen. Const. J-P Camail (28.08.18), paras 2-21
[58] Exhibit 1, Vol. 1, Tab 2, Report - FC Const. S Cervenak (11.08.19), pp3-4
[59] Exhibit 1, Vol. 1, Tab 26, Incident detailed report LWP18082000595995 (20.08.18)
[60] Exhibit 1, Vol. 1, Tab 11, Sen. Const. J-P Camail (28.08.18), para 4

40. The housemate also said that Mr Williams was doing front flips and trying to break his foot by placing it into the toilet bowl and that he was talking to voices "*in his head*". She called police again at 10.00 am to say she was trying to keep Mr Williams calm until police arrived. Officers subsequently attended and Mr Williams told police he was struggling and had been "*taking drugs for a few months and hearing voices in his head*".[61]

41. Although Mr Williams appeared calm and was not agitated, he said the voices in his head were telling him to hurt himself. Police told Mr Williams they had concerns for his welfare and asked him to accompany them to KHC for assessment. Mr Williams agreed and got into the secure pod on the back of the police vehicle. He was calm and compliant during the journey to KHC and showed no signs of aggression. Officers said Mr Williams seemed "*happy to go to hospital*" and they left him in the care of ED staff at about 11.00 am.[62]

TREATMENT AT KALGOORLIE HEALTH CAMPUS[63]

Presentation - 20 August 2018[64]

42. Dr Lynette Foster (senior medical officer) reviewed Mr Williams in the ED at about 5.30 pm, and her detailed assessment appears in the hospital record. Mr Williams said he had been hearing voices for one to two years after using methylamphetamine, but he denied recent illicit drug use. He said he could hear the voices of his flatmates and his grandmother telling him that "*to lessen the pain in the world that he should inflict harm on himself*".[65]

43. Mr Williams also said he had been trying to break bones in his foot and perform a "*devil's twist*" to collide his "*spirit*" with that of his housemate and thereby go to heaven. Mr Williams also said he was dying from AIDS and that his housemate was the Devil.[66]

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[61] Exhibit 1, Vol. 1, Tab 11, Sen. Const. J-P Camail (28.08.18), para 8
[62] Exhibit 1, Vol. 1, Tab 29.11 - 29.12, KHC ED Notes (5.30 pm, 20.08.18)
[63] Exhibit 1, Vol. 1, Tab 29.6, KHC Discharge Summary (24.08.18)
[64] Exhibit 1, Vol. 1, Tab 29.4 & 29.5, ED Notes & ED Continuation Notes (20.08.18)
[65] Exhibit 1, Vol. 1, Tab 29.11 - 29.12, KHC Integrated Progress Notes (20.08.18)
[66] Exhibit 1, Vol. 1, Tab 28, Report - Dr J Hope (20.10.20), pp1-2

44. Mr Williams underwent a routine urine drug test and a breathalyser for alcohol. Both tests were negative.[67] Dr Forster diagnosed him with first episode psychosis, and he was admitted on a voluntary basis under Dr Hope. Mr Williams was allocated a bed on a surgical ward (D Ward) because the MHU was full and placed on hourly observations. Routine tests [i.e.: an STI check, a brain CT scan, and an electrocardiogram (ECG)] were ordered and Mr Williams was prescribed the antipsychotic medication, olanzapine and the sedative, diazepam.

45. Despite Mr Williams' admission as a voluntary patient, Dr Foster's entry in the hospital record at 5.30 pm on 20 August 2018, states: "*I have advised pt* (patient) *that if he attempts to leave he will be placed under MHAct*[68] *and may be brought back by Police as I do not feel he is safe to go home*".[69] As if to reinforce the point, a security guard was stationed outside Mr Williams' room because he was considered to be an absconding risk.

46. As a voluntary patient, Mr Williams was of course free to leave KHC at any time. Given that status, I am unclear what authority the allocated security guard would have relied on to prevent Mr Williams leaving KHC had he chosen to do so. Given that the application of force in circumstances not otherwise permitted by law constitutes an assault, the security guard appears to have been placed in an untenable position. In my view, it would be prudent for WACHS to clarify the position for security guards allocated to voluntary patients.

47. The guard allocated to Mr Williams was Mr Steven McNamara, an experienced security officer and co-owner of MCM Protection Pty Ltd (MCM), a company that had been providing security services to KHC since 2006. Mr McNamara said that Mr Williams was predominantly asleep during the time he was responsible for him and never displayed any signs of aggression or voiced self-harm or suicidal ideation.[70]

[67] Exhibit 1, Vol. 1, Tab 29.4, ED Notes (1.05 pm & 3.10 pm, 20.08.18)
[68] That is, the *Mental Health Act 2014* (WA)
[69] Exhibit 1, Vol. 1, Tab 29.11, KHC Integrated Progress Notes (5.30 pm, 20.08.18)
[70] Exhibit 1, Vol. 1, Tab 15, Statement - Mr S McNamara (25.08.18), paras 11-13 and ts 19.01.22 (McNamara), p141-142

Treatment - 21 August 2018[71,72]

48. Nursing entries in the hospital record for 21 August 2018, state that Mr Williams was "*alert and orientated*" and that hourly observations were being maintained. He was described as "*settled*" and it was noted that he was well-behaved and polite and had been visited by friends. Mr Williams was reported as "*a little unsettled*" in the late evening but was asleep by 1.00 am on 22 August 2018.[73,74]

49. At 3.30 pm on 21 August 2018, Mr Williams was reviewed on D Ward by Dr Hope and Dr Forster. Mr Williams reported having slept well and said his mood was "*really good*". Dr Hope confirmed Dr Foster's earlier diagnosis of first episode psychosis and added the further possible diagnoses of drug-induced psychosis and schizophreniform disorder and/or schizophrenia of uncertain duration.

50. As Mr Williams' behaviour had settled, his security guard was dispensed with and he was permitted escorted leave from the ward. He was also started on the antipsychotic, lurasidone, with the aim of gradually ceasing his olanzapine so as to minimise potential side-effects. An ECG was ordered to monitor the effects of Mr Williams' medication on his heart, along with a brain CT to exclude any organic causes for his psychosis.[75]

Treatment - 22 August 2018[76,77,78]

51. According to an entry at 12.45 pm on 22 August 2018, Mr Williams returned to D Ward after escorted leave with his family in a highly distressed state. He was crying inconsolably, saying he wanted to die and claiming that his family were trying to kill him. Ward staff attempted to contact the psychiatric liaison nurse (who was on leave) and they subsequently requested an urgent review by the psychiatric team.

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[71] Exhibit 1, Vol. 1, Tab 29.12, KHC Integrated Progress Notes (3.30 pm, 21.08.18)
[72] Exhibit 1, Vol. 1, Tab 28, Report - Dr J Hope (20.10.20), pp2-3
[73] Exhibit 1, Vol. 1, Tab 29.12, KHC Integrated Progress Notes (3.25 am; 3.30 pm & 6.20 pm, 21.08.18)
[74] Exhibit 1, Vol. 1, Tab 29.12, KHC Integrated Progress Notes (2.00 am, 22.08.18)
[75] Exhibit 1, Vol. 1, Tab 29.12, KHC Integrated Progress Notes (6.20 pm, 21.08.18)
[76] Exhibit 1, Vol. 1, Tab 29.12, KHC Integrated Progress Notes (1.45 pm, 22.08.18)
[77] Exhibit 1, Vol. 1, Tab 28, Report - Dr J Hope (20.10.20), p3
[78] Exhibit 1, Vol. 1, Tab 29.12, KHC Integrated Progress Notes (22.08.18)

52. When Dr Hope reviewed Mr Williams at 1.15 pm, he seemed settled but he was voicing psychotic ideas including that he wanted to die and go into a new body because his brain wasn't working. He reported visual hallucinations including seeing his mother's womb, his ex-girlfriend and the Devil, as well as "*full on*" auditory hallucinations. Dr Hope ordered an immediate dose of olanzapine with twice daily doses thereafter. At his request, Mr Williams was prescribed a nicotine patch to help address his cigarette cravings. The aim was to reduce his need to leave the ward as Mr Williams said he felt less troubled lying when in bed.[79]

53. Dr Hope's later report states that Mr Williams' escorted leave was cancelled, although this does not appear to have been recorded in his hospital record.[80,81] A nursing entry at 1.35 pm says Mr Williams was more settled and trying to sleep and that his vital signs were within normal limits. An entry at 1.50 pm states that Mr Williams' aunt had reported that during lunch Mr Williams had tried to choke himself on some beans and she had taken his plate away.[82]

54. Ward staff requested an urgent psychiatric review, and Dr Foster saw Mr Williams at 2.45 pm. Dr Foster documented that Mr Williams had been repeatedly exposing himself on the ward and had tried to hurt himself by dropping to his knees and doing a flip. Mr Williams' antipsychotic medication (lurasidone) was increased, and a security guard was once again allocated. Ward staff reported that although Mr Williams had settled when given a dose of diazepam, he had continued to expose himself and a further review was requested.[83]

55. Dr Hope reviewed Mr Williams again at 6.15 pm, and documented he was "*highly psychotically motivated*" and his behaviour may be unpredictable. She noted his main risk was to himself and recommended "*kind but firm redirection*" be employed by staff. She also increased his olanzapine dose to three times daily, added regular doses of diazepam and scheduled an ECG for the following day.[84]

[79] Exhibit 1, Vol. 1, Tab 29.12, KHC Integrated Progress Notes (1.15 pm, 22.08.18)
[80] Exhibit 1, Vol. 1, Tab 28, Report - Dr J Hope (20.10.20), p3
[81] Exhibit 1, Vol. 1, Tab 29.12, KHC Integrated Progress Notes (1.15 pm, 22.08.18)
[82] Exhibit 1, Vol. 1, Tab 29.12, KHC Integrated Progress Notes (1.35 pm & 1.50 pm, 22.08.18)
[83] Exhibit 1, Vol. 1, Tab 29.12, KHC Integrated Progress Notes (2.45 pm & 5.20 pm, 22.08.18)
[84] Exhibit 1, Vol. 1, Tab 29.12, KHC Integrated Progress Notes (6.15 pm, 22.08.18)

56. A nursing entry after Dr Hope's review states that Mr Williams had been very polite and well-mannered, but had been unable to sleep. He was given 10 mg of diazepam to "*good effect*" and slept for the rest of the shift.[85] In passing, I note that this entry is entered in the notes at 4.00 am on 22 August 2018. However, the contents of the entry and timing of the one that immediately follows, make it clear that the entry was written at 4.00 am on 23 August 2018. Nothing turns on this minor error.

