JURISDICTION	**:**	CORONER'S COURT OF WESTERN AUSTRALIA
CORONER	**:**	MICHAEL ANDREW GLIDDON JENKIN, CORONER
HEARD	**:**	17 SEPTEMBER 2024
DELIVERED	**:**	22 OCTOBER 2024
FILE NO/S	**:**	CORC 3411 of 2022
DECEASED	**:**	TURNER, KARL JOHNATHAN

Catchwords:

Nil

Legislation:

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

Counsel Appearing:

Mr W. Stops appeared to assist the coroner.

Ms H. Richardson (State Solicitor's Office) appeared for the North Metropolitan Health Service.

Ms D. Oosthuizen (Belinda Burke Legal) appeared for Mr P. MacPherson.

Coroners Act 1996
(Section 26(1))

RECORD OF INVESTIGATION INTO DEATH

I, Michael Andrew Gliddon Jenkin, Coroner, having investigated the death of ***Karl Johnathan TURNER*** *with an inquest held at Perth Coroners Court, Central Law Courts, Court 85, 501 Hay Street, Perth, on 17 September 2024, find that the identity of the deceased person was* ***Karl Johnathan TURNER*** *and that death occurred on 6 December 2022 at 227 Hector Street, Tuart Hill, from combined drug toxicity in the following circumstances:*

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INTRODUCTION

1. Karl Johnathan Turner (Karl)[1] died on 6 December 2022 in Tuart Hill, from combined drug toxicity. He was 49 years of age.[2,3,4,5,6,7,8] At the time of his death, Karl was the subject of a community treatment order (CTO)[9] made under the *Mental Health Act 2014* (WA) (the MHA).[10] This made Karl an "*involuntary patient*", and thereby a "*person held in care*" and his death was therefore a "*reportable death*".[11]

2. In such circumstances, a coronial inquest is mandatory and where, as here, the death is of a person held in care, I am required to comment on the quality of the supervision, treatment and care the person received while in that care.[12]

3. I held an inquest into Karl's death on 17 September 2024 which was attended by his mother and stepfather. The inquest focused on the supervision, treatment and care that Karl received while he was the subject of a CTO, and the circumstances of his death. The Brief of evidence tendered at the inquest consisted of one volume, and included reports of investigations into Karl's death by the police, and a clinical panel (SAC1), as well as some of Karl's medical records.

4. Mr Peter MacPherson and Dr Ajay Velayudhan gave evidence at the inquest. At the relevant time, Mr MacPherson was a mental health nurse with the Intensive Clinical Outreach Team based at Osborne Clinic (ICOT), and he was Karl's case manager. Dr Velayudhan is a consultant psychiatrist, and he is the Medical Co-Director, Adult Community Mental Health Service at the North Metropolitan Health Service. Although Dr Velayudhan was not involved in Karl's care, he reviewed the SAC1 investigation conducted after Karl's death.[13]

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[1] At the request of his family, the deceased was referred to as "Karl" at the inquest, and in this finding
[2] Exhibit 1, Vol. 1, Tab 1, P100 - Report of Death (06.12.22)
[3] Exhibit 1, Vol. 1, Tab 2, Life Extinct Form (06.12.22)
[4] Exhibit 1, Vol. 1, Tab 3, P92 - Identification of Deceased by Visual Means (06.12.22)
[5] Exhibit 1, Vol. 1, Tab 4, P98 - Mortuary Admission Form (06.12.22)
[6] Exhibit 1, Vol. 1, Tab 5, Post Mortem Report (12.12.22)
[7] Exhibit 1, Vol. 1, Tab 5.1, Supplementary Post Mortem Report (17.08.23)
[8] Exhibit 1, Vol. 1, Tab 5.2, Toxicology Report (09.08.23)
[9] An order made under the MHA whereby a person receives treatment in the community on an involuntary basis
[10] Exhibit 1, Vol. 1, Tab 15, NMHS Medical Records (L5267195)
[11] Section 3, *Coroners Act 1996* (WA)
[12] Sections 3, 22(1)(a) & 25(3), *Coroners Act 1996* (WA)
[13] ts 17.09.24 (Velayudhan), pp27-28

KARL

Background[14,15]

5. Karl was born in South Perth on 14 March 1973, and he had two siblings. At the inquest, Karl's mother (Mrs Roslyn McCreadie) delivered a very moving tribute to her beloved son, and she outlined the support that she and her husband had provided Karl. Mrs McCreadie also told the Court that:

> Karl was sensitive and caring to those worse off. I saw him regularly donate and pledge money to many causes, and later, on many occasions, he took in homeless people. This caused some dreadful results, including being physically assaulted. He tried again with other people, but things didn't improve, and he was often taken advantage of.[16]

6. Karl was described as being "*highly adept at carpentry, brick work, and general tradesmanship*", and for about 10 years he was employed in the Merchant Navy as "*an integrated rating*". For reasons I will explain, Karl's employment with the shipping company was terminated in 2019 and he made concerted efforts to return to the shipping industry.

