JURISDICTION	**:**	CORONER'S COURT OF WESTERN AUSTRALIA
ACT	**:**	CORONERS ACT 1996
CORONER	**:**	PHILIP JOHN URQUHART, CORONER
HEARD	**:**	14-17 NOVEMBER 2023
DELIVERED	**:**	19 JULY 2024
FILE NO/S	**:**	CORC 1451 of 2020
DECEASED	**:**	VELTMAN, PHILLIP BENJAMIN

Catchwords:

Nil

Legislation:

Nil

Counsel Appearing:

Mr W. Stops assisted the Coroner
Mr D. Harwood and Ms E. Cavanagh (State Solicitors Office) appearing on behalf of the East Metropolitan Health Services
Ms J. Lee (Belinda Burke Legal) appearing on behalf of Zhi Xin Matthew Kong
Ms L. Allan-McConchie appearing on behalf of Ms Frances Veltman, sister of the deceased.
Mr A.G. Elliott, instructed by Frichot Lawyers, appearing on behalf of Lilian Mortimer

Case(s) referred to in decision(s):

Nil

Coroners Act 1996
(Section 26(1))

RECORD OF INVESTIGATION INTO DEATH

I, Philip John Urquhart, Coroner, having investigated the death of ***Phillip Benjamin VELTMAN*** *with an inquest held at Perth Coroners Court, Central Law Courts, Court 85, 501 Hay Street, Perth, on 14 - 17 November 2023, find that the identity of the deceased person was* ***Phillip Benjamin VELTMAN*** *and that death occurred on 16 July 2020 at Bentley Health Services, Mills Street, Bentley, from an unascertained cause in the following circumstances:*

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LIST OF ABBREVIATIONS & ACRONYMS

Abbreviation	Meaning
ACEM	Australasian College for Emergency Medicine
the Acuphase SOP	Zuclopenthixol Acetate (Clopixol Acuphase) Intramuscular Injection SOP
AORC	Adult Observation and Response Chart
BeSAFE	A multidisciplinary team of nursing and medical staff that provides service support to wards at BHS
BHS	Bentley Health Services
BMHS	Bentley Mental Health Services
BMI	Body Mass Index
the ***Briginshaw*** principle	The accepted standard of proof a court is to apply when deciding if a matter adverse in nature has been proven on the balance of probabilities
the Checklist	Post Acuphase Monitoring Checklist
the Court	the Coroner's Court
CPAP	Continuous positive airway pressure
CPR	Cardiopulmonary resuscitation
CT	Computerised Tomography
CTO	Community Treatment Order
CVC	Community and Virtual Care
ECG	Electrocardiogram
ED	Emergency Department
EMHS	East Metropolitan Health Service

the Handover	Mental Health Medical Handover
ICU	Intensive Care Unit
MET	Medical Emergency Team
mg	milligram
mm Hg	millimetres of mercury (used to determine blood pressure)
msec	millisecond
PLN	Psychiatric Liaison Nurse
QT	The heart's electrical activity that occurs between the Q and T waves
QTc	The corrected QT interval for the heart rate
QT prolongation	A prolonged QT interval demonstrates an irregular heart rhythm
RPH	Royal Perth Hospital
SAC1	A clinical incident in a hospital that has caused serious harm or death to a patient that may be attributed to their health care whilst in hospital
SOP	Standard Operational Procedure
SSO	State Solicitor's Office
The Working Group	EMHS Emergency Department and Mental Health Interface Collaborative Working Group

INTRODUCTION

"Mental health problems don't define who you are. They are something you experience."
Matt Haig – author

1. Phillip Benjamin Veltman (Mr Veltman) died from an unascertained cause on 16 July 2020 in the locked ward at Bentley Mental Health Services (BMHS) situated at Bentley Health Services (BHS). He was 49 years old.

2. At the time of his death, Mr Veltman was subject to a "*Form 1A - Referral for Examination by Psychiatrist*", pursuant to section 26(1) of the *Mental Health Act 2014* (WA). He was therefore an involuntary patient as defined in that Act.[1]

3. Accordingly, Mr Veltman was a "*person held in care*" within the meaning of the *Coroners Act 1996* (WA), and his death was a "*reportable death*".[2]

4. In such circumstances, a coronial inquest is mandatory as Mr Veltman was, immediately before his death, "*a person held in care*".[3] Where 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.[4]

5. From 14 November to 17 November 2023, I held a four day inquest into Mr Veltman's death at Perth. Eleven witnesses gave oral evidence at the inquest. They comprised of doctors and nurses who treated Mr Veltman at Royal Perth Hospital (RPH) and BHS, an independent emergency medicine consultant, an independent consultant psychiatrist, and an independent clinical pharmacologist and toxicologist. These witnesses were:[5]

    i. Dr Wesley Meintjes (Psychiatry Registrar at RPH);
    ii. Dr Daithi de Baroid (Emergency Physician at RPH);
    iii. Dr Gunvor Velure (Duty Medical Officer at BHS);
    iv. Matthew Murica (Registered Nurse at BMHS);