Treatment - 23 August 2018[86]

57. Nursing entries for 23 August 2018, record that Mr Williams was sleeping for most of the morning. An entry by Dr Foster at 11.00 am, states that Mr Williams sister had been updated on her brother's condition (with Mr William's permission) and an entry at 11.30 am, states that Mr Williams was transferred to the MHU and that a handover had been given.[87] At the inquest, Dr Hope said that Mr Williams' condition meant that his transfer to the MHU had been prioritised.[88]

58. Despite Mr Williams' status as a voluntary patient, his paperwork when he was admitted to the MHU (completed by Nurse Tunua) states: "*if pt* (i.e.: patient) *attempts to leave → forms*", meaning that he was essentially an involuntary patient.[89] In his statement, Nurse Tunua says that at the time Mr Williams was admitted to the MHU, it was determined that he did not require a 1:1 special.[90]

59. An entry by Nurse Tunua at 11.40 am, summarises Mr Williams' admission and confirms he was orientated to the ward and given written information about the MHU. Mr Williams was described as cooperative with staff and assessed as being a "*moderate risk to others/self*". Although the entry states that 30-minute observations were required, observation records for 23 August 2018, cannot be located and it is therefore impossible to know if these observations were actually performed.[91,92,93]

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[85] Exhibit 1, Vol. 1, Tab 29.12, KHC Integrated Progress Notes (4.00 am pm, 22.08.18)
[86] Exhibit 1, Vol. 1, Tab 28, Report - Dr J Hope (20.10.20), p4
[87] Exhibit 1, Vol. 1, Tab 29.12, KHC Integrated Progress Notes (11.00 am & 11.30 am, 23.08.18)
[88] ts 18.01.22(Retimana-Te Whatu), p90
[89] Exhibit 1, Vol. 1, Tab 29.10, KHC Admission Notification (23.08.18)
[90] Exhibit 1, Vol. 2, Tab 41, Statement - Nurse D Tunua (07.01.22), paras 20-33
[91] Exhibit 1, Vol. 1, Tab 29.12, KHC Integrated Progress Notes (11.40 am, 23.08.18)
[92] Exhibit 1, Vol. 2, Tab 41, Statement - Nurse D Tunua (07.01.22), paras 34-52 & 57-64
[93] Exhibit 1, Vol. 2, Tab 36, Statement - Dr K Lakshminarayanan (26.11.21), para 102 and ts 19.01.22 (Lakshminarayanan), p173

60. Mr Williams requested that his nominated next-of-kin (NOK) be changed to Mr Ben Williams and the words "*same changed*" appear in the hospital record in relation to this request. However, I was unable to locate anything in the Brief to confirm that the requested change was made, although the entry goes on to state that Mr Ben Williams had been advised of Mr Williams' transfer to the MHU.[94,95]

61. An entry in the hospital record by Nurse Piriangatikai Ngatama-Mathews[96] at 1.40 pm, records the fact that a physical examination of Mr Williams by a resident medical officer and a female student had to be aborted after Mr Williams became disinhibited and started exposing himself. A further attempt was abandoned after Mr Williams began masturbating and had to be helped to his room.[97,98,99]

62. Nurse Tunua asked Mr Williams what was going on and whether there was anything he could do to help, but Mr Williams just mumbled incoherently in response. A security guard was requested and consideration was given to a 1:1 nursing special, but there were not enough nurses in the MHU for one to be allocated.[100,101,102]

63. Nurse Ngatama-Mathews' entry also records self-harm attempts by Mr Williams, namely running into a hot shower to try to scald himself and running into walls in an attempt to injure himself. Nurse Tunua says that Mr Williams persisted in turning the hot water on and he (Nurse Tunua) had to turn it off several times so that Mr Williams would not burn himself. Ultimately, Nurse Tunua had to lock the bathroom door because Mr Williams "*was fixated on turning the hot water on and jumping under it*".[103,104,105]

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94 Exhibit 1, Vol. 1, Tab 29.12, KHC Integrated Progress Notes (11.40 am, 23.08.18)
95 Exhibit 1, Vol. 2, Tab 41, Statement - Nurse D Tunua (07.01.22), paras 53-55
96 Nurse Ngatama-Mathews was the shift co-ordinator on the MHU at the relevant time
97 Exhibit 1, Vol. 1, Tab 29.13, KHC Integrated Progress Notes (1.40 pm, 23.08.18)
98 Exhibit 1, Vol. 2, Tab 41, Statement - Nurse D Tunua (07.01.22), paras 79-87
99 Exhibit 1, Vol. 2, Tab 45, Statement - Nurse P Ngatama-Mathews (12.01.22), paras 14-15 & 22
100 Exhibit 1, Vol. 1, Tab 29.13, KHC Integrated Progress Notes (1.40 pm, 23.08.18)
101 Exhibit 1, Vol. 2, Tab 41, Statement - Nurse D Tunua (07.01.22), paras 79-87
102 Exhibit 1, Vol. 2, Tab 45, Statement - Nurse P Ngatama-Mathews (12.01.22), paras 14-15 & 22
103 Exhibit 1, Vol. 1, Tab 29.13, KHC Integrated Progress Notes (1.40 pm, 23.08.18)
104 Exhibit 1, Vol. 2, Tab 41, Statement - Nurse D Tunua (07.01.22), paras 88-94
105 Exhibit 1, Vol. 1, Tab 29.13, KHC Integrated Progress Notes (1.40 pm, 23.08.18)

64. Nurse Ngatama-Mathews directed the security guard assigned to Mr Williams (i.e.: Mr McNamara) to remain in the proximity of Mr Williams and keep him in "*line-of-sight*" at all times. Bathroom privacy was denied, meaning that Mr Williams was monitored during toileting and showering and Mr McNamara was instructed to alert nursing staff if Mr Williams wanted to use these facilities. Nurse Ngatama-Mathews also directed that Mr Williams' door remain open at all times with Mr McNamara positioned outside.[106]

65. Nurse Tunua says Mr Williams appeared to settle briefly, but then began running into the walls of his room, and Nurse Tunua tried to "*guide him away*" to stop him hurting himself. In her statement, Nurse Ngatama-Mathews said that after a visit from his relatives, Mr Williams asked if he could go to the Courtyard for a cigarette. Although Nurse Ngatama-Mathews was concerned for his safety, Mr Williams was allowed to have a cigarette in the Courtyard after agreeing to remain seated on the paved area just outside the MHU.[107,108,109]

66. Nurse Ngatama-Mathews' had seen Mr Williams running towards the front floor of the MHU in an apparent attempt to abscond, and her entry says she maintained a close watch on Mr Williams, and a security guard remained within arm's reach while he was in the Courtyard. Because of her concerns, Nurse Ngatama-Mathews asked Mr Williams to come back inside after his cigarette and he did so.[110,111,112]

67. The entry also refers to an attempt by Mr Williams to abscond from the MHU by scaling the Courtyard fence because he "*wanted to go home*". On this occasion, the security guard was "*able to get him down*" and Mr Williams did not struggle as he was returned to his room. He was given diazepam to "*good effect*", the Courtyard doors were locked, and Mr Williams was denied access to the Courtyard.[113,114,115]

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[106] Exhibit 1, Vol. 2, Tab 45, Statement - Nurse P Ngatama-Mathews (12.01.22), paras 17-20
[107] Exhibit 1, Vol. 1, Tab 29.13, KHC Integrated Progress Notes (1.40 pm, 23.08.18)
[108] Exhibit 1, Vol. 2, Tab 41, Statement - Nurse D Tunua (07.01.22), paras 94-113
[109] Exhibit 1, Vol. 2, Tab 45, Statement - Nurse P Ngatama-Mathews (12.01.22), paras 23-25
[110] Exhibit 1, Vol. 1, Tab 29.13, KHC Integrated Progress Notes (1.40 pm, 23.08.18)
[111] Exhibit 1, Vol. 2, Tab 45, Statement - Nurse P Ngatama-Mathews (12.01.22), paras 26-29
[112] ts 18.01.22(Ngatama-Mathews), p69-71 & 76-77
[113] Exhibit 1, Vol. 1, Tab 29.13, KHC Integrated Progress Notes (1.40 pm, 23.08.18)
[114] Exhibit 1, Vol. 2, Tab 45, Statement - Nurse P Ngatama-Mathews (12.01.22), paras 28-29
[115] ts 18.01.22 (Hope), p44; ts 18.01.22(Ngatama-Mathews), p73; and ts 19.01.22(Paradza), p103

68. Because of his self-harming behaviour and his attempts to abscond from the ward, Mr Williams was made an involuntary patient at 3.15 pm on 23 August 2018, and Dr Hope subsequently signed the necessary forms under the *Mental Health Act* 2014 (WA) (MHA).[116,117]

69. An entry in the hospital record at 4.00 pm, noted Mr Williams' unpredictability and self-harm ideation and his risk to himself and his impulsivity were assessed as "*high*", whereas his risk to others was "*low*". The entry records that Mr Williams' NOK was to be notified of his involuntary patient status and that his medication chart had been re-written to avoid any confusion due to recent medication changes.[118]

70. Dr Hope reviewed Mr Williams at 6.30 pm, and found he was "*floridly psychotic*" and experiencing auditory hallucinations. His bizarre ideation about needing to die or be injured was noted, as were his self-harm attempts, his disinhibited behaviour and his attempt to abscond from the ward. Dr Hope was concerned that Mr Williams was at high risk of self-harm and/or absconding and made detailed orders including that Mr Williams be given regular medication (olanzapine and diazepam) and that line-of-sight observation be maintained at all times. Dr Hope also ordered that his oral intake be monitored, and he be denied sharp/hard objects including cutlery. Dr Hope said she was mindful that a high dose of medication was being used to dampen Mr Williams' psychotic symptoms, so she ordered a repeat ECG to check his heart function.[119]

71. A nursing entry at 8.45 pm, records a visit from Mr Williams' family and a request by Mr Ben Williams to be advised of the timing of Mr Williams' next medical review. Cans of soft drink given to Mr Williams by his family were decanted into polystyrene cups and he was permitted to access the Courtyard with security guards. Once he was in the Courtyard, Mr Williams reportedly become increasingly more animated, and he began jumping onto the wall of the garden bed in the Courtyard.[120]

[116] Exhibit 1, Vol. 1, Tab 29.7, Form 6A - Inpatient Treatment Order in Authorised Hospital (3.15 pm, 23.08.18)
[117] Exhibit 1, Vol. 1, Tab 29.8, Form 1A - Referral For Examination Y Psychiatrist(3.15 pm, 23.08.18)
[118] Exhibit 1, Vol. 1, Tab 29.13, KHC Integrated Progress Notes (4.00 pm, 23.08.18)
[119] Exhibit 1, Vol. 1, Tab 29.13, KHC Integrated Progress Notes (6.30 pm, 23.08.18)
[120] Exhibit 1, Vol. 1, Tab 29.13, KHC Integrated Progress Notes (8.45 pm, 23.08.18)

72. Mr Williams complied with a direction to return to his room and the doors to the Courtyard were locked. Access to his bathroom was restricted and a security guard was placed in the corridor outside his room. Mr Williams' 5.00 pm dose of diazepam was withheld after consultation with Dr Hope and Mr Williams was reported to be asleep until he was woken when his family visited.[121]

Treatment - 24 August 2018[122]

73. The night shift nurse assigned to Mr Williams made an entry in the hospital record at 6.25 am on 24 August 2018. That entry records the fact that although Mr Williams was asleep at 12.15 am, he woke at some point thereafter and was given Milo and some toast. A security guard reported that Mr Williams woke again around 2.00 am, but that he returned to bed after realising the kitchen was locked.

74. The entry notes Mr Williams was asleep and remained at "*High risk to self, low to others*" and so constant line-of-sight observation by the security guard was maintained. The 6.25 am entry is the last contemporaneous observation in the hospital record until Dr Hope's later review of Mr Williams at 6.00 pm.[123,124] Thus, for a period of over 11 hours, there were no entries about Mr Williams' mental state or his treatment. This is clearly unsatisfactory and appears to have been due, at least in part, to staff shortages on the MHU. I will comment on this issue later in this finding.