7. In 2022, Karl began studying for a Bachelor of Nursing at the Mandurah campus of Murdoch University. However, Karl found the course workload and the extended travelling times too demanding, and he subsequently deferred his studies.[17]

8. At the time of his death, Karl was in receipt of the Disability Support Pension, and he was living in Tuart Hill. In the period before his death, Karl's financial affairs were managed by the Public Trustee, and a guardian was appointed. At the inquest, Mrs McCreadie explained that she had been required to intervene on occasions when Karl had been unable to get in contact with his guardian so that funds could be released to enable Karl to buy food.[18]

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[14] Exhibit 1, Vol. 1, Tab 14, SAC1 Investigation Report (05.05.23), pp3-5
[15] ts 17.09.24 (McCreadie), pp36-39
[16] ts 17.09.24 (McCreadie), pp37-38 and see also: ts 17.09.24 (MacPherson), pp12-13
[17] Exhibit 1, Vol. 1, Tab 20, Discharge Summary - Graylands Hospital (29.06.22), p2
[18] ts 17.09.24 (McCreadie), pp38-39

9. To help cover his mortgage expenses, Karl took in lodgers, who stayed for various periods of time, while Karl lived in the garage which he had converted into a bedroom. Karl's treating clinicians say that Karl disclosed that his lodgers (many of whom appeared to have polysubstance use issues) "*did not pay rent, stole property, and caused damage to* (Karl's) *house*".[19]

Medical history[20,21,22]

10. Karl's medical history included schizoaffective disorder, depression, cellulitis, drug-induced psychosis, and chronic lower back pain. Karl was also diagnosed with Attention Deficit Hyperactivity Disorder in 2003, and was under the care of a private psychiatrist. Karl was treated with atomoxetine, dexamphetamine, and lisdexamfetamine, for over 10 years, until his private psychiatrist retired.[23]

11. After Karl had purchased a home in Tuart Hill in 2017, he complained to his GP that "*drug dealers*" had moved in next door, and that he had been subjected to threats, bullying, assaults, and home invasions. Karl told his GP that in order to cope with his distress, he had started using methylamphetamine.

12. It appears that Karl's methylamphetamine use led to an acute psychotic episode and on 9 May 2017, he was admitted to Graylands Hospital (Graylands) for two weeks. He was diagnosed with schizophreniform psychosis and treated with olanzapine and sodium valproate. During his admission to Graylands, Karl's symptoms settled, and he was discharged home.

13. In early April 2018, Karl experienced an apparent psychotic episode whilst working on a vessel in Darwin. He was admitted to Darwin Hospital on an involuntary basis, and was diagnosed with a psychotic episode with manic features. He was discharged home on 24 April 2018.

[19] Exhibit 1, Vol. 1, Tab 14, SAC1 Investigation Report (05.05.23), pp4-5 and ts 17.09.24 (MacPherson), pp12-13
[20] Exhibit 1, Vol. 1, Tab 18.2, Letter - Dr S Osborne (02.02.22)
[21] Exhibit 1, Vol. 1, Tab 19, Letter - Dr C Carter (05.09.17)
[22] Exhibit 1, Vol. 1, Tab 20, Discharge Summary - Graylands Hospital (29.06.22)
[23] Exhibit 1, Vol. 1, Tab 15, Client Management Plan (14.11.22)

14. On 25 May 2018, Karl's employer gave him an opportunity to "*explain his behaviour*", but Karl's recollection of events was described as poor, and he "*presented as mentally unwell*".[24,25] Karl made various unsuccessful applications for worker's compensation in relation to this illness, and he was given notice of his termination in October 2019.[26,27]

15. The evidence before me establishes that the management of Karl's mental health was exacerbated by his persistent polysubstance use, and when his mental health deteriorated, he was admitted to psychiatric hospitals. In addition to his admissions to Graylands in 2017, and Darwin Hospital in 2018, Karl was also admitted to Graylands on several occasions between 2019 and 2022 as an involuntary patient, and to Bentley Hospital as an involuntary patient in 2021.

Last admission at Graylands[28]

16. Karl's last admission to Graylands occurred on 19 June 2022. He was admitted on an involuntary basis after concerns had been raised about his mental state by his family and a housemate. Karl had reportedly been "*walking in the middle of the road with a handwritten letter, talking and laughing to himself*", with cars having to avoid him.

17. During his admission, Karl was diagnosed with schizoaffective disorder, and substance use (i.e.: methylamphetamine and cannabis). Karl initially refused his depot injection of paliperidone, and requested a second opinion. A second opinion was obtained and it was recommended that Karl continue to receive his depot injections of paliperidone.