[1] *Mental Health Act 2024* (WA) ss 4 and 21(1)
[2] *Coroners Act 1996* (WA) s 3
[3] *Coroners Act 1996* (WA) s 22(1)(c)
[4] *Coroners Act 1996* (WA) s 25(3)
[5] The listed positions of those witnesses who treated Mr Veltman are the positions they held at the relevant time

v. Zhi Xin Matthew Kong (Registered Nurse at BMHS);

vi. Dr Linda Vu (Medical Registrar at BHS);

vii. Lilian Mortimer (Psychiatric Liaison Nurse at RPH);

viii. Dr Vinesh Gupta (Medical Co-Director, Mental Health Division, Royal Perth Bentley Group);

ix. Associate Professor David Mountain (Emergency Medicine Consultant);

x. Professor David Joyce (Clinical Pharmacologist and Toxicologist); and

xi. Dr Adam Brett (Consultant Psychiatrist)

6. At the conclusion of the inquest's oral evidence, Ms Frances Veltman (Ms Veltman), the sister of Mr Veltman, read from a prepared statement.[6]

7. The documentary evidence comprised of one volume of material which was tendered by counsel assisting at the commencement of the inquest and became exhibit 1. Various other documents were tendered during the inquest and these became exhibits 2 – 7.

8. At the completion of the inquest, I sought additional information from the East Metropolitan Health Service (EMHS). That information was sent to the Court by the State Solicitor's Office (SSO) via email on 31 May 2024. It comprised of (i) an undated letter from a senior medico legal officer at the EMHS, (ii) a statement dated 31 May 2024 from Mahmud Abubakar,[7] (iii) a revised version dated 30 May 2024 (with attachments) of the previous report from Dr Vinesh Gupta that was exhibit 2, and (iv) a copy of the EMHS "*Rights of Carers and Personal Support Persons Policy*" as of July 2020.

9. During the course of her oral closing submissions at the inquest, I gave Ms Allan-McConchie, counsel for Ms Veltman, the opportunity of providing additional material and written submissions regarding the Community Treatment Order (CTO) dated 7 July 2020. This CTO came into effect when Mr Veltman was discharged from BHS on that date. That material and the submissions were to be confined to the question of

[6] Exhibit 7, Statement of Frances Veltman (undated)
[7] The nurse co-ordinator for the locked ward at BMHS on 16 July 2020

whether there should have been a condition in the CTO that Mr Veltman reside in supported accommodation. I also stated that the SSO would have the opportunity to respond on behalf of the EMHS.[8] I specified 28 February 2024 as the closing date for this material to be filed with the Court. I subsequently granted several requests for an extension, with the final closing date becoming 1 July 2024.

10. On 1 July 2020, Ms Allan-McConchie filed written submissions with attachments. These attachments comprised of BHS medical records for Mr Veltman, a witness statement from Ms Veltman's husband regarding the condition of Mr Veltman's home in Como, and photographs he had taken of the residence in July 2018.

11. The submissions and attached material went beyond the question regarding the suitability of discharging Mr Veltman to live by himself on 7 July 2020 as they also addressed the prior discharge from BHS on 15 April 2020. I have only considered this material as background for what occurred when Mr Veltman was discharged on 7 July 2020.

12. After it received the submissions from Ms Allan-McConchie, the Court advised the SSO that it was inviting submissions in response from the EMHS and identified four questions to be addressed. The Court received that response from the EMHS on 15 July 2024.

13. My primary function at the inquest was to investigate the quality of the medical supervision, treatment and care that was provided to Mr Veltman when he attended the ED at RPH on 15 July 2020, and when he was admitted to BMHS late in the afternoon of 15 July 2020 until his death on the following day.

14. In making my findings, I have applied the standard of proof as set out in ***Briginshaw v Briginshaw*** (1938) 60 CLR 336, 361-362 (Dixon J) which requires a consideration of the nature and gravity of the conduct when deciding whether a matter adverse in nature has been proven on the balance of probabilities (the ***Briginshaw*** principle).

15. I am also mindful not to assert hindsight bias into my assessment of the action taken by Mr Veltman's health service providers in their treatment of

[8] Ts 17.11.2023, pp.400-401

him in RPH and BMHS. Hindsight bias is the tendency, after an event, to assume the event was more predictable or foreseeable than it was at the time.[9]

MR VELTMAN

Background [10]

16. Mr Veltman was born in Broadmeadows, Victoria and he had a brother and sister. He achieved very good grades at school and had commenced a computer science course at university. He was also an excellent guitarist.