75. A retrospective nursing entry by Nurse Emma Cornelius at 1.37 pm on 25 August 2018, relates to the events of the morning and early afternoon of 24 August 2018. That entry states that Mr Williams was woken at 8.00 am so his vital signs could be recorded but he declined breakfast and went back to sleep. He was woken again at 12.00 pm, and given some sandwiches and his prescribed medication.[125,126]

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[121] Exhibit 1, Vol. 1, Tab 29.13, KHC Integrated Progress Notes (8.45 & 9.45 pm, 23.08.18)
[122] Exhibit 1, Vol. 1, Tab 28, Report - Dr J Hope (20.10.20), pp4-5
[123] Exhibit 1, Vol. 1, Tab 29.13, KHC Integrated Progress Notes (6.25 am, 24.08.18)
[124] Exhibit 1, Vol. 1, Tab 29.13, KHC Integrated Progress Notes (6.00 pm, 24.08.18)
[125] Exhibit 1, Vol. 1, Tab 29.14, KHC Integrated Progress Notes (1.37 pm, 25.08.18 - Retrospective entry re 24.08.18)
[126] Exhibit 1, Vol. 2, Tab 43, Statement - Nurse E Cornelius (10.01.18), para 8

76. Nurse Cornelius says that at lunchtime, she noticed the security guard allocated to Mr Williams eating lunch in the Courtyard. She told the guard this was unacceptable, and that he needed to be in Mr Williams room at all times. The security guard was reportedly extremely apologetic and said he thought he was permitted to go to the Courtyard because Mr Williams was asleep. This is an example of miscommunication between nursing and security staff on the MHU, a matter identified in the root cause analysis (or SAC1) undertaken after Mr Williams' death.[127,128]

77. Nurse Cornelius' entry in the hospital record also states Mr Williams told nursing staff he was "*bored*" and was "*over being stuck in my room*". After a discussion between nursing and medical staff, it was agreed that Mr Williams could access the Courtyard briefly on the basis that "*he had been calm and quiet the whole day*". Mr Williams went into the Courtyard with a security guard (Mr McNamara) and was apparently also under observation by nursing staff. After finishing a cigarette, Mr Williams returned to his room and he agreed to keep his door open so that Mr McNamara could maintain line-of-sight observation.[129,130]

78. Mr Williams is described in the entry as being polite and pleasant in his interactions with staff and no psychotic symptoms were observed. A mental health advocate contacted the ward seeking to speak to Mr Williams but he was asleep and so she arranged to contact the ward again on 25 August 2018. Visual observations were maintained and Mr Williams was assessed as "*High risk to self, absconding risk, self-harm. Low risk to others*".[131]

79. In his police statement, Mr McNamara says he assumed responsibility for Mr Williams at about 3.00 pm on 24 August 2018. Mr McNamara said he started work at midnight that day and was due to finish at 6.00 pm. According to Mr McNamara, Mr Williams seemed relaxed and happy and was "*polite and on his best behaviour*". Mr Williams was also awake and alert and made no mention of self-harm.[132]

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[127] Exhibit 1, Vol. 2, Tab 43, Statement - Nurse E Cornelius (10.01.18), para 12
[128] See also: ts 19.01.22 (Truran), pp129, 131, 134 & 137 and ts 19.01.22 (McNamara), p143
[129] Exhibit 1, Vol. 1, Tab 29.14, KHC Integrated Progress Notes (1.37 pm, 25.08.18 - Retrospective entry re 24.08.18)
[130] Exhibit 1, Vol. 2, Tab 43, Statement - Nurse E Cornelius (10.01.18), para 12
[131] Exhibit 1, Vol. 1, Tab 29.14, KHC Integrated Progress Notes (1.37 pm, 25.08.18 - Retrospective entry re 24.08.18)
[132] Exhibit 1, Vol. 1, Tab 17, Statement - Mr S McNamara (25.08.18), paras 5-10 & 14-16

80. A retrospective nursing entry by Nurse Retimana Te Whatu at 3.40 pm on 26 August 2018, relates to the events of 24 August 2018 from 4.30 pm to 5.30 pm. The entry states that at 4.30 pm, Mr Williams was in bed under observation from a security guard. He ate some sandwiches at around 5.00 pm and was given his diazepam dose at 5.30 pm. The entry states Mr McNamara was aware of "*close proximity required due to unpredictability, possible abscond risk and disinhibited behaviours @ times on ward*".[133] However, at the inquest, Mr McNamara denied being given any specific directions by nursing staff, other than to maintain line-of-sight observation.[134]

81. An undated retrospective nursing entry by Nurse Tonderai Paradza deals with the events of 24 August 2018 between 5.20 pm and 7.50 pm and notes that at 5.20 pm, Mr Williams seemed pre-occupied and was given a 5mg dose of diazepam. The entry states that Dr Hope reviewed Mr Williams at 5.45 pm and made no changes to his treatment regime and that Mr Williams had been in the Courtyard with a security guard.[135]

82. When she reviewed Mr Williams, Dr Hope noted he was "*more settled today*" and although he denied current auditory or visual hallucinations, he disclosed he had experienced visual hallucinations (with orange colours) during the previous night. Mr Williams denied self-harm or suicidal ideation although he said he previously thought Dr Hope was his mother. Mr Williams denied any physical issues but was noted to have a "*fruity cough*". Dr Hope was concerned Mr Williams was at risk of a chest infection because he was as a smoker and had spent several days lying in bed and recommended he spend some time walking around the ward.[136]

83. Dr Hope also noted Mr Williams said he thought "*Jaiden*" was racing him and trying to take over his body "*to the dark light and shadows*" (or words to that effect) and that he remained an ongoing risk of unpredictability, self-harm and absconding. After completing her notes of her review of Mr Williams , Dr Hope attended to another patient.[137]

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[133] Exhibit 1, Vol. 1, Tab 29.14, KHC Integrated Progress Notes (3.40 pm, 26.08.18 - Retrospective entry re 24.08.18)
[134] ts 19.01.22 (McNamara), p148
[135] Exhibit 1, Vol. 1, Tab 29.14, KHC Integrated Progress Notes (26.08.18 - Retrospective entry re 24.08.18)
[136] Exhibit 1, Vol. 1, Tab 29.14, KHC Integrated Progress Notes (6.00 pm, 24.08.18) and ts 18.01.22 (Hope), p54
[137] Exhibit 1, Vol. 1, Tab 29.14, KHC Integrated Progress Notes (6.00 pm, 24.08.18)

EVENTS LEADING TO MR WILLIAMS' DEATH

First absconding event - 24 August 2018[138,139]

84. Shortly before 6.00 pm, Mr McNamara said he was in the communal area of the MHU conducting a handover with Mr Robert Truran, the security guard taking over responsibility for Mr Williams. Mr McNamara says he told Mr Truran that Mr Williams was at high risk of absconding from the ward and self-harm before leaving Mr Williams in Mr Truran's care and going to the ward office to sign off duty.[140,141]

85. Mr McNamara says a short time later, Mr Truran came to the office to advise that Mr Williams had absconded from the MHU by climbing over the rear fence of the Courtyard. Mr McNamara told Mr Truran to tell ward staff what had happened and then ran out of the MHU to search for Mr Williams. Although Mr Truran's version of events up to this point is similar to Mr McNamara's, he says that Mr Williams absconded from the MHU during the handover from Mr McNamara.[142,143]

86. In an undated retrospective entry for 24 August 2018, labelled 5.55 pm Nurse Paradza says he was advised by a security guard (presumably Mr Truran) that Mr Williams had absconded from the MHU by "*jumping over the fence*". Nurse Paradza's entry says he asked the security guards to "*do a grounds search*" for Mr Williams and that about five minutes later, the security guards returned to the MHU with Mr Williams.[144,145]

87. Meanwhile, Mr McNamara ran through the hospital grounds and encountered a man who said someone was lying in shrubbery "*just outside the entrance*". Mr McNamara found Mr Williams attempting to conceal himself in bushes and as he was lifting Mr Williams up by the arm, he was joined by Mr Truran. Together, he and Mr Truran started escorting Mr Williams back towards the MHU.[146]

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138 Exhibit 1, Vol. 2, Tab 37.1, CCTV Guide - Chronology and screenshots
139 Exhibit 1, Vol. 2, Tab 48, Statement - Mr S McNamara (13.01.22), paras 53-98
140 Exhibit 1, Vol. 1, Tab 15, Statement - Mr S McNamara (25.08.18), paras 17-20 and ts 19.01.22 (McNamara), p150
141 Exhibit 1, Vol. 1, Tab 14, Statement - Mr R Truran (25.08.18), paras 6-10 and ts 19.01.22 (Truran), pp128-129
142 Exhibit 1, Vol. 1, Tab 15, Statement - Mr S McNamara (25.08.18), paras 21-23 and ts 19.01.22 (McNamara), p150
143 Exhibit 1, Vol. 1, Tab 14, Statement - Mr R Truran (25.08.18), paras 10-12 and ts 19.01.22 (Truran), pp128-129
144 Exhibit 1, Vol. 1, Tab 29.14, KHC Integrated Progress Notes (26.08.18 - Retrospective entry re 24.08.18)
145 ts 19.01.22 (Paradza), p107
146 Exhibit 1, Vol. 1, Tab 15, Statement - Mr S McNamara (25.08.18), paras 24-30 and ts 19.01.22 (McNamara), p150

88. Mr McNamara says that initially, Mr Williams offered no resistance but all of a sudden he broke free. Mr Williams then ran across the carpark at the rear of KHC towards the intersection of Charlotte Street and St Albans Road, near the railway line that runs along the rear of KHC. Mr McNamara says that Mr Williams then ran across the railway tracks before laying on the ground and placing his head on blue metal, a few centimetres from one of the tracks.[147]

89. Mr McNamara says he checked for trains before walking over to Mr Williams and asking him to get up. He tapped Mr Williams on the foot but there was no response and so he reached down and grabbed Mr Williams' right arm and applied some pressure. According to Mr McNamara, as Mr Williams got to his feet, he (Mr Williams) clenched his fists as if to punch Mr McNamara and his fists stopped a few centimetres from Mr McNamara's face.[148]

90. Mr McNamara says he pulled Mr Williams across the railway tracks and escorted him back towards KHC with Mr Truran's help. At the inquest, Mr McNamara was adamant that Mr Truran had assisted him to escort Mr Williams back to the MHU from the railway line. After returning Mr Williams to the MHU, Mr McNamara says he told Nurse Paradza what had occurred. However, at the inquest Mr McNamara said he told Mr Truran "*you really need to monitor this fellow*" before leaving the MHU without speaking to any of the nursing staff.[149]

91. Mr McNamara says that after leaving the MHU, he went home and typed up a report about the incident, the contents of which are broadly consistent with his statement to police and his evidence at the inquest.[150,151,152] Notably however, Mr McNamara's evidence about Mr Truran assisting him to bring Mr Williams back from the railway line at the rear of KHC is inconsistent with Mr Truran's recollection of events.

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147 Exhibit 1, Vol. 1, Tab 15, Statement - Mr S McNamara (25.08.18), paras 31-37 and ts 19.01.22 (McNamara), pp151-152
148 Exhibit 1, Vol. 1, Tab 15, Statement - Mr S McNamara (25.08.18), paras 40-46 and ts 19.01.22 (McNamara), pp151 & 158
149 Exhibit 1, Vol. 1, Tab 15, Statement - Mr S McNamara (25.08.18), paras 47-52 and ts 19.01.22 (McNamara), pp151 & 157-158
150 Exhibit 1, Vol. 1, Tab 15, Statement - Mr S McNamara (25.08.18), paras 53
151 ts 19.01.22 (McNamara), pp151, 153-154 & 157-158
152 Exhibit 1, Vol. 1, Tab 15A, Report - Mr S McNamara (24.08.18)

92. In his police statement, Mr Truran says after a short search of the grounds of KHC he and Mr McNamara found Mr Williams on St Albans Street "*approximately 100 metres from the hospital grounds*". Mr Truran says Mr Williams was then "*detained*" and brought back to the MHU. Mr Truran also said that Mr Williams "*did not state any particular actions he wished to inflict upon himself or any other person*".[153]

93. At the inquest, Mr Truran said he saw Mr McNamara bringing Mr Williams "*across from the train track back onto St Albans Road*", but denied being aware that Mr Williams had laid down on blue metal close to the tracks. Mr Truran said he could not recall if Mr McNamara had given any information to nursing staff about where Mr Williams was found, although it appears that he (i.e.: Mr Truran) did so.[154]

94. In his retrospective entry in the hospital record and in his police statement, Nurse Paradza says he was told by a security guard (presumably Mr Truran) that Mr Williams was found at the back of the hospital, although at the inquest, Nurse Paradza said he was told Mr Williams "*was found on the grounds*". Either way Nurse Paradza flatly denied being told that Mr Williams had been found on railway tracks at the time he was returned to the MHU. Nurse Paradza said he only become aware of this information after Mr Williams' death.[155,156]

95. In his retrospective entry in the hospital record (timed at 5.55 pm), Nurse Paradza says after Mr Williams had been returned to the ward, he told Mr Williams that his behaviour was unacceptable and he should approach nursing staff if he needed support. Mr Williams was encouraged to rest in his room and Nurse Paradza recorded his request that Mr Truran keep Mr Williams at arm's length when Mr Williams was in communal areas, and inform him if Mr Williams wanted to go to the Courtyard. Nurse Paradza's retrospective entry for 6.30 pm, states that Mr Williams was in bed and the security guard was outside his room.[157]

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153 Exhibit 1, Vol. 1, Tab 14, Statement - Mr R Truran (25.08.18), paras 13-15 and ts 19.01.22 (Truran), pp129-131
154 ts 19.01.22 (Truran), p131
155 Exhibit 1, Vol. 1, Tab 29.14, KHC Integrated Progress Notes (26.08.18 - Retrospective entry re 24.08.18)
156 Exhibit 1, Vol. 2, Tab 42, Statement - Mr T Paradza (10.01.22), para 90 and ts 19.01.22 (Paradza), pp108-109
157 Exhibit 1, Vol. 1, Tab 29.14, KHC Integrated Progress Notes (26.08.18 - Retrospective entry re 24.08.18)

96. As noted, Dr Hope had attended to another patient after reviewing Mr Williams and at about that time, Nurse Paradza advised her that Mr Williams had absconded from the ward. Dr Hope says she was told that Mr Williams had clambered over the Courtyard fence "*into the hospital grounds but was quickly intercepted and brought back to the ward*".[158] However, as I have explained, on either Mr McNamara's or Mr Truran's version of events, this information was clearly wrong.