18. During his admission, Karl's mental state improved and he was placed on a CTO and discharged home on 29 June 2022. Karl's next depot injection was due on 27 July 2022, and follow up care was arranged with the Osborne Community Mental Health Service (the Service). Karl was told an appointment had been made for him at the Service at 11.30 am on 11 July 2022, and that he should contact his GP within two weeks.[29]

[24] Exhibit 1, Vol. 1, Tab 21, Email - Ms S Osten (10.04.18)
[25] Exhibit 1, Vol. 1, Tab 22, Letter - Ms M Parker-Doney (13.06.18)
[26] Exhibit 1, Vol. 1, Tab 16, Letter - Ms S Osten (29.10.19)
[27] Exhibit 1, Vol. 1, Tab 18.4, Statement setting out the findings of material questions of fact (19.05.22)
[28] Exhibit 1, Vol. 1, Tab 15, Graylands Hospital Discharge Summary (29.06.22)
[29] Exhibit 1, Vol. 1, Tab 15, Graylands Hospital Discharge Summary (29.06.22), p4

Community treatment order[30,31,32]

19. The MHA provides that a person is not to be placed on a CTO unless: "*[T]he person cannot be adequately provided with treatment in a way that would involve less restriction on the person's freedom of choice and movement than making a community treatment order*".[33]

20. A CTO was required in Karl's case because he was non-compliant with his medication regime, and lacked insight into his mental illness. In addition to disputing his diagnosis and his need for treatment, Karl also expressed a mistrust of mental health services, and he regularly failed to attend scheduled appointments.[34]

21. Placing Karl on a CTO meant that he could be regularly monitored, and if he declined his depot medication he could be required to attend an authorised place for an assessment by a psychiatrist. If necessary, his CTO could also be revoked and he could be admitted to an authorised hospital on an involuntary basis.[35]

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

Management by the Service[36,37,38]

23. Prior to his discharge from Graylands on 29 June 2022, Karl was placed on a CTO, and was thereafter managed by the Service. At the time of his discharge, Karl's medication regime included the antidepressant, fluoxetine (which was subsequently ceased), and monthly depot injections of paliperidone. At the inquest, Dr Velayudhan confirmed that Karl was receiving an appropriate dose of this medication.[39]

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[30] Exhibit 1, Vol. 1, Tab 15, Continuation of Community Treatment Order (21.09.22)
[31] Exhibit 1, Vol. 1, Tab 15, Graylands Hospital Discharge Summary (29.06.22)
[32] Exhibit 1, Vol. 1, Tab 24, Statement - Mr P MacPherson (16.09.24), para 14
[33] s25(2)(e), *Mental Health Act 2014* (WA)
[34] Exhibit 1, Vol. 1, Tab 14, SAC1 - Investigation Report (05.05.23), p4 and see: ts 17.09.24 (MacPherson), p21
[35] See: Division 4, Part 8, *Mental Health Act 2014* (WA)
[36] Exhibit 1, Vol. 1, Tab 14, SAC1 - Investigation Report (05.05.23), pp3-12
[37] Exhibit 1, Vol. 1, Tab 24, Statement - Mr P MacPherson (16.09.24)
[38] Exhibit 1, Vol. 1, Tab 15, NMHS Medical Records (L5267195)
[39] ts 17.09.24 (Velayudhan), p28

24. Staff from the Service had regular contact with Karl and his family, and he was provided with support in relation to access to food, and with medical and other appointments. Home visits were also conducted, sometimes with support from police due to safety concerns related to the lodgers living at Karl's home from time to time. Karl was also regularly reviewed by his treating psychiatrist, and his interactions with clinical staff were described as frequently aggressive and hostile.[40]

25. Karl continued to receive his monthly depot injections of paliperidone, and home visits were often required when Karl did not attend scheduled appointments at the Service. Karl continued to deny he had a psychotic illness and he was unhappy about being obliged to receive monthly depot injections. I note that it was reported that on occasions Karl expressed suicidal ideation in relation to this requirement, but this does not appear to have been an ongoing concern.

26. Multiple tenants were noted at Karl's home, and during home visits clinicians noted drug paraphernalia, including syringes lying about the premises. Despite encouragement, Karl declined to comply with requests to undergo urine drug screening, and he regularly denied using illicit drugs, despite evidence to the contrary including the presence of injection sites (track marks) on his arms.[41]

Management by ICOT[42,43,44]

27. On 14 September 2022, Karl's care was transferred to the Intensive Clinical Outreach Team at Osborne Clinic (ICOT), a service which: "*works with people with persistent and enduring mental illness and comorbidity who have often been excluded from mainstream mental health services because of aggression or antisocial behaviours*".[45] In his statement, Mr MacPherson noted that ICOT clients commonly have physical comorbidities, housing issues, financial adversity, substance misuse, and interpersonal difficulties resulting in social isolation.[46]