17. Mr Veltman was described by his sister as "*a person of contradiction*". His understanding of physics, mathematics, computers, politics and maps was excellent, yet he could not make himself a sandwich and needed to be reminded to have a shower or wash his clothes. Mr Veltman experienced difficulty in undertaking ordinary everyday tasks.

Mr Veltman's mental health [11]

18. Mr Veltman had his first psychiatric hospital admission in 1992 when he was in his early 20's. He was subsequently diagnosed with bipolar affective disorder.

19. Mr Veltman had at least 41 admissions to hospital psychiatric wards since 1992. From 31 August 2016, he had had 14 such admissions and in this period before his death (less than four years) he had been in hospital in excess of three years. This included an admission in Graylands Hospital from December 2017 to December 2019.

20. I agree with the assessment from Dr Adam Brett (Dr Brett), independent consultant psychiatrist, that: "*Mr Veltman had a history consistent with a chronic treatment-resistant psychotic disorder*".

21. Mr Veltman's most recent diagnosis was schizoaffective disorder. His mental health treatment regime included anti-psychotic and mood stabiliser medications.

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[9] Dillon H and Hadley M, *The Australasian Coroner's Manual* (2015) 10

[10] Exhibit 1, Tab 5, Coronial Investigation Squad Report dated 11 January 2022, Exhibit 7, Statement of Frances Veltman (undated)

[11] Exhibit 1, Tab 5, Coronial Investigation Squad Report dated 11 January 2022, Exhibit 1, Tab 16.1, Report from Dr Adam Brett dated 1 June 2023, Exhibit 7, Statement of Frances Veltman (undated)

Mr Veltman's physical health [12]

22. In addition to his mental health complications, Mr Veltman had significant physical health comorbidities. These included congestive heart failure, obstructive sleep apnoea, hypertension, type-2 diabetes, obesity, aspiration pneumonia and hyperlipidaemia. He was prescribed various medications to treat a number of these conditions.

23. Although Mr Veltman had been seeing a cardiologist since June 2014, his cardiologist had last seen him in December 2018. An electrocardiogram (ECG) arranged by the cardiologist at that time showed stable findings with mild to moderate aortic regurgitation. The cardiologist noted that these findings were reassuring and suggested stability from a cardiology point of view. Nevertheless, the cardiologist was concerned about the possibility of underlying coronary artery disease. Although he recommended a CT coronary angiogram scan to exclude obstructive coronary artery disease, it would appear Mr Veltman never had this scan.

Admission to RPH on 22 March 2020 [13]

24. On 22 March 2020, a community health nurse conducted a mental health assessment of Mr Veltman at his home with police officers present. This assessment had followed a relapse of his schizoaffective disorder which had led to aggressive and threatening behaviour. At the completion of the assessment, Mr Veltman was taken by police under the *Mental Health Act 2014* (WA) to the ED at RPH for an involuntary psychiatric assessment. Given his agitated behaviour at the ED, Mr Veltman was sedated with 10 mg of midazolam and 10 mg of droperidol, together with 350 mg of ketamine. These three medications were all administered intravenously. Later, Mr Veltman's consciousness became impaired and he was admitted to the ICU at RPH with aspiration pneumonia. He was medically cleared on 23 March 2020.

[12] Exhibit 1, Tab 5 Coronial Investigation Squad Report dated 11 January 2022, Exhibit 1, Tab 10, Letter from Dr Barry McKeon dated 26 October 2020, Exhibit 2, Report from Dr Vinesh Gupta dated 13 November 2023

[13] Exhibit 1, Tab 13, RPH medical records

Admission to BHS on 24 March 2020 [14]

25. On 24 March 2020, Mr Veltman was transferred from RPH as an involuntary patient and admitted to the locked ward (ward 6) within BMHS at BHS. It was clear Mr Veltman remained unwell with pressured speech, thought disorder, and persecutory and paranoid ideas. He was commenced on depot anti-psychotic medication and he was eventually transferred to an open ward (ward 7) at BMHS. By 14 April 2020, his behaviour had settled with no florid psychotic symptoms.

26. On 15 April 2020, Mr Veltman was discharged from BHS with a diagnosis of schizoaffective disorder. He was discharged on various medications to treat his mental health conditions, metabolic syndrome and type-2 diabetes. Follow-up was arranged through his community mental health service. Discharge planning was not clearly articulated and it was not clarified where he would be getting his medications or where he would be living.

Admission to BHS on 13 May 2020 [15]

27. On 13 May 2020, Mr Veltman was transferred from the ED at RPH to BMHS at BHS. He had been taken to the ED at RPH the previous day by police after members of the public complained of his aggressive behaviour. He was thought disordered, grandiose and disinhibited with an elevated mood.

28. At BMHS, Mr Veltman was diagnosed with a relapse of his schizoaffective disorder, and during this eight-week stay he was transferred to and from the open and locked wards at BMHS.

29. During this admission at BMHS, Mr Veltman was supplied with a CPAP machine for treatment of his obstructive sleep apnoea. However, he was not always compliant with its use.