97. Nevertheless, on the basis of the information she had been given, Dr Hope ordered that Mr Williams be given his previously withheld dose of diazepam in order to sedate him. Mr Williams was returned to his room and a security guard was directed to maintain line-of-sight observations at all times. Dr Hope says she discussed the need for a nurse to "*special*"[159] Mr Williams, but once again, there were no available nurses in the MHU to do this. When Dr Hope left the MHU some two hours after her scheduled finish time, she was satisfied that all patients on the ward, including Mr Williams, were safe.[160]

98. Nurse Paradza's retrospective entry for 6.35 pm states that the security guard advised him that Mr Williams wanted a drink and Nurse Paradza gave Mr Williams an orange juice and an apple juice while he was resting in bed.[161]

99. At the inquest, Nurse Paradza said that if (at the time Mr Williams was returned to the MHU) he had been told that Mr Williams was found next to railway tracks at the rear of KHC, he would have discussed this "*key piece of information*" with Dr Hope and escalated his concerns. Dr Hope confirmed that had she been aware that Mr Williams had been found near the railway tracks, she would have ordered he be denied access to the Courtyard for the rest of the night.[162]

[158] Exhibit 1, Vol. 1, Tab 28, Report - Dr J Hope (20.10.20), p4 and ts 18.01.22 (Hope), p47
[159] In other words, for a nurse to be allocated exclusively to Mr Williams in order to closely monitor him
[160] Exhibit 1, Vol. 1, Tab 28, Report - Dr J Hope (20.10.20), p4 and ts 18.01.22 (Hope), p53
[161] Exhibit 1, Vol. 1, Tab 29.14, KHC Integrated Progress Notes (26.08.18 - Retrospective entry re 24.08.18)
[162] ts 18.01.22 (Hope), p47-49 and ts 19.01.22 (Paradza), pp108-109 & 122-123

100. The discrepancy between the evidence of Mr McNamara and Mr Truran about the circumstances of Mr Williams' first absconding event is perplexing. However, at the inquest, Mr McNamara's recollection of events seemed clear and he was adamant that Mr Truran had seen Mr Williams on the railway tracks. Although Mr Truran acknowledged in his police statement that he saw Mr Williams on St Albans Road (which runs along the railway line), at the inquest he categorically denied being aware that Mr Williams had been lying next to the tracks.[163]

101. After listening carefully to the evidence of both men, I have concluded that Mr McNamara's evidence is more reliable. He was clear and concise and readily conceded he did not tell staff about finding Mr Williams at the railway tracks. Mr Truran's version of events was less coherent, but even on his evidence, Mr Williams was clearly apprehended outside the hospital grounds in the vicinity of the railway. The fact that nursing staff were not told Mr Williams had been found outside the grounds of KHC, much less that he was lying next to railway tracks, is obviously deeply regrettable.

102. At the inquest, Mr McNamara acknowledged he had not briefed nursing staff about the circumstances of Mr Williams' absconding and properly conceded that he should have done so.[164,165] However, regardless of what Mr McNamara and/or Mr Truran should have told clinical staff, nursing staff were at least aware that Mr Williams had successfully absconded from the MHU, in circumstances where he had made an earlier unsuccessful attempt to do so.

103. With great respect to all of the clinical staff involved in his care, it is astonishing that Mr Williams was not confined to his room when he was returned to the MHU having successfully absconded for the first time. The risks clearly identified by Dr Hope during her review of Mr Williams before he absconded should to have led to a heightened level of concern amongst staff about what Mr Williams might do next.

[163] ts 19.01.22 (Truran), p131 and ts 19.01.22 (McNamara), pp151 & 158
[164] ts 19.01.22 (McNamara), p157
[165] Exhibit 1, Vol. 2, Tab 36, Statement - Dr K Lakshminarayanan (26.11.21), para 268-269

104. I acknowledge that at the time of Dr Hope's review (i.e.: before he absconded) Mr Williams appeared "*slowed by the medication*" and "*bleary-eyed*". I also accept that it was assumed that the dose of diazepam he was given at 5.30 pm (which had previously been withheld) would have a sedative effect. Nevertheless, Mr Williams' unpredictability, as well as his known risks of self-harm and absconding, should have led to more stringent restrictions being applied.

105. Specifically, when Mr Williams was returned to the MHU at about 6.15 pm on 24 August 2018, he should have been confined to his room. Further, the Courtyard doors should have been locked (as had happened on several previous occasions) and for the rest of the night, Mr Williams should not have been allowed into the Courtyard under **any** circumstances. The reality is that had these relatively simple restrictions been imposed, it is unlikely that Mr Williams would have been able to abscond from the MHU for a second time. In those circumstances, I am obliged to point out the agonising truth that in those circumstances, the outcome in this case would almost certainly have been different.

Second absconding event - 24 August 2018

106. Nurse Paradza's retrospective entry for 7.05 pm states Mr Williams was in the communal area of the MHU in the company of a security guard. Mr Williams seemed pre-occupied and to be responding to unseen stimuli.[166] According to Mr Truran, Mr Williams stayed in his room until about 7.25 pm at which time he made a coffee in the communal area before giving some of his cigarettes to other patients, presumably because he thought he was not allowed into the Courtyard.[167]

107. According to Mr Truran, one of the nurses (who mut have been Nurse Kimberley Burns, a graduate nurse on her second unsupervised shift) told Mr Williams to stop giving away his cigarettes. In her statement Nurse Burns says that at about 7.25 pm, Mr Williams asked if he could go to the Courtyard to retrieve his cigarettes from a couple of patients who by then had moved into the Courtyard.[168,169]

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[166] Exhibit 1, Vol. 1, Tab 29.14, KHC Integrated Progress Notes (26.08.18 - Retrospective entry re 24.08.18)
[167] Exhibit 1, Vol. 1, Tab 14, Statement - Mr R Truran (25.08.18), paras 16-18 and ts 19.01.22 (Truran), pp132
[168] Exhibit 1, Vol. 1, Tab 14, Statement - Mr R Truran (25.08.18), paras 19-20 and ts 19.01.22 (Truran), pp133
[169] Exhibit 1, Vol. 2, Tab 44, Statement - Nurse K Burns (10.01.22), para 22

108. Nurse Burns says she discussed this request with the shift co-ordinator (Nurse Paradza) who agreed, and that she and Mr Truran accompanied Mr Williams to the Courtyard for this purpose.[170] Nurse Paradza's retrospective entry for 7.30 pm, states Mr Williams was given his night medication in the Courtyard in the company of other patients and the security guard. Nurse Paradza said he administered this dose earlier than charted because he had an uneasy feeling about Mr Williams. The entry also states Mr Williams was encouraged to "*come into the clinic post smoking his cigarette*" and that he had agreed to do so.[171,172]

109. In her statement, Nurse Burns says that although Mr Williams was given permission to briefly access the Courtyard to retrieve his cigarettes, he lit up a cigarette and then had to finish it before he could return inside. Nurse Burns says she sat on the wall of the garden bed in the Courtyard whilst Mr Williams smoked his cigarette. As Mr Williams was in the Courtyard, several patients started kicking a football between themselves and Mr Williams and Mr Truran joined in.[173,174]

110. Mr Truran says he deliberately positioned himself near the rear fence of the Courtyard because this was where Mr Williams had earlier absconded from. At some point, Mr Williams kicked the football to Mr Truran but "*left it short*", meaning Mr Truran had to step away from the rear fence to retrieve the ball. As Mr Truran did so, Mr Williams suddenly sprinted towards the rear fence of the Courtyard and scaled it, before dropping into the sparse bush on the other side.[175]

111. At about the same time, Nurse Burns says that as she turned to walk towards the Courtyard door, she heard patients in the Courtyard yell "*help*" and became aware that Mr Williams had absconded from the MHU.[176] As Mr Williams had earlier demonstrated, his athleticism and level of fitness meant he had no difficulty in scaling the rear fence, despite the fact that it was about 3.27 metres high.

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[170] Exhibit 1, Vol. 1, Tab 14, Statement - Mr R Truran (25.08.18), paras 20-21 and ts 19.01.22 (Truran), p134
[171] Exhibit 1, Vol. 1, Tab 29.14, KHC Integrated Progress Notes (26.08.18 - Retrospective entry re 24.08.18)
[172] ts 19.01.22 (Paradza), p110
[173] Exhibit 1, Vol. 1, Tab 14, Statement - Mr R Truran (25.08.18), paras 21-23 and ts 19.01.22 (Truran), p134
[174] Exhibit 1, Vol. 2, Tab 44, Statement - Nurse K Burns (10.01.22), paras 26-29
[175] Exhibit 1, Vol. 1, Tab 14, Statement - Mr R Truran (25.08.18), paras 24-27 and ts 19.01.22 (Truran), p134
[176] Exhibit 1, Vol. 2, Tab 44, Statement - Nurse K Burns (10.01.22), paras 22 & 30

112. Nurse Paradza's retrospective entry for 7.35 pm, states he was told by a colleague (who must have been Nurse Burns) that Mr Williams had jumped over the Courtyard fence. The entry says that on hearing this, he asked the security guard (Mr Truran) to do an immediate ground search starting with the rear of Ward B.[177,178]

113. Nurse Paradza asked Nurse Burns to make an entry in the hospital record about her observations and she did so at 8.00 pm in these terms:

> Jordan was in the Courtyard smoking towards the front of the Courtyard away from the gate. The patient was towards the left of the Courtyard kicking the ball with the security guard that was in line-of-sight special and fellow patients…The patient jumped over the fence.[179,180]

114. Nurse Paradza's retrospective entry for 7.35 pm also states that he called Dr Hope to advise her Mr Williams had absconded. Given Mr Williams' level of risk to himself, Nurse Paradza also called the Police (i.e.: Constable Proctor) to seek urgent assistance and was advised that a patrol car had already been despatched.[181] Constable Proctor later described the call as unusual, with the caller more interested in obtaining contact details than providing information about Mr Williams or the absconding event. Constable Proctor said she felt the caller was already aware (or suspected) that Mr Williams had been struck by a train.[182]

115. Nurse Paradza's entry also states that Mr Williams' NOK (presumably Mr Ben Williams) had attended the MHU and been advised that Mr Williams had absconded and that a security guard and the police were out looking for him. The entry also notes that the NOK said they would join in the search and had expected Mr Williams might try "*something like that*". Nurse Paradza's entry says he asked the NOK to make contact when Mr Williams was located "*in case they needed assistance*".[183]

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[177] Exhibit 1, Vol. 1, Tab 29.14, KHC Integrated Progress Notes (26.08.18 - Retrospective entry re 24.08.18)
[178] ts 19.01.22 (Paradza), p1112
[179] Exhibit 1, Vol. 1, Tab 29.14, KHC Integrated Progress Notes (8.0 pm, 24.08.18)
[180] Exhibit 1, Vol. 2, Tab 44, Statement - Nurse K Burns (10.01.22), paras 33-35
[181] Exhibit 1, Vol. 1, Tab 29.14, KHC Integrated Progress Notes (26.08.18 - Retrospective entry re 24.08.18)
[182] Exhibit 1, Vol. 2, Tab 40, Report - Insp. J Tarasinski, p6
[183] Exhibit 1, Vol. 1, Tab 29.14, KHC Integrated Progress Notes (26.08.18 - Retrospective entry re 24.08.18)