[40] See also: ts 17.09.24 (MacPherson), p15
[41] See also: ts 17.09.24 (MacPherson), pp13-14
[42] Exhibit 1, Vol. 1, Tab 14, SAC1 - Investigation Report (05.05.23), pp3-12
[43] Exhibit 1, Vol. 1, Tab 24, Statement - Mr P MacPherson (16.09.24) and ts 17.09.24 (MacPherson), pp10-26
[44] Exhibit 1, Vol. 1, Tab 15, NMHS Medical Records (L5267195)
[45] See: www.nmhs.health.wa.gov.au/Hospitals-and-Services/Mental-Health/Community/Clinics
[46] Exhibit 1, Vol. 1, Tab 24, Statement - Mr P MacPherson (16.09.24), para 12

28. Mr MacPherson also confirmed that caseloads in ICOT teams are lower, and that this means that clinicians are able to visit clients at least weekly, if not more frequently as may be required. At the time he was Karl's case manager, Mr MacPherson had a caseload of nine clients, compared with his caseload of about 30 clients when he had previously worked for the Service.[47]

29. Mr MacPherson said that Karl met the criteria for management by ICOT because he was the subject of a CTO, and was also under a guardianship and administration order. In addition, Karl had "*frequent hospital admissions, ongoing substance use, financial adversity, and his life was in utter chaos*". The rationale for the ICOT referral was that more intensive care support "*might meet Karl's multiple unmet needs and improve his quality of life*".[48]

30. Mr MacPherson explained that as Karl's case manager, he dealt with various aspects of Karl's care. This included conducting home visits and mental health and risk assessments, administering monthly depot injections, arranging medical appointments, taking Karl to appointments (including the foodbank), and attending psychiatric reviews and reviews in the Mental Health Tribunal. Mr MacPherson also said that he would liaise with various services on Karl's behalf (including Karl's guardian), and he also responded to concerns raised with him by Mrs McCreadie.

31. It is clear that Karl was a very private person, and as mentioned he lacked insight into his mental illness and his need for treatment. He was therefore very guarded with mental health professionals (including Mr MacPherson) and "*highly suspicious*" of mental health services generally. Mr MacPherson noted that Karl consistently disputed that he had a psychotic illness, and instead:

> Karl…maintained that his adversities in life were due to his untreated attention-deficit/hyperactivity disorder (ADHD). Karl did not appear to have insight into his mental illness, which created a significant barrier to therapeutic engagement, treatment, and recovery.[49]

[47] Exhibit 1, Vol. 1, Tab 24, Statement - Mr P MacPherson (16.09.24), para 12 and ts 17.09.24 (MacPherson), pp10-11
[48] Exhibit 1, Vol. 1, Tab 24, Statement - Mr P MacPherson (16.09.24), paras 14-15
[49] Exhibit 1, Vol. 1, Tab 24, Statement - Mr P MacPherson (16.09.24), para 23

32. Mr MacPherson also observed that Karl's mental state was adversely affected by his "*apparent ongoing use*" of methylamphetamine, which Karl said he used to "*counteract the lethargy he experienced*". In addition to wanting to return to sea, Karl was also fixated on being prescribed dexamphetamine to address his ADHD, but this was contraindicated because of the medications he was taking for his mental illness. Nevertheless, Karl was prescribed atomoxetine, a non-stimulant medication which is used successfully in children and adults.[50,51]

33. Mr MacPherson last saw Karl on 24 November 2022, and in his statement he makes the following observations about that home visit:

> My last contact with Karl was on 24 November 2022 (not 29 November 2022 as stated in the SAC 1 report). I administered his anti-psychotic depot injection without issue and conveyed him to Warwick Dentist for treatment of an ongoing toothache. He presented as unkempt and dishevelled and in discomfort from his toothache, evidenced by his grimacing face.
>
> **At the time of my contact and assessment of Karl, I noted nil acute risk to him and others**. I documented the fact that he had evidence of track marks on his right inner elbow suggestive of illicit drug use, however he denied any substance misuse. Karl was aware he could contact the clinic if he required further support. My plan was to continue case management and contact him the following week.[52,53] [Emphasis added]

[50] ts 17.09.24 (MacPherson), p13 and ts 17.09.24 (Velayudhan), pp31-32
[51] See: www.drugs.com/drug-interactions/atomoxetine-with-invega-sustenna-275-0-1781-13969.html
[52] Exhibit 1, Vol. 1, Tab 24, Statement - Mr P MacPherson (16.09.24), para 27
[53] See also: ts 17.09.24 (MacPherson), pp15-18

EVENTS LEADING TO KARL'S DEATH[54,55,56]