30. On 7 July 2020, Mr Veltman was discharged from BHS. The discharge diagnoses was schizoaffective disorder, manic type and Mr Veltman's medical conditions were documented. He was discharged on a CTO with

[14] Exhibit 1, Tab 14, Bentley Health Service medical records
[15] Exhibit 1, Tab 14, Bentley Health Service medical records, Exhibit 1, Tab 16.1, Report from Dr Adam Brett dated 1 June 2023

monthly depot injections of 150 mg of paliperidone. In addition, he was discharged on 11 other medications to treat his various health conditions.

31. Sadly, and arguably unsurprisingly given his treatment-resistant disorder and his inability to care for himself, it was barely a week before Mr Veltman was hospitalised again.

EVENTS LEADING TO MR VELTMAN'S DEATH

Mr Veltman is taken to the ED at RPH on 15 July 2020 [16]

32. At about 3.30 am on 15 July 2020, police attended a 24-hour supermarket in Como due to a complaint from an employee of a man's behaviour. This man was Mr Veltman and when spoken to by police, it was noted he was acting in an erratic manner. From information obtained from Mr Veltman, police arranged to take him to his brother's residence in a nearby suburb. Mr Veltman's brother advised police that given Mr Veltman's behaviour and as he was placed on a CTO, they should take him to the ED at RPH.

33. At 4.45 am, police conveyed Mr Veltman to the ED at RPH. Given his agitation and his elevated and unpredictable presentation, Mr Veltman was sedated with the anti-psychotic medication, quetiapine, and the sedative, ketamine, which was intravenously administered. He had to be physically restrained by hospital security for the insertion of the intravenous cannula.

34. Dr Wesley Meintjes (Dr Meintjes) was the ED Psychiatry Registrar on duty at the relevant time. He had previously dealt with Mr Veltman and was able to review him at 5.44 am when he was slightly less agitated.

35. Dr Meintjes' assessment was that Mr Veltman was having an acute manic psychosis in the context of treatment-resistant schizoaffective disorder and that he required a transfer to an authorised locked mental health ward.

36. As Dr Meintjes was aware of Mr Veltman's previous aspiration event at RPH in March 2020 and because of his comorbidities, an ICU physician was consulted regarding the care of Mr Veltman whilst he remained at the ED.[17] At 6.15 am, an ICU Senior Registrar reviewed Mr Veltman and it

[16] Exhibit 1, Tab 1, Mortuary Admission Form, Exhibit 1, Tab 12, SAC1 Clinical Investigation Report, Exhibit 1, Tab 13, RPH medical records, Exhibit 1, Tab 26.1, Statement of Dr Wesley Meintjes dated 7 November 2023, Exhibit 1, Tab 24, Statement of Dr Daithí de Baroid dated 6 November 2023
[17] Ts 14.11.2023 (Dr Meintjes), pp.35-36

was determined that it would not be suitable for Mr Veltman to be placed in the ICU unless he became unmanageable in the ED. It was also recommended his transfer to a locked mental health ward be expedited.

37. At 6.41 am, Dr Meintjes completed a "*Form 1A - Referral for Examination for Psychiatrist*" under section 26(1) of the *Mental Health Act 2014* (WA). This provided authority for Mr Veltman to be taken involuntarily to a locked mental health ward for a psychiatric examination.

38. As of July 2020, RPH did not have an involuntary inpatient mental health ward.[18] Consequently, Dr Meintjes completed a "*Form 3A - Detention Order*" pursuant to section 28 of the *Mental Health Act 2024* (WA). This permitted RPH to detain Mr Veltman in order for him to be taken to an authorised psychiatric hospital. That authorised hospital was to be BHS.[19]

39. Dr Meintjes also completed a Mental Health Assessment form[20] which contained relevant information regarding the ongoing treatment and care for Mr Veltman.

40. Given his ongoing agitation, at 9.28 am, the ED consultant psychiatrist prescribed a one-off dose of 150 mg of zuclopenthixol acetate (also known as Acuphase)[21] for Mr Veltman. A short time later, a Code Black was called after Mr Veltman had struck the ED consultant psychiatrist on his shoulder. Mr Veltman was subsequently given the prescribed dose of Acuphase by an intramuscular injection at 9.58am.[22]

41. At 10.22 am, Mr Veltman was declared medically fit for a transfer to a locked mental health ward. Although it appears BHS had accepted the referral by 11.27 am,[23] Mr Veltman remained in the ED at RPH for at least another five hours.

42. From about 11.00 am, Mr Veltman only slept briefly and when he did, his head fell forward, obstructing his airway. When he was awake, he was loud, agitated and aggressive, frequently removing monitoring equipment.