116. Meanwhile, Mr Truran had made his way to the carpark at the rear of KHC and a short time later saw Mr Williams next to a bus shelter on Charlotte Street. It appears that Mr Williams spotted Mr Truran, because he ran across the carpark before jumping the boundary fence and running onto the railway tracks. Mr Truran tried to cut Mr Williams off but was unsuccessful and instead, made for the corner of the railway fence in order to get access to the tracks. Mr Truran then heard the sound of a train at the nearby Piccadilly Street crossing and says he was obliged to stay where he was until the train had passed. Mr Truran says the train then came to a stop, which he took as a bad sign, and he made his way along the railway line inside the fence to search for Mr Williams. Mr Truran says that although he went as far as the traffic bridge at Maritana Street, he saw nothing.[184]

117. Meanwhile, the driver of the train (operated by the rail transport company, Aurizon) says that at about 7.40 pm, he was in the front left-hand driver's seat approaching Kalgoorlie. Another employee was in the cabin and when the train was about 200 metres north of the Maritana Street bridge, the driver says he saw a dark shape lying in the gully between the two sets of railway tracks. The shape was illuminated by the train's lights for about 15 seconds, and the driver realised it was a slim male with dark hair wearing dark blue clothes.[185]

118. The driver says the male (later identified as Mr Williams) looked at the train before running towards the left-hand railway tracks and placing his chest on the rails.[186] The driver applied the train's emergency brakes while his partner made an emergency radio call to police and the train came to a stop after about 200 metres. Police attended shortly thereafter.[187] Meanwhile, Mr Truran had made his way back to the MHU, where staff asked him to find out what had happened. By the time Mr Truran returned to the railway line police had arrived, and they confirmed that a person had been struck and killed by the train. Mr Truran was later advised that the deceased person was Mr Williams.[188,189]

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[184] Exhibit 1, Vol. 1, Tab 14, Statement - Mr R Truran (25.08.18), paras 28-43 and ts 19.01.22 (Truran), pp135-136
[185] Exhibit 1, Vol. 1, Tab 16, Statement - Mr M Wheeler (24.08.18), paras 3-10
[186] According to Sen. Const. Castlehow, the train driver told him Mr Williams had placed his head on the tracks
[187] Exhibit 1, Vol. 1, Tab 16, Statement - Mr M Wheeler (24.08.18), paras 12-19
[188] Exhibit 1, Vol. 1, Tab 14, Statement - Mr R Truran (25.08.18), paras 30-35 and ts 19.01.22 (Truran), p136

119. Meanwhile, Dr Hope received a call from Nurse Paradza at 7.42 pm, advising her that Mr Williams had absconded from the MHU for the second time. At 7.57 pm, Dr Hope received a further call and was asked to return to the MHU. She arrived a short time later and was told that the person police had found at the railway tracks was believed to be Mr Williams. Dr Hope called the regional clinical director, Dr Roland Main, and he advised that Mr Williams' family should be notified by police and that Dr Hope should offer support to the family and staff and "*provide open disclosure*".[190]

120. While this was occurring, Mr McNamara was at home and had completed his report. He called his wife who is the co-owner of MCM and she told him that that Mr Williams had absconded from the MHU. Together, Mr McNamara and his wife arranged for all of MCM's security patrols to search for Mr Williams, but Mr McNamara was subsequently advised by his wife that Mr Williams had died.[191]

121. A retrospective entry by Nurse Paradza for 7.50 pm, states that he was contacted by a police officer and informed that Mr Williams had been found, but was deceased.[192,193] In an entry in the hospital record at 8.20 pm, Dr Hope records the information she was given about Mr Williams. That information is consistent with the facts I have outlined, and Dr Hope's entry also states she was waiting notification from the police and had called Dr Main. The following plan of action is then recorded:

1. Family to be notified by Police;
2. Family to be offered support and open disclosure ASAP, following identification (of Mr Williams);
3. Support to staff;
4. Notify Hospital Coordinator;
   Addition: Hospital Coordinator and myself are awaiting call to identify.

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189 Exhibit 1, Vol. 1, Tab 33A & 33B, Incident reports LWP180824006066995 & LWP18082400607014 (24.08.18)
190 Exhibit 1, Vol. 1, Tab 28, Report - Dr J Hope (20.10.20), p5 and ts 18.01.22 (Hope), p48
191 Exhibit 1, Vol. 1, Tab 15, Statement - Mr S McNamara (25.08.18), paras 56-62 and ts 19.01.22 (McNamara), ppxx-xx
192 Exhibit 1, Vol. 1, Tab 29.14, KHC Integrated Progress Notes (26.08.18 - Retrospective entry re 24.08.18)
193 Exhibit 1, Vol. 2, Tab 42, Statement - Mr T Paradza (10.01.22), para 130 and ts 19.01.22 (Paradza), p113

122. As noted, MHU staff were aware that Mr Williams had died because the Police had told them so.[194] However, most unfortunately, MHU staff were instructed by the Police not to notify Mr Williams' family of this fact. This direction placed MHU staff in an invidious position. When Mr Ben Williams rang the MHU, he was told that staff "*did not have clear information*", which was clearly untrue.[195]

123. The direction by the Police had the effect of denying MHU staff the opportunity to provide support to Mr Ben Williams and other members of the Williams . For reasons which I will now explain, Mr Williams' family were not advised by Police that Mr Williams had had died until five hours after his death. On any view, this is unacceptable.

Notification of family[196]

124. At the relevant time, the Officer-in-Charge of the Kalgoorlie police station was Senior Sergeant Peter Healy (Officer Healy). Following the death of Mr Williams' father in February 2018, Officer Healy had significant contact with the Williams family and formed the view that Mr Ben Williams "*was not dealing well*" with his brother's death. As a result, Officer Healy was concerned about how the notification of Mr Williams' death would "*impact on the safety and welfare of the Williams family, particularly Ben and the deceased's sister*".[197]

125. Having taken the view that the Williams family needed support, Officer Healy determined that it would be appropriate to arrange for Mr Williams' grandfather to come to Kalgoorlie before the NOK notification occurred. The problem with this plan was that the grandfather lived in Ravensthorpe, some six hours from Kalgoorlie by road. Unfortunately, efforts to contact the grandfather were also hampered by the fact that a police officer from Hopetoun (48 km away) had to be recalled to duty to assist the officer based at Ravensthorpe. This resulted in a delay in police attending the grandfather's home, only to find he wasn't there.[198]

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[194] Exhibit 1, Vol. 2, Tab 42, Statement - Mr T Paradza (10.01.22), para 130 and ts 19.01.22 (Paradza), p124
[195] Exhibit 1, Vol. 1, Tab 28, Report - Dr J Hope (20.10.20), p5 and ts 18.01.22 (Hope), pp50-51
[196] Exhibit 1, Vol. 1, Tab 33A & 33B, Incident reports LWP180824006066995 & LWP18082400607014 (24.08.18)
[197] Exhibit 1, Vol. 2, Tab 40, Report - Insp. J Tarasinski, pp4-5
[198] Exhibit 1, Vol. 2, Tab 40, Report - Insp. J Tarasinski, pp5 & 10-11

126. It appears that no consideration was given to using the experienced mental health staff at KHC to assist in providing support to members of the Williams family during the NOK notification, notwithstanding the fact that it was known that Mr Williams had been an inpatient at KHC since 20 August 2018. This is particularly unfortunate, as is the assumption that Mr Williams' grandfather was sufficiently robust to support the family on his own.

127. As it happens, when Mr Williams' grandfather was eventually contacted by phone (sometime after midnight on 25 August 2018) it was discovered he was actually in Kalgoorlie. Both he and Mr Ben Williams subsequently attended the Kalgoorlie police station and were notified of Mr Williams' death at about 12.30 am. Mr Williams' grandfather said he would notify other family members, and he and Mr Ben Williams left after police had served a brochure (Coroner's brochure) containing information mandated by the *Coroners Act 1996* WA (the Act).[199,200]

128. Whilst I accept that the Police were motivated by a desire to ensure that appropriate supports were in place before formal notification occurred, as things transpired the NOK notification process in Mr Williams' case was a very unfortunate affair and was particularly distressing to the family.[201]

129. In passing, I want to briefly deal with an erroneous view expressed in the Police report dealing with the NOK notification (the Report). The erroneous view appears in the following passage:

> WA Police perform the role of coroner's investigator and are responsible for completing the Next Of Kin notification and serving the Coroner's brochure with required information as required by the legislation. Therefore the advice provided to hospital staff not to notify the deceased's family was the correct advice, despite phone calls being received from the hospital by the deceased's family.[202]

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[199] Exhibit 1, Vol. 2, Tab 40, Report - Insp. J Tarasinski, pp10-12
[200] s20, *Coroners Act 1996* (WA)
[201] ts 18.01.22 (Williams, B via Tyler), p61
[202] Exhibit 1, Vol. 2, Tab 40, Report - Insp. J Tarasinski, p7

130. To suggest that when a coronial investigation is underway no person other than a police officer is permitted to notify NOK of a death is plainly wrong and appears to be based on a misunderstanding of relevant provisions of the Act.[203] Briefly, all police officers are "*coroner's investigators*" and are required to assist a coroner who is carrying out duties under the Act. Further, a coroner with jurisdiction to investigate a death (because the death is reportable) must provide the deceased's NOK with information on a range of matters. In practical terms, this requirement is achieved by police serving of a Coroner's brochure on the NOK.[204]

131. However, the fact that a police officer acting as a coroner's investigator has certain powers and duties under the Act does not mean that no one other than a police officer is authorised to inform a NOK of a deceased's death. Nowhere in the Act is there any such prohibition. Of course, NOK are routinely notified of the death of a loved one by a range of people other than police officers including ambulance officers, family members, neighbours, members of the public and so on.

132. It is simply wrong to conflate the task of serving a Coroner's brochure with the task of notifying the NOK of a deceased's death when the tasks are clearly separate. Indeed, section 20 of the Act (which deals with the information to be provided to a NOK) presupposes that the NOK is aware of the deceased's death and does not deal with the notification issue at all.

133. In short, it is my view that it would have been appropriate for police to have involved staff at the MHU in the NOK notification process. This is particularly so given that the police plan for providing family support would have required Mr Williams' grandfather to embark on a six-hour drive in the middle of the night (had he not already been in Kalgoorlie). The experienced staff at the MHU had been caring for Mr Williams in the days prior to his death and would have been able to provide excellent professional mental health support to the Williams' family.

[203] Exhibit 1, Vol. 2, Tab 40, Report - Insp. J Tarasinski, p7
[204] ss3, 14, 19 & 20, *Coroners Act 1996* (WA)

Return of Mr Williams' personal belongings[205]

134. According to family members, Mr Williams' belongings were released to a person without the permission of his immediate family.[206] It is not entirely clear how or why this occurred, but this was clearly contrary to the relevant WACHS policy, entitled "*Patients' Valuables Procedure*" (the Policy).[207]

135. In this case, the release of Mr Williams' property to a person other than his nominated NOK caused his family concern.[208] However, in fairness to staff at KHC, it is my view that the Policy is problematic. Whilst the Policy makes "*the social worker*" responsible for determining who an unconscious or deceased patient's property should be released to, it provides no guidance whatsoever as to how this is to be achieved.

136. In my view, the following section of the Policy is unintelligible:

> Cash and valuables are not to be taken by the **relatives** in the case of an unconscious or deceased patient. Items are to be taken into safe keeping and the social worker is to confirm who the **legal guardian** is, and the unconscious or deceased's patient's property can then be released to the **guardian**.[209] (Emphasis added)

137. Presumably, the aim of the Policy is to ensure that an unconscious or deceased's patient's property is released to their nominated NOK. However, the Policy uses the undefined terms "*relatives*", "*legal guardian*" and "*guardian*" in the same paragraph.