34. At about 3.30 pm on 6 December 2022, one of Karl's friends visited his home and found Karl lying on the garage floor. As the friend had seen Karl do this before, he was not unduly concerned, and assumed that Karl had merely "*passed out*". The friend was aware that Karl used illicit drugs but did not see any "*needles*" near his body.[57]

35. When the friend shook Karl and asked if he was awake, there was no response. The friend then went to one of the bedrooms in Karl's home and asked a male who was living there at the time to call an ambulance. The male tenant said he would do so, and added (in relation to Karl) "*He'll be alright*". After speaking with the male tenant, the friend left Karl's home.[58]

36. At about 6.40 pm, detectives from the Regional Investigations Unit arrived at Karl's home to investigate "*a high-risk electronic monitoring breach*" relating to someone who was thought to be at Karl's home. During their search of the property, the detectives found Karl lying, unresponsive, on his garage floor. The officers requested an ambulance before starting CPR.[59,60,61]

37. Ambulance officers arrived a short time later and took over resuscitation efforts, but Karl could not be revived. He was declared deceased at 6.57 pm on 6 December 2022.[62,63]

[54] Exhibit 1, Vol. 1, Tab 7, Report - Coronial Investigator D Jackson (06.09.23)
[55] Exhibit 1, Vol. 1, Tab 9, Incident Report 061222 1840 16123 (06.12.22)
[56] Exhibit 1, Vol. 1, Tab 10, Running Sheet - Incident Report 061222 1840 16123 (06.12.22)
[57] Exhibit 1, Vol. 1, Tab 12, Statement - Mr D Black (06.12.22), paras 21-32
[58] Exhibit 1, Vol. 1, Tab 12, Statement - Mr D Black (06.12.22), paras 33-39
[59] Exhibit 1, Vol. 1, Tab 13, Mr M Vitnell (06.12.22), paras 35-40
[60] Exhibit 1, Vol. 1, Tab 7, Report - Coronial Investigator D Jackson (06.09.23), p1
[61] Exhibit 1, Vol. 1, Tab 8, Memo - Det. FC Const. M Smith (07.12.22)
[62] Exhibit 1, Vol. 1, Tabs 6.1 & 6.2, SJA Patient Care Records OPK24D2 & OPK44DD (06.12.22)
[63] Exhibit 1, Vol. 1, Tab 2, Life Extinct Form (06.12.22)

CAUSE AND MANNER OF DEATH

38. A forensic pathologist (Dr Joe Ong) conducted a post mortem examination of Karl's body on 12 December 2022. Dr Ong noted an apparent puncture mark to Karl's right elbow crease, and evidence of recent resuscitation attempts.[64]

39. Karl's heart was enlarged, and there was thickening and narrowing of the vessels supplying the heart muscle (coronary artery atherosclerosis). Karl's lungs were found to be congested, but this is regarded as a non-specific finding.[65]

40. Microscopic examination of tissues confirmed coronary artery atherosclerosis, but was "*otherwise non-contributory*". There was no significant viral infection in the heart or lungs, and microbiological testing of Karl's lungs did not identify a specific bacterial microorganism.[66]

41. Toxicological analysis detected morphine in Karl's system at levels within the known fatal range, along with codeine (a common impurity in heroin) and monoacetylmorphine, confirming recent use of heroin. Pregabalin was also detected, along with atomoxetine, and a metabolite of paliperidone. The analysis also found methylamphetamine, and tetrahydrocannabinol indicating recent use of cannabis. Alcohol was not detected.[67,68]

42. Dr Ong noted that many of the substances found in Karl's system have sedative properties and can have an enhanced effect when taken in combination. Dr Ong said this can result in "*increased sedation, with a risk of loss of consciousness, coma and even death, particularly in the presence of morphine*", and that pregabalin may lower the threshold at which a person succumbs to fatal opiate/opioid toxicity.[69]

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[64] Exhibit 1, Vol. 1, Tab 5.1, Supplementary Post Mortem Report (17.08.23), p1
[65] Exhibit 1, Vol. 1, Tab 5.1, Supplementary Post Mortem Report (17.08.23), p1
[66] Exhibit 1, Vol. 1, Tab 5.1, Supplementary Post Mortem Report (17.08.23), p1
[67] Exhibit 1, Vol. 1, Tab 5.1, Supplementary Post Mortem Report (17.08.23), pp1-2
[68] Exhibit 1, Vol. 1, Tab 5.2, Toxicology Report (09.08.23)
[69] Exhibit 1, Vol. 1, Tab 5.1, Supplementary Post Mortem Report (17.08.23), p2

43. At the conclusion of the post mortem examination, Dr Ong expressed the opinion that the cause of Karl's death was combined drug toxicity.[70]

44. I respectfully accept and adopt Dr Ong's conclusion as my finding in relation to the cause of Karl's death.

45. Further, on the basis that there is no evidence that Karl consumed heroin, methylamphetamine, and various medications with the intention of taking his life, I find his death occurred by way of accident.