[18] Ts 14.11.2023 (Dr Meintjes), p.34
[19] Ts 14.11.2023 (Dr Meintjes), p.34
[20] Also known as an "8 pager"
[21] For the balance of this finding I will refer to this medication as "Acuphase"
[22] Exhibit 1, Tab 13, RPH medical records, medication chart
[23] This was the time that the "*Form 4A - Transport Order*" had been completed

When it was noted his oxygen levels were decreasing, ED staff tried to apply an oxygen mask. However, Mr Veltman became aggressive and refused to wear it. Due to his behaviour and to ensure his and staff safety, ketamine was frequently administered intravenously. Between 7.30 am and 4.31 pm, Mr Veltman received a total of 340 mg in doses between 10 mg and 30 mg.

43. At 3.54 pm, Mr Veltman's observations were recorded as: heart rate 82 beats per minute, blood pressure 180/90 mm Hg and respiratory rate 14 breaths per minute.

44. By 5.00 pm, an ambulance and a police escort (which comprised of four police officers) had been arranged to transfer Mr Veltman to BMS. All relevant medical information from RPH was to accompany Mr Veltman in this transfer. This information should have included an up-to-date medication chart detailing all the medications given to Mr Veltman at RPH that day.

Mr Veltman's admission to BHS [24]

45. At about 5.40 pm, Mr Veltman attended BMHS at BHS. At this time, Dr Gunvor Velure (Dr Velure) was the after-hours duty medical officer at BHS. She was contacted by BMHS to admit Mr Veltman. At the time, Mr Veltman was highly aroused. He was singing loudly, shouting, unwilling to cooperate and making bizarre references. He had to be separated from other patients.

46. Dr Velure was unable to carry out any meaningful medical assessment of Mr Veltman due to his behaviour. Dr Velure found him difficult to understand and her recorded impression was "*schizoaffective disorder relapse with manic features*". Dr Velure's plan was for Mr Veltman to be admitted to the locked ward at BMHS and his usual medications were charted, with additional lorazepam (a benzodiazepine) and quetiapine as needed. No attempt of a physical examination was made by Dr Velure due to Mr Veltman's level of arousal.

[24] Exhibit 1, Tab 14, BHS medical records, Exhibit 1, Tab 19, Statement of Matthew Kong dated 1 November 2023, Exhibit 1, Tab 25, Statement of Dr Gunvor Velure dated 7 November 2023

47. During the night of 15 and 16 July 2020, Mr Veltman was often awake and irritable. At 5.18 am on 16 July 2020, it was recorded that he had been asleep at the start of the night shift (9.00 pm on 15 July 2020) but awoke mid-shift and walked naked around the ward demanding "*jam jars*" (i.e. specimen containers).

48. Another nursing entry noted Mr Veltman was asleep at the start of the morning shift on 16 July 2020 (7.00 am), and that attempts to wake him up for physical observations at 10.00 am, 11.00 am, 12.30 pm, and 1.00 pm were unsuccessful. As he slept, Mr Veltman was snoring very loudly.

Mr Veltman is found unresponsive in bed [25]

49. Matthew Kong (Mr Kong), a Registered Nurse, was allocated to Mr Veltman when he commenced his shift at 7.00 am on 16 July 2020. At 1.00 pm, Mr Veltman was recorded as being in his bedroom asleep with a respiratory rate of 18. Mr Kong completed the last entry in the Integrated Progress Notes for Mr Veltman at 1.30 pm. This entry read:

> Phillip was asleep at commencement of the shift. Remains deeply asleep throughout the morning. Attempted to wake him up multiple times for meds and doctor's review without success. Meds ordered and arrived. Remains asleep during all checks.

50. In order to allow him to sleep, the decision was made to postpone the doctor's review of Mr Veltman until 1.40 pm. At about that time, Mr Kong, another nurse, the psychiatry registrar and the intern medical officer entered Mr Veltman's room. Mr Veltman was found unconscious and not breathing. He was extremely pale. At 1.46 pm, the Medical Emergency Team (MET) at BHS was notified and CPR was commenced.

51. When the MET arrived, Mr Veltman was still unconscious with CPR underway and defibrillation pads in place. Oxygen was applied and a Laryngeal Mask Airway was inserted. Despite a number of attempts, no intravenous line could be achieved and consequently no adrenaline was administered.

[25] Exhibit 1, Tab 14, Bentley Health Service medical records, Exhibit 1, Tab 19, Statement of Matthew Kong, dated 1 November 2023, Exhibit 1, Tab 22, Statement of Linda Vu, dated 5 November 2023

52. The defibrillator registered Mr Veltman as asystole.[26] At 1.55 pm, he was certified life extinct.[27]

CAUSE AND MANNER OF DEATH [28]

53. Dr Clive Cooke (Dr Cooke), a forensic pathologist, conducted a post mortem examination on Mr Veltman's body on 23 July 2020. The examination found Mr Veltman was overweight at 125 kg with a BMI of 40.8. There was evidence of recent medical care, including attempts at CPR. Mr Veltman's heart was enlarged, with discoloration on part of the heart muscle, and an artery on the surface of the heart showed localised arteriosclerotic hardening and narrowing (focal arteriosclerosis – right coronary artery).