138. At the inquest, I asked Dr Lakshminarayanan how a social worker (a person without legal training) was supposed to interpret this paragraph of the Policy. Her response was that the social worker would liaise with the Legal Services section of the Department of Health and/or the Police.[210]

[205] ts 19.01.22 (Lakshminarayanan), p187-189
[206] ts 18.01.22 (Tyler), p97
[207] Exhibit 1, Vol. 2, Tab 49, WACHS Policy - Patients' Valuables Procedure
[208] ts 18.01.22 (Tyler), p97
[209] Exhibit 1, Vol. 2, Tab 49, WACHS Policy - Patients' Valuables Procedure, para 2.1.5
[210] ts 19.01.22 (Lakshminarayanan), p188

139. In my view, the Policy is unclear on its face and it is unacceptable to dump onto the social worker the responsibility of determining who a patient's property should be released to. It should not be necessary for a social worker (or anybody else for that matter) to have to seek legal advice on such a routine matter. Therefore, I strongly recommend that the Policy be urgently amended in order to clarify the person (or persons) to whom a patient's property may be released.[211]

CAUSE AND MANNER OF DEATH

Cause of death

140. Two forensic pathologists (i.e.: Dr Jodi White and Dr Nadia Vagaja), conducted a post mortem examination of Mr Williams' body on 29 August 2018. They found he had sustained blunt force head and neck injuries, with fractures of the cervical spine and skull and scattered soft tissue injuries to his trunk and limbs.[212,213,214,215]

141. Specialist examination of Mr Williams' brain did not reveal any significant findings and microscopic examination of tissues confirmed Dr White's and Dr Vagaja's post mortem findings.[216,217] Toxicological analysis found therapeutic levels of the sedating medications olanzapine and diazepam (and its metabolite) in Mr Williams' system. Alcohol and other common drugs were not detected.[218]

142. At the conclusion of the post mortem examination, Dr White and Dr Vagaja expressed the opinion that the cause of death was head and neck injuries.[219] I accept and adopt the conclusion of Dr White and Dr Vagaja as my finding in relation to the cause of Mr Williams' death.

[211] ts 19.01.22 (Lakshminarayanan), pp188-189
[212] Exhibit 1, Vol. 1, Tab 6A, Interim Post Mortem Report (29.08.18)
[213] Exhibit 1, Vol. 1, Tab 6B, Supplementary Post Mortem Report (10.03.19)
[214] Exhibit 1, Vol. 1, Tab 6C, Post Mortem Report (29.08.18)
[215] Exhibit 1, Vol. 1, Tabs 7A-7C, Neuropathology reports Report (03.09.18; 24.12.18 & 31.12.18)
[216] Exhibit 1, Vol. 1, Tab 6B, Supplementary Post Mortem Report (10.03.19)
[217] Exhibit 1, Vol. 1, Tabs 7A-7C, Neuropathology reports Report (03.09.18; 24.12.18 & 31.12.18)
[218] Exhibit 1, Vol. 1, Tab 8, ChemCentre toxicology report (09.10.18)
[219] Exhibit 1, Vol. 1, Tab 6B, Supplementary Post Mortem Report (10.03.19)

Manner of death

143. An obvious issue that arises is whether Mr Williams' death occurred by way of suicide. In a finding relating to the death of another inpatient on the MHU (who died in 2011 after also being struck by a train) Coroner King (as he then was) noted:

> In some circumstances, it is possible to infer a person's likely intention from the nature of the act that led to death; for example, when a person hangs herself or places herself directly in front of an oncoming train, the likely consequences in each scenario are clear.[220]

144. Whilst that statement is undoubtedly correct, in my view, the present case is more complicated because, at all relevant times, Mr Williams' was "*psychotically motivated*". The term "*psychotic*" is used by health professionals to describe a mental disorder where a person's thinking and perceptions are abnormal.

145. At various times during his admission, Mr Williams was described as "*floridly psychotic*". He also reported auditory and visual hallucinations and frequently expressed delusional beliefs. These beliefs included that a person called "*Jaiden*" was racing to take control of his body and that by harming himself, Mr Williams would not die but would instead "*take away the pain of the world*".[221]

146. In his evidence at the inquest, Dr Brett said that although Mr Williams may have had the capacity to form an intention to take his life, that capacity was impaired by his mental disorder.[222] Meanwhile, Dr Hope said that a person experiencing psychosis may often be unable to understand the consequences of their actions. Dr Hope expressed the opinion that on the basis of the available evidence, it was not possible to say with confidence that when Mr Williams lay on the railway tracks, he did so with the intention of taking his life.[223]

[220] Finding in relation to the death of Frances May Cooper, per Coroner B King (34/15, 30.11.15), para 129
[221] ts 18.01.22 (Hope), pp52-53 and 58-60
[222] ts 18.01.22 (Brett), p20
[223] ts 18.01.22 (Hope), pp59-61

147. In the context of Mr Williams' psychosis and his disordered thinking, Dr Hope was asked whether Mr Williams would have been able to understand that by acting as he had, he was placing his life in grave peril. Her response was:

> Jordan may have had ideas that, for instance that he wouldn't die or that something might happen after that had global significance. He certainly had an idea that if he harmed himself then it would take away the pain of the world, and…not just metaphorically; actually take away the pain of the world…And so it's very difficult to understand those actions about whether they were about trying to end his life or whether they were in response to a psychotic motivation for something else to occur…and that is very unclear in my mind.[224]

148. Mr Williams was clearly psychotic at the time he absconded from the MHU on 24 August 2018, and as a result, it seems most likely that he was unable to understand the consequences of his actions. Having carefully considered all of the available evidence (especially the views expressed by Dr Brett and Dr Hope) I find myself unable to conclude, to the relevant standard, that Mr Williams was capable of forming an intention to take his life.

149. In those circumstances, I have been unable to conclude that Mr Williams death occurred by way of suicide and instead, I make an open finding as to the manner of his death.

[224] ts 18.01.22 (Hope), p60

SAC1 REVIEW[225]

Overview

150. A confidential clinical investigation report (SAC1) was completed after Mr Williams' death. The purpose of a SAC1 is to establish what occurred and, where appropriate, make recommendations for immediate improvements. Dr Brett was critical of the SAC1 in this case. He said it had failed to "*get to the root cause*" of Mr Williams' death because it did not examine systemic issues such as staffing levels.[226,227,228]

151. At the inquest, Dr Lakshminarayanan rejected Dr Brett's criticisms and noted that the SAC1 (which had to be completed with 28-days of the incident being investigated) had addressed the use of security guards and touched on infrastructure and staffing issues. Dr Lakshminarayanan made the following comments about the scope of a SAC1:

> You have to understand that when you do a SAC1, it is not like a full-fledged review where you can go over and beyond and look into things and recommend things which are beyond your control. Staffing requires budgeting and finance and most of the time, you try to stay away from that…in a SAC 1 report, you will try to look at day to day processes, procedures that you are following…(asking)…What can we do differently and how can we do it different?[229]

152. Whilst I agree that a key aim of the SAC1 is to promptly identify issues that require immediate attention, Dr Brett's comments are pertinent. In this case, the roster in the MHU did not allow for a 1:1 special by a psychiatric nurse to be allocated to Mr Williams and this may have been a factor in him being able to abscond from the MHU. Some analysis of systemic issues (in this case, staffing levels) was therefore warranted. Although the SAC1 timeframe may mean that a comprehensive analysis may not be feasible, systemic issues should be identified where relevant.

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[225] Exhibit 1, Vol. 1, Tab 23, SAC1 Report and Exhibit 1, Vol. 2, Tab 36.31, SAC1 Report
[226] Exhibit 1, Vol. 2, Tab 36, Statement - Dr K Lakshminarayanan (26.11.21), paras 270-280
[227] ts 19.01.22 (Lakshminarayanan), pp185-186
[228] Exhibit 1, Vol. 1, Tab 30, Report - Dr A Brett (17.05.21), pp10-11 and ts 18.01.22 (Brett), p15
[229] ts 19.01.22 (Lakshminarayanan), p186

SAC1 review findings and recommendations

153. The SAC1 noted that Dr Hope was a locum on her second placement and had not worked in Western Australia before. It also was noted that Dr Hope had not been informed that Mr Williams had been found lying on the railway tracks after he absconded from the MHU for the first time, and she was unaware of KHC's close proximity to the railway line. The SAC1 also noted that security guards engaged by KHC had a range of experience levels and that the expectations of clinical staff in relation to those guards had not been communicated well.

154. The SAC1 identified that the MHU was not a secure facility. It also noted that the perimeter fence in the Courtyard was not compliant with the March 2018 version of Australian Facility Guidelines for Mental Health Facilities, which required a fence height of 3.5 metres. The SAC1 also noted that a Code Yellow was in place at KHC during the period of Mr Williams' admission to KHC.

155. The SAC1 review made a number of recommendations, with which I agree, namely:

a. Remediate courtyard fencing;

b. Develop a local procedure or guidance document to assist staff to determine appropriate 1:1 specials to care for mental health patients;

c. Develop a specific patient instruction handover communication tool for security services/personnel; and

d. Review the utilisation of security guards providing 1:1 specialised monitoring of patients who are acutely ill in the mental health inpatient unit.[230]

[230] Exhibit 1, Vol. 1, Tab 23, SAC1 Report, p9

ISSUES RAISED BY EXTERNAL PARTIES

Overview

156. The Brief contains several documents which address systemic issues at KHC generally and the MHU in particular. I have had regard to:

a. Report of Dr Brett: reviewing Mr Williams' treatment and touching on infrastructure and staffing issues, including the appropriateness of using security guards to monitor psychiatric patients;[231]

b. Report by the Mental Health Advocacy Service (MHAS): outlining the results of an investigation of the adequacy of mental health services at KHC (November 2018);[232]

c. Correspondence from the Office of the Chief Psychiatrist: dealing with the appropriateness of facilities at the MHU, including the height of the Courtyard fence;[233] and

d. Report by Drs Windsor, Main and Crampin: dealing with a service review of the mental health patient journey at KHC.[234]

157. In my view, the systemic issues identified in these documents are directly related to Mr Williams' death and it is therefore appropriate that I comment on them.

Bed pressure

158. Mr Williams was not admitted to the MHU on 20 August 2018, because it was already full. Instead, he was admitted to a surgical ward where he remained until 23 August 2018, when a bed became available on the MHU. I accept that admitting Mr Williams to a surgical ward was preferable to keeping him in ED or not admitting him at all, but the practice is clearly suboptimal.[235,236]

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[231] Exhibit 1, Vol. 1, Tab 30, Report - Dr A Brett (17.05.21)
[232] Exhibit 1, Vol. 1, Tab 31, MHAS Inquiry into conditions at Kalgoorlie Hospital (Nov 2018)
[233] Exhibit 1, Vol. 1, Tab 32, Correspondence relating to the Office of the Chief Psychiatrist (2019)
[234] Exhibit 1, Vol. 2, Tab 38, KVL1 - Service review of the MHU (Oct 2018)
[235] Exhibit 1, Vol. 1, Tab 30, Report - Dr A Brett (17.05.21), p12, para 7 and ts 18.01.22 (Brett), pp10-11
[236] ts 18.01.22 (Hope), p41

159. As Dr Brett pointed out, Mr Williams was having his first psychotic episode in hospital. Further, the staff responsible for his day-to-day management were not psychiatric nurses and could not be expected to have experience in monitoring patients with mental health issues. This is clearly illustrated by the fact that the hospital record for D Ward contains a form assessing Mr Williams' risk of developing blood clots in his veins (a common risk after surgery), but not a mental health risk form.[237,238,239]

160. It is true that Dr Forster conducted a detailed assessment of Mr Williams' mental health risks on 20 August 2018.[240] Nevertheless, the point Dr Brett makes is a good one. Surgical nurses responsible for managing Mr Williams on D Ward focussed on those aspects of care they knew best.[241] This issue was touched on in the review by Dr Windsor and his colleagues.[242]

161. The unrelenting (and ever increasing) pressure on beds in the MHU is demonstrated by the fact that by August 2018, there had been a 38% increase in inpatient admissions, and by August 2021, that increase was 58%. The MHAS report noted KHC advice that of the approximately 270 mental health admissions annually, about 80% were outliers.[243] Until a purpose-built facility replaces the MHU (see discussion below), the pressure on MHU beds is being managed in accordance with WACHS polices.[244]

162. One policy, effective from 19 September 2018, permits the temporary accommodation of mental health patients on general wards (e.g.: surgical or medical wards). Another policy, effective from 4 October 2018, requires that a mental health assessment is undertaken on the ward the patient is assigned to at the first available opportunity, but no later than 72 hours after the patient's admission. That assessment must be undertaken by a mental health professional.[245,246,247]