46. For the sake of completeness, I note that one of the patient care records of an ambulance team that attended Karl's home mentions that syringes were seen near Karl's body. Given that Karl's friend says he did not see any syringes near Karl at about 3.30 pm, it seems reasonable to conclude that Karl injected himself with heroin sometime after 3.30 pm and before 6.40 pm, when he was found by police.[71,72,73]

[70] Exhibit 1, Vol. 1, Tab 5.1, Supplementary Post Mortem Report (17.08.23), pp1-2
[71] Exhibit 1, Vol. 1, Tabs 6.1 & 6.2, SJA Patient Care Records OPK24D2 & OPK44DD (06.12.22)
[72] Exhibit 1, Vol. 1, Tab 12, Statement - Mr D Black (06.12.22), paras 21-32
[73] Exhibit 1, Vol. 1, Tab 7, Report - Coronial Investigator D Jackson (06.09.23)

INDEPENDENT ASSESSMENT OF KARL'S CARE

Overview[74]

47. Following Karl's death, an independent panel (the Panel) conducted a clinical investigation of his care and treatment and published their findings in a document entitled SAC 1 Investigation Report (SAC1) on 5 May 2023. The purpose of the SAC1 was to identify the root cause of Karl's death and to identify any gaps in service delivery.

SAC1 Findings[75]

48. The SAC1 set out the background to Karl's care, and noted that his first contact with public mental health services occurred in 2017. The Panel also noted that between 2017 and his death, Karl had six inpatient admissions as an involuntary patient, but that he had mostly been managed in the community on a series of CTOs.

49. The Panel noted that after Karl's care was transferred to ICOT, he received seven psychiatric reviews. Five of these reviews were conducted by the same psychiatrist, but the first two were dealt with by separate clinicians, meaning that Karl was reviewed by three separate psychiatrists between 14 September 2022 and his death.

50. Continuity of care is clearly an important aspect of providing quality mental health care to consumers, and Karl was frustrated about seeing several psychiatrists. Dr Velayudhan acknowledged that this is an issue that mental health services are required to constantly address.[76]

51. From other inquests I have presided over, I am aware that the availability of suitably qualified mental health nurses, psychiatrists and allied health professionals is an issue throughout Western Australia. Dr Velayudhan advised that as a result of engaging with a recruiting agency, he is expecting several psychiatrists to start soon, including one who will offer greater stability to the ICOT team.[77]

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[74] Exhibit 1, Vol. 1, Tab 14, SAC1 Investigation Report (05.05.23)
[75] Exhibit 1, Vol. 1, Tab 14, SAC1 Investigation Report (05.05.23)
[76] ts 17.09.24 (MacPherson), p20 and ts 17.09.24 (Velayudhan), pp32-33
[77] ts 17.09.24 (Velayudhan), pp32-33

52. The Panel noted that the ICOT case manager had been working to build rapport with Karl. At the inquest Mr MacPherson confirmed that part of the care he was providing to Karl included regular home visits, and that he had also been taking Karl to medical appointments and to a food bank to obtain hampers. These activities provided opportunities to engage with Karl away from his home, where as Mr MacPherson confirmed, Karl's lodgers often made the environment unsafe.[78]

53. The Panel noted that in the last six months of his life, Karl was the subject of seven risk assessment and management plans, during which his mental state and risk of self-harm was reviewed. At the inquest, Mr MacPherson said that although Karl had occasionally expressed suicidal ideation, this was in the context of him not wishing to have his monthly depot injections, and was not considered to be an ongoing concern.[79] I agree with the Panel's assessment that "*risk assessment and management in relation to* (Karl's) *mental health was appropriate*".[80]

54. The Panel noted that at the time of his death, Karl was prescribed atomoxetine (for ADHD), and monthly depot injections of paliperidone (for his schizoaffective disorder). In the client management plan dated 14 November 2022 which Mr MacPherson drafted for Karl, "*Action 3*" states that Karl would be the subject of "*ongoing metabolic management of physical health*", as well as "*engagement with GP*" and "*discussion and encouragement re weight loss programmes, diet and exercise*".[81]

55. Although Mr MacPherson referred to a blood pressure check Karl had undergone several weeks before his death,[82] the uncontested evidence before me is that Karl was not the subject of any ongoing monitoring of his pulse rate, blood pressure or respiration rate, and he was not the subject of regular electrocardiograms. The reason this was potentially important was to monitor for (and detect) any side effects related to the medications Karl was prescribed, as well as any adverse interactions between those medications.[83]