54. Microscopic examination of Mr Veltman's major body organs detected early scarring of part of the heart muscle, as may occur with coronary arteriosclerosis, and the presence of cirrhosis of the liver was also noted. Testing for significant respiratory and cardiac viral infections was negative.

55. A specialist neuropathology examination of Mr Veltman's brain found no significant abnormalities.

56. Toxicological analysis detected medications that were consistent with Mr Veltman's recent medical care and were all noted to be at therapeutic levels. These medications were amlodipine, aripiprazole, ketamine, lamotrigine, paliperidone, quetiapine, and Acuphase.

57. After outlining his findings, Dr Cooke noted the following:[29]

> Based on these findings, it appears that Mr Veltman has died during his sleep of a fatal cardiac arrhythmia, with terminal aspiration, having been agitated the previous day and at least once during the night. He had a significant medical history with heart disease, obstructive sleep apnoea, hypertension, diabetes mellitus and schizoaffective disorder and was receiving care with a number of

[26] Asystole occurs when the heart fails to generate and propagate normal electrical impulses, resulting in the cessation of effective cardiac contractions and circulation
[27] Exhibit 1, Tab 8, Death in Hospital Form dated 16 July 2020
[28] Exhibit 1, Tabs 4.1-4.8, Email correspondence involving Dr Cooke and the Court, Supplementary Post Mortem Report, Toxicology Report, Supplementary Toxicology Report, Neuropathology Report, Full Post Mortem Report, Interim Post Mortem Report, Exhibit 1, Tab 15.3, Report from Professor David Joyce dated 5 September 2022
[29] Exhibit 1, Tab 4.3, Supplementary Post Mortem Report dated 23 July 2020, pp.1-2

> medications. Many of these pre-existing disorders, particularly heart disease, sleep apnoea, and schizophrenia are associated with sudden cardiac death. Episodes of acute mania are also associated with sudden cardiac death, but in this case there appears to be a number of hours between Mr Veltman's last episode of mania and his apparent sudden death.
>
> Additionally, Mr Veltman was being treated with a number of medications, which have potential to be a further factor in the death – firstly, some can affect the heart rhythm which may result in an arrhythmia, and secondly, their combined effects may have caused over-sedation (potentially predisposing to an arrhythmia).
>
> I recommend that consultation be made with Professor Joyce, Clinical Pharmacologist, to assess any possible role of the medications in Mr Veltman's death.

58. At the completion of the post mortem investigations, Dr Cooke expressed the opinion that the cause of death was: "*Unascertained (cardiac arrhythmia with terminal aspiration, in an overweight, medicated man with enlargement of the heart, focal coronary arteriosclerosis, a history of sleep apnoea and a recent episode of manic psychosis).*"[30]

59. The Court subsequently obtained a report from Professor Joyce. After reviewing the relevant material, Professor Joyce noted that Mr Veltman was at an increased risk for two potentially lethal outcomes, namely respiratory obstruction, and QT prolongation[31] causing ventricular arrhythmia. Professor Joyce noted: "*The fact that Mr Veltman died at a time when he was at increased risk of both these outcomes suggests that one or the other was the cause of death. Both seemed consistent with post mortem findings.*"[32]

60. As to the contribution to Mr Veltman's death of the medications given to him at RPH and BMHS, Professor Joyce stated:[33]

> The post mortem toxicology does not point towards excessive drug concentration. That seems to be the usual situation among patients who die unexpectedly in the day or so after an admission for severe agitation and psychosis.
>
> …
>
> In our current state of knowledge, therefore, we should just acknowledge that patients with the clinical picture that Mr Veltman presented at the time of admission are at risk of dying during early hospital care. Patients with such severe

[30] Exhibit 1, Tab 4.3, Supplementary Post Mortem Report dated 23 July 2020, p.1
[31] A prolonged QT interval demonstrates an irregular heart rhythm
[32] Exhibit 1, Tab 15.3, Report from Professor David Joyce dated 5 September 2022, p.13
[33] Exhibit 1, Tab 15.3, Report from Professor David Joyce dated 5 September 2022, p.14

> psychiatric illness have to be treated with effective drugs because the untreated psychiatric condition would have unacceptable morbidity and probably higher mortality than any contemporary drug treatment for it. Where the amounts of administered drug seem appropriate to the circumstances, and leave post-mortem concentrations that seem safe, it is not possible to isolate a specific contribution of the drugs to the death. It is the whole clinical circumstance, the sum of disease of mind and body and, maybe, treatment that constitutes the risk.