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237 Exhibit 1, Vol. 1, Tab 30, Report - Dr A Brett (17.05.21), p12, paras 7
238 Exhibit 1, Vol. 1, Tab 29.19, Venous Thromboembolism Risk Assessment (20.08.18)
239 ts 18.01.22 (Hope), p34
240 ts 19.01.22 (Lakshminarayanan), p190
241 Exhibit 1, Vol. 1, Tab 29.11 - 29.12, KHC Integrated Progress Notes (20.08.18)
242 Exhibit 1, Vol. 2, Tab 38, Service review of the MHU (Oct 2018)
243 Exhibit 1, Vol. 1, Tab 31, MHAS Inquiry into conditions at Kalgoorlie Hospital (Nov. 2018), para 13
244 Exhibit 1, Vol. 2, Tab 36, Statement - Dr K Lakshminarayanan (26.11.21), paras 36
245 Exhibit 1, Vol. 2, Tab 36, Statement - Dr K Lakshminarayanan (26.11.21), paras 61-88
246 Exhibit 1, Vol. 2, Tab 36, Att. KVL-6, Mental Health Care in Emergency Departments and General Wards Policy (Sep 2018)
247 Exhibit 1, Vol. 2, Tab 36, Att. KVL-7, Goldfields Mental Health Service: Mental Health Triage & Short Term Procedure(Oct 2018)

163. The MHAS report also dealt with the issue of transferring of mental health patients to other facilities, especially in Perth. These transfers are typically achieved using aircraft and issues with delays and the sedation of mental health patients are validly raised. Although these matters are outside the scope of this inquest, they warrant careful attention.[248,249]

Use of security guards

164. Dr Lakshminarayanan's statement makes it clear that the prevailing practice at KHC in 2018, was that security guards were used to provide "*continuous observation*" of patients because of the unavailability of nursing staff. The evidence of Nurses Tunua, Cornelius, and Burns, makes it clear that in practical terms, continuous observation by security guards was a *de facto* 1:1 special.[250,251,252,253,254,255]

165. The MHAS report (dated November 2018) refers to anecdotal evidence that when 1:1 specials were needed in the MHU security guards were used 95% of time, with nursing staff assisting in 4% of cases and patient care assistants being used in 1% of cases. Regardless of the accuracy of these numbers, it seems clear that the use of security guards in the MHU to perform what was, in effect, 1:1 specials was commonplace.[256]

166. I accept that there is a legitimate role for hospital security guards in the context of a patient exhibiting (or who is thought to be at risk of exhibiting) violent and/or unpredictable behaviour. In that situation, the security guard's role would be to protect other patients and staff, as well as potentially, the patient from themselves. However, security guards do not have the clinical training to enable them to continuously monitor patients in order to detect signs of clinical deterioration. That is to say, security guards do not have the skills or training to provide a de facto 1:1 special.[257]

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[248] Exhibit 1, Vol. 1, Tab 31, MHAS Inquiry into conditions at Kalgoorlie Hospital (Nov. 2018), paras 69-97
[249] See also: ts 19.02.22 (Lakshminarayanan), pp180-181 & 187
[250] Exhibit 1, Vol. 2, Tab 36, Statement - Dr K Lakshminarayanan (26.11.21), paras 143-167
[251] ts 19.02.22 (Lakshminarayanan), pp183-184
[252] Exhibit 1, Vol. 2, Tab 41, Statement - Nurse D Tunua (07.01.22), paras 139-147
[253] Exhibit 1, Vol. 2, Tab 43, Statement - Nurse E Cornelius (10.01.18), paras 18-21
[254] Exhibit 1, Vol. 2, Tab 44, Statement - Nurse K Burns (10.01.22), paras 36-38
[255] ts 18.01.22(Retimana-Te Whatu), p88
[256] Exhibit 1, Vol. 1, Tab 31, MHAS Inquiry into conditions at Kalgoorlie Hospital (Nov. 2018), para 65
[257] ts 19.01.22 (Truran), p127

167. I was alarmed at the widespread use of security guards to monitor mental health patients at KHC during the period of Mr Williams' admission. I therefore agree with the "*significant concern*" Dr Brett expressed about the practice[258] and I note that similar concerns had earlier been expressed in the MHAS report. It seems clear that the use of security guards to essentially "*special*" patients was indicative of a systemic issue, namely the chronic shortage of nursing staff on the MHU.[259]

168. In passing, I note that the MHAS report discovered that in 2018, two MHU staff were under the impression that security guards were not permitted to apprehend or restrain patients. MHAS raised this issue with the Goldfields Regional Director who indicated this was not the case and took immediate steps to arrange for a statement clarifying the situation to be sent to all staff at KHC.[260]

169. I also note with concern, that at one stage at KHC security guards tasked with monitoring patients were expected to record whether or not the patient allocated to them was "*agitated*" or not. Quite how a person with no clinical training was supposed to have been able to make such an assessment is unclear. Pleasingly, this practice was abandoned and the observation document is no longer used.[261]

170. According to Dr Lakshminarayanan, the situation at KHC with respect to 1:1 specials has changed. In her statement, Dr Lakshminarayanan stated:

> I have made enquiries and was informed that the current practice always uses nursing staff for specials or continues observation with the addition of security staff when patients present with risk to staff or other patients.

171. At the inquest, Dr Lakshminarayanan confirmed that in situations where a 1:1 nursing special is deemed necessary and a nurse is unavailable, a patient care assistant is allocated to the patient. A security guard is only be used when a patient care assistant is unavailable and only then to monitor the safety of the patient and others on the ward.[262]

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[258] Exhibit 1, Vol. 1, Tab 30, Report - Dr A Brett (17 May 21), p12, para 7 and ts 18.01.22 (Brett), pp10-11 & 29
[259] Exhibit 1, Vol. 1, Tab 31, MHAS Inquiry into conditions at Kalgoorlie Hospital (Nov. 2018), para 67
[260] Exhibit 1, Vol. 1, Tab 31, MHAS Inquiry into conditions at Kalgoorlie Hospital (Nov. 2018), para 68
[261] Exhibit 1, Vol. 2, Tab 36.16, Security Observation Report ((22.12.16)
[262] ts 19.01.22 (Lakshminarayanan), p183

Courtyard fence

172. In 2014, the Chief Psychiatrist requested the Courtyard fence be raised to 2.8 m and in 2015, 200 mm diameter plastic pipe was added to various sections of the fence to increase the height and reduce potential handholds. In 2018, the fence height was increased to 3.5 m (at its highest point), leverage points were removed, and anti-grip paint was applied. Despite these modifications, the wall height adjacent to the garden bed remained at 2.9 m.[263]

173. The Chief Psychiatrist visited KHC on 26 September 2018, and in a letter to WACHS dated 9 November 2018, referred to various issues which needed to be addressed. He said this about the Courtyard fence:

> The courtyard fence at the mental health unit is inadequate. Whilst I understand the concerns raised regarding Aboriginal needs space, this fence contributed directly to one of the two recent deaths and multiple historical abscondings. It remains easily scalable. It also provides no protection to individuals within the unit who may be the victims of domestic violence where those third parties might seek to enter the building.
>
> **It must be raised significantly, and steps taken to prevent access to the roof – there should be no "accessible points" at all in the perimeter of the courtyard. I would ask for this to be addressed as a matter of urgency.**[264] (Emphasis added)

174. Similar concerns about the safety of the Courtyard fencing were also being raised by the MCM, the company providing security services to KHC at the relevant time. The co-owner of MCM, Mr McNamara, says that about five-months before Mr Williams' death, he raised concerns that the Courtyard fencing was too low and was easily scalable by the average patient. He says he also raised the issue that the Courtyard fencing allowed easy access to the patio roof, from where patients could also abscond from the MHU.[265,266]

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[263] Exhibit 1, Vol. 1, Tab 20, Letter from Dr C McIver to Sgt L Housiaux (26.01.20)
[264] Exhibit 1, Vol. 1, Tab 32A, Letter from Chief Psychiatrist to WACHS (09.11.18)
[265] Exhibit 1, Vol. 2, Tab 48, Statement - Mr S McNamara (13.01.22), p2, para 24
[266] ts 19.01.22 (McNamara), pp158-159

175. In a letter to the Chief Psychiatrist dated 23 August 2019, the Acting Chief Executive of WACHS stated:

> The rear courtyard fence of the mental health inpatient unit (MHIU) has been increased in height, with a design (and costing) for a totally enclosed courtyard being considered with the expectation this will occur in the next few months.[267]

176. Notwithstanding this optimistic update from WACHS, during a visit to KHC to re-authorise the MHU in August 2021, the Chief Psychiatrist found the fence height on the right-hand side of the Courtyard was still too low and asked that it be raised within four-months.[268]

177. The KHC executive management team agreed to raise the height of Courtyard fencing to 4.27 m "*as per previous recommendations*" but were reportedly concerned that the requested timeframe was unrealistic. Although WACHS successfully secured funding for the required works in September 2021, as at the date of the inquest the necessary remediation work has still not been completed.[269,270]

178. In his statement, Mr Colin Crabtree (WACHS' Regional Manager, Infrastructure and Support Services) advised that the tendering process was scheduled for February 2022, however in a subsequent email he said:

> The work towards the new increased height to 4.3m for the perimeter fence is progressing really well and we are planning to go out to tender March/April 2022.[271]

179. I am deeply troubled by the fact that despite the recommendation of the Chief Psychiatrist in November 2018 and August 2021, work on upgrading the Courtyard fence will not even be going to tender until March or even April 2022.

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[267] Exhibit 1, Vol. 1, Tab 32D, Letter from A'Chief Executive, WACHS to Chief Psychiatrist (23.08.19)
[268] Exhibit 1, Vol. 2, Tab 47, Statement - Mr C Crabtree (12.01.22), paras 46-48
[269] Exhibit 1, Vol. 2, Tab 36, Statement - Dr K Lakshminarayanan (26.11.21), paras 216-217
[270] Exhibit 1, Vol. 2, Tab 47, Statement - Mr C Crabtree (12.01.22), paras 46-48
[271] Email to Ms P Femia from Mr C Crabtree (08.02.22)

180. I acknowledge that governmental procurement procedures must be followed. I also accept that there are technical difficulties with installing a fence of the required height given the cyclonic conditions Kalgoorlie is occasionally exposed to, and that there are difficulties with obtaining suitable tradespeople and materials, particularly in regional areas.

181. However, even given these difficulties, it is appalling that an obvious security vulnerability in the MHU has still not been addressed. The inordinate delay in completing this essential upgrade cannot possibly be justified. To be clear, it is my view that work on upgrading the Courtyard fence should be made an **absolute** priority. The continued failure to ensure this critical work is completed is totally unacceptable.

Retrospective entries

182. Accurate, timely entries in a patient's hospital record are a hallmark of good clinical practice. However, I accept that hospital wards are busy places and at times, patient care has to be prioritised over the documenting of that care.[272] When a clinician is unable to make a contemporaneous entry in the notes, the expectation must be that an entry is made as soon as possible thereafter. The entry must be clearly marked "*written in retrospect*" (or similar) and every effort should be made to capture the essence of the treatment or care provided.[273]

183. As noted, for a period of 11-hours on 24 August 2018, no contemporaneous entries were made in Mr Williams' hospital record. That vacuum was eventually filled by a series of retrospective entries, made by MHU nursing staff during the period 25 - 26 August 2018. In a perfect world, retrospective entries would be rare. Such entries are necessarily problematic precisely because they are written after the fact.

184. At the inquest I had great difficulty identifying the precise chain of events in the period immediately prior to Mr Williams' death because of the absence of entries written at the time. Retrospective entries following a patient's death are especially fraught.

[272] ts 18.01.22 (Brett), p23
[273] ts 18.01.22(Ngatama-Mathews), p78-79

185. As Dr Brett pointed out:

> Obviously, retrospective notes, as the coroner mentioned at the start of this hearing, are often made with hindsight, and so they're harder to give a lot more weight to because people's opinions will change following a serious incident like this.[274]

186. I accept that the explanation for the number of retrospective notes in this case is that at the relevant time the MHU was at capacity and nursing staff were having to work additional hours to cover staff absences. My only observation would be that wherever possible, retrospective entries should be avoided and that even during busy times, brief contemporaneous entries should always be preferred.[275]

Recruiting and retaining staff

187. Although not directly related to Mr Williams' death, I wish to make some brief comments about recruiting and retaining staff at KHC. Put simply, Kalgoorlie struggles to recruit staff because it does not have the natural attractions of centres like Albany and Broome. This fact was demonstrated by the difficulties KHC experienced in recruiting allied health professionals and its repeated efforts to recruit a clinical director for the MHU, which as noted, have finally been successful.