[78] ts 17.09.24 (MacPherson), pp12-13
[79] ts 17.09.24 (MacPherson), pp17-18
[80] Exhibit 1, Vol. 1, Tab 14, SAC1 Investigation Report (05.05.23)
[81] Exhibit 1, Vol. 1, Tab 15, Client Management Plan (14.11.22), p2 and ts 17.09.24 (MacPherson), pp24-26
[82] ts 17.09.24 (MacPherson), p19
[83] ts 17.09.24 (MacPherson), p19 and ts 17.09.24 (Velayudhan), pp29-30

56. Paliperidone (which Karl received by way of monthly depot injections) works by altering the balance of chemical substances in the brain in order to improve thinking, mood, and behaviour. Monthly depot injections enable a therapeutic level to be maintained without daily doses of tablets. Paliperidone is associated with a slightly increased risk of fatal side effects, including stroke and heart failure explaining the need for ongoing monitoring, especially in vulnerable patients.[84]

57. Further, when atomoxetine is used with paliperidone (as was done in Karl's case) this can increase the risk of a serious and potentially life-threatening irregular heartbeat, but this is regarded as a "*relatively rare side effect*", and is more likely in individuals that have various heart diseases, none of which Karl appears to have been experiencing.[85] I also note that at the inquest, Dr Velayudhan confirmed that Karl had been started on a lower dose of atomoxetine than normal.[86]

58. Nevertheless, I agree with the Panel's assessment that "*greater attempts*" should have been made to monitor Karl's physical health, "*including ECG, blood pressure and heart rate*" when he was started on atomoxetine. This is especially relevant given that MIMS[87] notes: "*A pharmacological potential exists for all ADHD drugs to increase the risk of sudden/cardiac death*".[88]

59. At the inquest, both Mr MacPherson and Dr Velayudhan agreed that more frequent monitoring of Karl's physical health would have been appropriate. I accept that Karl would have had to consent to any ongoing monitoring of his physical health, and that this may have been difficult given he was highly suspicious of mental health services.[89]

60. During Karl's last admission to Graylands (in June 2022) he received a comprehensive physical assessment including blood tests. No issues were identified during that review.[90,91]

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[84] See: www.mayoclinic.org/drugs-supplements/paliperidone-intramuscular-route/before-using/drg-20073158
[85] See: www.drugs.com/drug-interactions/atomoxetine-with-invega-sustenna-275-0-1781-13969.html
[86] ts 17.09.24 (Velayudhan), p32
[87] MIMS Australia has been publishing medicines information since 1963
[88] Exhibit 1, Vol. 1, Tab 15, Client Management Plan (14.11.22), p9
[89] ts 17.09.24 (MacPherson), p20 and ts 17.09.24 (Velayudhan), pp29-30
[90] Exhibit 1, Vol. 1, Tab 20, Discharge Summary - Graylands Hospital (29.06.22)
[91] ts 17.09.24 (Velayudhan), pp34-35

61. On the basis of the available evidence, I have concluded that Karl's physical health (including his heart health) should have been regularly monitored. That was certainly the intention of his last client management plan, and such monitoring was appropriate because of the potential side effects of the medications Karl was taking. Nevertheless, there is no evidence before the Court that the failure to conduct regular reviews of Karl's physical health (including his blood pressure and heart health) was in any way connected to the cause of death.[92,93]

62. In relation to Karl's ongoing polysubstance use, the Panel noted that:

> (Karl) was known to be actively using substances, which was linked to his first presentation to mental health services with drug induced psychosis and subsequent relapses of his psychosis. It was difficult for services to have a clear picture of (Karl's) substance use as he was often very guarded, denied use, and failed to cooperate with requests for urine drug screens despite assistance by the Case Manager to attend the pathology centre.[94]

63. As Mr MacPherson noted, Karl declined offers of referrals to rehabilitation services, and refused to submit to urine drug assessments.[95] In the face of these refusals, Karl's treating clinicians had limited available options, other than to continue to try to develop a therapeutic rapport, and to encourage him to reconsider engaging with drug rehabilitation services.

64. In his statement, Mr MacPherson also noted that in the face of Karl's refusal to engage with rehabilitation services, he adopted a "*harm minimisation*" approach to Karl's polysubstance use. This included providing Karl with advice and education about the harmful effects of illicit drug use, and the adverse impact of this usage on his mental health, as well as information about (and encouragement to use) safe practices when using illicit drugs.[96]

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[92] Exhibit 1, Vol. 1, Tab 20, Discharge Summary - Graylands Hospital (29.06.22)
[93] Exhibit 1, Vol. 1, Tab 5.1, Supplementary Post Mortem Report (17.08.23)
[94] Exhibit 1, Vol. 1, Tab 14, SAC1 Investigation Report (05.05.23), p10
[95] ts 17.09.24 (MacPherson), pp13-15
[96] Exhibit 1, Vol. 1, Tab 24, Statement - Mr P MacPherson (16.09.24), para 26

65. In an inquest I conducted into the death of a person with a chronic mental illness, and a long-standing history of polysubstance use, mention was made of secure extended care units (SECU), an initiative which may have been of assistance to Karl. In that inquest, the Mental Health Commissioner explained that:

> These facilities are intensive inpatient rehabilitation units. They are designed for individuals admitted on an involuntary basis, who have severe and chronic mental health illnesses with co-occurring conditions and challenging behaviours, who pose a significant risk. The goal of treatment at a SECU is for the patient to be transitioned to community rehabilitation and eventually to either supported, or independent living. A planned 12-bed SECU, to be located on the Bentley Hospital campus is due to open in the next few years.[97]

66. Given Karl's deep suspicion of mental health services and his lack of insight into his mental health, I accept that he would probably have resisted an admission to a SECU.