61. I accept those observations made by Professor Joyce. I also accept his evidence at the inquest with respect the following questions I asked him:[34]

> So, Professor, on the balance of probabilities, would you say it [the drugs administered to Mr Veltman on 15 and 16 July 2020] played a role or it did not play a role [in Mr Veltman's death]? ---If I was forced to say whether the needle lay above or below 50 per cent, I would say below 50 per cent.
>
> So below?---Yes.
>
> So did not contribute?---On the balance of probabilities, that's where I would put it. Yes.
>
> Okay. Because that's the test that I need to apply in making my findings, and that's why I've asked you that question?---Yes. But I think that if that question was put to me formally, then I would say on the balance of probabilities, the drugs have not been a contributor.
>
> And that is all the drugs that had been administered to this individual on 15 and 16 July?---That – yes. All the drugs administered from the beginning of that admission until the time he died. Yes.

62. I am satisfied that since Dr Cooke's conclusion that Mr Veltman's cause of death could not be ascertained, he has carefully considered the additional information that has come to light to reexamine whether a cause of death can now be established. That further information has not changed his original opinion that the cause of death was unascertained.

63. Consequently, I am satisfied that the cause of Mr Veltman's death must remain as "*unascertained*". As Dr Cooke has correctly pointed out, a cardiac arrhythmia is a mechanism of death, rather than a cause of death.[35] Nevertheless, Dr Cooke was of the view that Mr Veltman's death was a

[34] Ts 16.11.2023 (Professor Joyce), p.339
[35] Exhibit 1, Tab 4.1, Email from Dr Clive Cooke to counsel assisting dated 7 December 2022

consequence of the factors included in his opinion as to the unascertained cause of death.[36]

64. I am satisfied to the required standard that Mr Veltman's death was precipitated by a cardiac arrhythmia with terminal aspiration, in an overweight man with an enlargement of the heart, focal coronary atherosclerosis, a history of sleep apnoea and a recent episode of manic psychosis. This conclusion repeats the factors cited by Dr Cooke, with the exception of the word "medicated". Given Professor Joyce's opinion that the medications Mr Veltman received on 15 and 16 July 2020 did not contribute to his death, I have reached the view that this word should be omitted.

65. As I have not been satisfied to the required standard that the medications given to Mr Veltman had contributed to his death, I find that death occurred by way of natural causes.

THE CLINICAL INCIDENT INVESTIGATION OF MR VELTMAN'S DEATH [37]

66. A clinical incident in a hospital which has caused serious harm or death to a patient that may be attributable to the patient's health care (rather than their underlying condition or illness) is known as a SAC1 clinical incident. Such an incident always become the subject of an investigation by the hospital in question. The goal of a SAC1 investigation is to find out what happened, why it happened, and what can be done to prevent it from happening again. The investigation focuses on these considerations, rather than the individuals involved, in order to understand the system-level factors that may have contributed to the incident.

67. The SAC1 investigation into Mr Veltman's death concluded:[38]

- Mr Veltman's death was potentially preventable to the extent that had the deterioration of his clinical condition been recognised earlier, i.e. during the morning of 16 July 2020, it is possible that resuscitation measures may have prevented his death.

[36] Exhibit 1, Tab 4.1, Email from Dr Clive Cooke to counsel assisting dated 7 December 2022
[37] Exhibit 1, Tab 12, SAC1 Clinical Incident Investigation Report dated 23 September 2020
[38] Exhibit 1, Tab 12, SAC1 Clinical Incident Investigation Report dated 23 September 2020, p.8

- Delays in transferring a patient under the *Mental Health Act 2014* (WA) with behavioural disturbances and medical comorbidities, and who requires assertive medical management in an ED, can place the patient at risk.
- In order to ensure best patient care and outcomes, comprehensive and timely communication is essential for mental health patients who have their care transferred to peripheral mental health hospitals.
- The pharmacological management of a mental health patient with acute behavioural disturbances and significant medical comorbidities needs to be carefully considered, especially in regard to the administration of high-risk medication.
- All available resources should be employed to assist in the management of high-risk mental health patients, including specialised teams such as BeSAFE.[39]

68. The SAC1 investigation also made recommendations in several areas.[40] These recommendations are considered later in this finding.

ISSUES RAISED BY THE EVIDENCE

Where should Mr Veltman have resided following his discharge from BHS on 7 July 2020?