188. I agree with the following observation by Dr Lakshminarayanan:

> Kalgoorlie doesn't have the natural incentives. It doesn't have the other incentives…and this is a government policy. There is nothing we can do at a local level…so we need some policy change, which looks at this incentivisation. And it can't be just financial because I'm sure the other sectors…education, child care, housing - all that is difficult here. So all that would benefit from some level of incentivisation for Kalgoorlie. If we don't have that, in 10 years' time we will be still talking about how we are struggling with some positions.[276]

[274] ts 18.01.22 (Brett), pp15-16
[275] ts 19.01.22 (Burke), p217 and ts 19.01.22 (Femia), pp221-222
[276] ts 19.01.22 (Lakshminarayanan), pp196-197

189. I am aware that a great deal of effort has been put into encouraging doctors to move to, and practice in rural areas. A report in 2015 identified a number of positive factors influencing a doctor's decision to "*go rural*". Those factors included a previous connection to a rural area, a desire for a flexible, balanced lifestyle, opportunities to practise autonomy and an attractive remuneration package. Factors mitigating against rural practice included concerns about limited services, heavy workload, a harsh environment and issues around separation from family and friends.[277]

190. The issue is clearly a complex one and financial incentives, whilst important, are not the complete solution. In addition to salary incentives, subsidised housing, travel and vehicle allowances and sponsored traineeships are all important. Some of these incentives are already in place for particular categories of employment in Western Australia.

191. Although financial incentives are not the only important incentive, it is worth noting that the location allowance payable under a range of industrial Awards to workers in Kalgoorlie are a fraction of those paid to workers in other centres. For example, the weekly location allowance for workers in Kalgoorlie is $9.70, compared with $60.80 for those in Kununurra, $59 for workers in Marble Bar and $36.50 for those in Broome.[278,279]

192. An incentive package currently being trialled by the government in New South Wales (NSW) aims to recruit and retain allied health professionals in rural areas. The scheme provides a range of benefits including incremental annual contributions (of up to $20,000 over four years)[280] to assist employees with HECS-HELP debt.[281] Other benefits include additional annual and professional development leave and protected weekly clinical supervision.[282]

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277 See: www.ruralhealthwest.com.au/about-us/finding-my-place
278 2021 WAIRC 00167, General Order relating to location allowances
279 For example, the weekly location allowance at Kalgoorlie is$9.70 compared with $60.80 at Kununurra
280 1st year: $3000, 2nd year: $4,000, 3rd year: $6,000 and 4th year: $7,000
281 Higher Education Contribution Scheme / Higher Education Loan Program
282 See: www.health.nsw.gov.au/careers/imagine-rural/Pages/rural-incentives.aspx

193. The need to recruit and retain quality staff across a range of disciplines at KHC will become even more important as the population of the Goldfields region increases and when the new proposed purpose-built mental health facility is opened. The new mental health facility will require additional medical, nursing, and allied health professionals and I urge WACHS to redouble its recruiting efforts. I also suggest that WACHS gives consideration to whether the NSW scheme I referred to might be worth recommending to Government.

PURPOSE BUILT MENTAL HEALTH UNIT

194. The evidence before me overwhelmingly supports the need for a purpose-built mental health facility in Kalgoorlie. WACHS has made a submission to Government seeking a 12-bed in-patient facility to be constructed on the grounds of KHC.[283] Other parts of the State have benefitted from purpose-built mental health facilities (e.g.: Broome) and the proposed facility at KHC would replace the current MHU which, in my view, is no longer fit for purpose.[284,285,286,287,288]

195. The aim of the purpose-built facility is to provide a quality mental health service to the Goldfields region in a modern world-class facility. Nevertheless, the proposal comes with challenges. First, there is the timeframe. The evidence before me is that it may take five to seven years before the facility is able to receive patients. This is clearly unacceptable. The need for the facility has been obvious for years, and every effort should be made to fast-track the approval process to ensure that facility is available as soon as possible.[289]

196. Another challenge is the one I have already referred to, namely the need to ensure that the facility is fully staffed with medical, nursing and allied health professionals. Whilst an enormous amount of effort will rightly be put into ensuring the facility is world-class, an equal amount of effort must be put into recruiting (and retaining) quality health professionals.

[283] Exhibit 1, Vol. 2, Tab 47, Statement - Mr C Crabtree (12.01.22), paras 61-
[284] Exhibit 1, Vol. 2, Tab 38, KVL1 - Service review of the MHU (Oct 2018), pp4 & 20-21
[285] Exhibit 1, Vol. 2, Tab 38, Statement - Dr K Lakshminarayanan (21.12.21), paras 7-11
[286] ts 19.02.22 (Lakshminarayanan), pp184-185
[287] ts 18.01.22(Ngatama-Mathews), p80 and ts 18.01.22 (Retimana Te Whatu), pp94-95
[288] ts 18.01.22 (Brett), p22
[289] ts 19.01.22 (Lakshminarayanan), p196

197. It will also be necessary to manage bed pressure when the new facility is opened. The MHAS Report refers to modelling suggesting that by 2025, KHC will require 25 mental health in-patient beds.[290] Even if this modelling is only partially accurate, it appears that the proposed 12-bed facility will be insufficient. Dr Lakshminarayanan conceded that the proposal for the purpose-built facility was not "*future proofed*" and that mental health units across the State will be under pressure because of an ever-increasing need.[291]

QUALITY OF SUPERVISION, TREATMENT AND CARE

Treatment and care

198. Having carefully assessed the available evidence, I am satisfied that the treatment and care provided to Mr Williams' during his admission was appropriate. Mr Williams' admission coincided with a period of unprecedented pressure on beds at KHC, including the MHU. The bed pressure at KHC was further exacerbated by the fact that hospitals around Western Australia were similarly full. In those circumstances, it is my view that MHU staff did a commendable job caring for their allocated patients, including Mr Williams.

199. Whilst at KHC, Mr Williams was appropriately medicated and was promptly assessed on a number of occasions when his mental health deteriorated. When it became clear that the risk to himself had significantly increased, he was appropriately made an involuntary patient under the MHA. In my view, this was the least restrictive form of care possible in the circumstances.[292,293]

Supervision

200. Although the treatment and care provided to Mr Williams at KHC was appropriate, the standard of supervision he received was clearly and demonstrably sub-optimal. Mr Williams should have been allocated a 1:1 special by a psychiatric nurse at the time he was made an involuntary patient, namely at 3.15 pm on 23 August 2018.

[290] Exhibit 1, Vol. 1, Tab 31, MHAS Inquiry into conditions at Kalgoorlie Hospital (Nov. 2018), p 23
[291] ts 19.01.22 (Lakshminarayanan), pp184-185 & 198-199
[292] ts 18.01.22 (Brett), pp14-15
[293] ts 19.01.22 (Lakshminarayanan), p191

201. Further, after Mr Williams had successfully scaled the Courtyard fence and absconded from the MHU at about 6.00 pm on 24 August 2018, it is absolutely astonishing that he was allowed back into the Courtyard again, particularly given his earlier unsuccessful attempt to abscond in this way.

202. Allowing Mr Williams into the Courtyard under any circumstances after he had demonstrated he was capable of scaling the rear fence of the Courtyard was a serious error of judgment. The fact that MHU staff were not told that Mr Williams was found near railway tracks after absconding is irrelevant. MHU staff were clearly aware he had successfully absconded from the MHU. That should have been enough.

203. After he had absconded and been returned, Mr Williams said he wanted to go into the Courtyard to retrieve cigarettes from other patients. This trivial request could easily have been accommodated by the security guard or a nurse. The ease with which Mr Williams had earlier absconded from the Courtyard (despite the presence of a security guard and a nurse) should have placed staff on high alert, especially as given Mr Williams' documented unpredictability and his previous unsuccessful attempt to abscond through the MHU front doors and via the Courtyard.

204. Hindsight was not required to see that for the rest of the evening on 24 August 2018, the doors to the Courtyard should have been locked (as they had been on recent previous occasions) and Mr Williams should have been confined to his room. It beggars belief that these simple precautions were not taken after Mr Williams' first successful departure from the MHU.[294,295]

205. It is cold comfort that had these basic restrictions been in place, it is very unlikely that Mr Williams would have been able to abscond from the MHU for a second time. It is also the case that had the Courtyard fence height been at an appropriate height, it is unlikely that Mr Williams would have been able to abscond from the MHU in the first place.[296]

[294] See also: ts 18.01.22 (Brett), pp18-19
[295] See also: ts 19.01.22 (Paradza), pp119-120
[296] See also: ts 19.01.22 (Lakshminarayanan), p192

RECOMMENDATIONS

206. In view of the observations I have made in this finding, I make the following recommendations:

Recommendation 1
The Western Australian Country Health Service (WACHS) should take **immediate** steps to ensure that the remediation works needed to raise the height of the boundary fencing of the courtyard attached to mental health unit at the Kalgoorlie Health Campus are **urgently** completed. This remediation work should be made an **absolute** priority by WACHS.

Recommendation 2
The Western Australian Country Health Service should approach the lessee of the railway line at the rear of the Kalgoorlie Health Campus (KHC) and advise that the chain link fence running along that railway line needs urgent inspection with a view to upgrading the fence (as soon as reasonably practicable) so that it properly restricts access to the railway tracks in the vicinity of KHC.

Recommendation 3
The Western Australian Country Health Service (WACHS) should urge the Department of Finance to fast-track the WACHS proposal to construct a purpose-built mental health facility at the Kalgoorlie Health Campus so that construction of the facility can start as soon as possible. WACHS should also undertake detailed planning to ensure that when opened, the new facility is appropriately staffed by mental health and allied health professionals.

Comments relating to recommendations

207. In accordance with my usual practice, a draft of these recommendations was forwarded to counsel for parties appearing at the inquest by Ms Tyler, on 10 February 2022.[297] On 18 February 2022, responses were received from Ms Femia and Mr Scott Denman (counsel for Dr Hope).

208. Mr Denman advised that Dr Hope supported the draft recommendations and had nothing to add. Ms Femia advised that WACHS had no comments to make on draft recommendation 1 and she provided helpful comments about draft recommendation 2. Ms Femia also advised that WACHS supported draft recommendation 3.[298,299]

CONCLUSION

209. Mr Williams was a dearly loved family member who was only 20-years old when he died after being struck by a rain at the rear of KHC on 24 August 2018. The fact that he was able to abscond from the MHU on two occasions after previously making an unsuccessful attempt to do so, demonstrates that all relevant times, the supervision Mr Williams received was woefully inadequate. It is also the case that fencing in the Courtyard attached to the MHU is too low and this issue has still not been rectified.

210. Mr Williams' death highlights systemic issues faced by clinicians tasked with delivering mental health services in regional areas of Western Australia, including staff shortages and the standard of mental health facilities. It is patently obvious that the current mental health inpatient facilities at KHC are not fit for purpose. As I have explained, the evidence before me is overwhelmingly in support of a purpose-built mental health facility and it is my sincere hope that the Government will urgently fund this desperately needed resource.

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[297] Email - Ms S Tyler to counsel for parties appearing at the inquest (10.02.22)
[298] Email - Ms P Femia to Ms S Tyler (18.02.22)
[299] Email - Mr S Denman to Ms S Tyler (18.02.22)

211. However, I am well aware that bricks and mortar facilities are only one aspect of providing a quality mental health service. Of equal, if not greater importance, is the imperative to recruit, and importantly, retain experienced mental health and allied health professionals. I can only hope that once the purpose-built facility at KHC has been approved, serious planning will be undertaken to ensure that a pool of suitable staff is available. The people of the Goldfields deserve nothing less.

212. I feel sure that the family and friends of Mr Williams appreciated the heart-felt expressions of condolence from staff involved in Mr Williams' care, as well as the condolences conveyed on behalf of WACHS by Dr Lakshminarayanan. However, as I said at the inquest, those condolences will ring hollow unless urgent action is taken to address the current state of mental health facilities at KHC.

MAG Jenkin
Coroner
25 February 2022