67. I accept that the issue is moot given that there are currently no SECU in Western Australia. However, if it had been possible to admit Karl to a SECU prior to his death, then there is at least the possibility that during his admission, it may have been possible to address Karl's polysubstance use at the same time as his mental illness was being treated.

[97] Investigation into the death of Boris Drleski [2022] WACOR 24, para 83(a)

QUALITY OF SUPERVISION, TREATMENT AND CARE

68. The evidence establishes that Karl had complex mental health needs, and that the management of his mental health was complicated by his chronic lack of insight into his diagnosis, and therefore his need for treatment. In my view, the decision to manage Karl on a CTO in the community was the least restrictive way to manage his mental health.[98]

69. Karl's longstanding polysubstance use was a major impediment to the management of his mental illness. Karl regularly denied using illicit drugs despite clear evidence to the contrary. Although he was given education about the adverse impacts of illicit drug use on his mental health, Karl declined referrals to rehabilitation services and refused to submit to urine drug assessments. This left his treating clinicians with few options.

70. At the inquest, Mr MacPherson said that with the benefit of hindsight, there was nothing he could think of that he could have done, which could have improved Karl's care.[99]

71. During her remarks at the inquest, Mrs McCreadie said this about Karl's care:

> I would like to acknowledge the care and support Karl received from Osborne Park Clinic and the hospitals he was admitted to. To my knowledge, everyone always treated him with respect and went out of their way to help him. Once Karl had reconnected with me, I was kept informed by his medical and support team, for which I am very grateful.[100]

72. After carefully considering all of the available evidence, I have concluded that the standard of supervision, treatment and care Karl received whilst he was the subject of a CTO was reasonable, particularly when considered in the context of the resources available to his treating clinicians at the relevant time.

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[98] ts 17.09.24 (MacPherson), p12
[99] ts 17.09.24 (MacPherson), pp20-22
[100] ts 17.09.24 (McCreadie), p38

CONCLUSION

73. Karl was 49 years of age when he died at his home in Tuart Hill on 6 December 2022. I found that the cause of Karl's death was combined drug toxicity, and that his death occurred by way of accident.

74. Karl was very clearly a dearly loved family member and friend, and he was a kind and intelligent person who went out of his way to help others. I want to acknowledge the very moving tribute that Karl's mother delivered to her beloved son at the inquest, and to thank her for providing several photographs of Karl to the Court, one of which has been published in this finding at her request.

75. During her remarks at the inquest, Mrs McCreadie made the following observations about Karl:

> My son, Karl, and stepson to my husband, Bill, for 29 years, was a much-loved member of our family. He and his brothers, Trent and Jared, all said they had a happy childhood, and although in recent years estranged from them, in the months prior to his death he was speaking to me about how to mend those relationships. Karl had many close friends he had made from grade two and up through high school, and although many had drifted away in more recent years, about 20 of them wrote in a book that they gave me, telling me what they had shared together and what Karl had meant to them.[101]

76. The evidence at the inquest starkly described Karl's struggles with his mental illness, and the challenges he faced in trying to get his life back on track after he lost his job in the shipping industry. The management of Karl's mental health was adversely affected by his continuing polysubstance use, and his case manager worked hard to develop a therapeutic alliance with Karl, and get him to consider a referral to rehabilitation services, which Karl declined.

77. After carefully examining the available evidence, I concluded that the care, supervision, and treatment Karl received while he was the subject of a CTO was reasonable.

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[101] ts 17.09.24 (McCreadie), p36

78. I also noted that Karl may have benefitted from being admitted to a SECU, where his polysubstance use and his mental health could be addressed at the same time. I therefore again urge the Government to expedite the construction of the SECU planned for the Bentley Hospital site.

79. In conclusion, as I did at the conclusion of the inquest, I wish to convey to Karl's family and loved ones, as well as to those who provided care to

him, my very sincere condolences for your loss.

In memory of Karl Jonathan Turner[102]
14 March 1973 - 6 December 2022

MAG Jenkin
Coroner
22 October 2024

[102] This photograph of Karl was provided to the Court by Mrs McCreadie, and is published here at her request