69. On behalf of Ms Veltman, Ms Lindsay-McConchie submitted that given the uninhabitable condition of his Como property and BHS's knowledge of his clear inability to self-care, Mr Veltman should not have been residing in his Como home after his discharge on 7 July 2020.[41] It was also contended that had Ms Veltman been consulted, she would have been able to explain that the Como property was not fit for habitation. Furthermore, a visit to the property by a social worker or occupational therapist would have confirmed its unsuitability. The submission was also made there were

[39] BeSAFE is a multidisciplinary team of nursing and medical staff that provides service support to wards at BHS, including attending Code Blue calls with the MET.
[40] Exhibit 1, Tab 12, SAC1 Clinical Incident Investigation Report dated 23 September 2020, p.9
[41] It was also submitted that Mr Veltman should not have been discharged from BHS to live in his home on 15 April 2020. However, it is beyond the scope of the coronial investigation to consider this matter as it was three months before Mr Veltman's death. In contrast, the discharge on 7 July 2020 was only eight days before his last hospital admission

shortfalls in the communication with the next of kin (i.e. Ms Veltman) about appropriate discharge planning and options.[42]

70. Given these submissions, the Court invited the EMHS to respond to these questions:

1. As at the time of Mr Veltman's penultimate hospital admission (from 13 May to 7 July 2020), is it accepted the EMHS possessed credible information that demonstrated Mr Veltman was not fit to look after himself?
2. Why did the CTO dated 7 July 2020 not have a condition that Mr Veltman was to live in supported accommodation?
3. If part of the answer to 2. is that Mr Veltman refused to live in supported accommodation, what alternatives were available and were these alternatives considered (apart from Mr Veltman living in his Como property by himself)?
4. What efforts were made by the EMHS to determine whether the Como property Mr Veltman resided in following his discharge on 7 July 2020 was suitable?

71. By letter dated 15 July 2024 with attachments, the acting Manager of the Medical Treatment Liability Service at the EMHS addressed these questions.[43]

72. As to question 1, it was accepted that as Mr Veltman was an involuntary patient during his hospital admission, he was not able to look after himself. That is self-evident. The intent of the Court's question (which may not have been expressed with sufficient clarity) was whether the EMHS accepted it had credible information that demonstrated Mr Veltman was not fit to look after himself as at the discharge date. As to this question, it was submitted that as Mr Veltman was discharged on a CTO, it meant he no longer met the criteria to be an involuntary patient; however, he met the criteria under the *Mental Health Act 2014* (WA) for a CTO.[44]

73. As to question 2, the EMHS submitted that it was the writer's understanding the *Mental Health Act 2014* (WA) did not provide for the enforcing of a residential location for a patient, other than by making the

[42] Additional Submissions on behalf of Interested Party dated 1 July 2024
[43] Letter from the EMHS to the Court dated 15 July 2024, with attachments
[44] Letter from the EMHS to the Court dated 15 July 2024, p.2

patient an involuntary inpatient.[45] There is some merit in that submission, particularly when section 115(1) of the *Mental Health Act 2014* (WA) is examined. That section stipulates the terms of a CTO "*must*" include a number of matters, including requirements that the patient is to notify their supervising psychiatrist or treating practitioner of any change in their residential address, or any interstate or overseas travel.[46] The logical inference to be drawn from these mandatory requirements is that a CTO would not be able to enforce a residential location upon an involuntary community patient.

74. The EMHS also noted that Mr Veltman's residential address on the CTO dated 7 July 2020 was listed as "27 Hyland Avenue, Wilson",[47] and not Mr Veltman's Como property.[48] Despite the requirement in his CTO that he was to notify his supervising psychiatrist or treating practitioner of any change to his residential address, there is no information before the Court that Mr Veltman did this when he apparently moved into his Como property between 7 and 15 July 2020.

75. As to question 3, the EMHS submitted: "*Mr Veltman had a guardian who had engaged NDIS support including funding for accommodation options, a support coordinator and in-home services through private organisations.*"[49] I accept that the following examples cited by the EMHS illustrate the extent to which various accommodation and support options were explored for Mr Veltman prior to his discharge on 7 July 2020:[50]

> 15 June 2020 – Mr Veltman expressed that he did not want to live in supported accommodation.
>
> 16 June 2020 – Mr Veltman had agreed to go to visit St Jude's, a private organisation that had supported independent living (SIL) that was registered

[45] Letter from the EMHS to the Court dated 15 July 2024, p.2
[46] *Mental Health Act 2014* (WA) s 115(1)(g) and (h)
[47] It would appear this address should have read "27 Hyland *Way*, Wilson"
[48] Exhibit 1, Tab 14, Bentley Health Service medical records, Form 5A-Community Treatment Order dated 7 July 2020
[49] Exhibit 1, Tab 14, Bentley Health Service medical records, Form 5A-Community Treatment Order dated 7 July 2020, p.3
[50] Letter from the EMHS to the Court dated 15 July 2024, pp.3-4, Exhibit 1, Tab 14, Bentley Health Service medical records, Form 5A - Community Treatment Order dated 7 July 2020, p.3, Exhibit 1, Tab 14, Bentley Health Service medical records, Discharge Summary dated 7 July 2020 and Client Management Plan dated 4 July 2020

with the NDIS at the time. I am informed that the St Jude's SIL was located in Midland and Mr Veltman refused to visit or live in Midland.

20 June 2020 – Mr Veltman agreed to meet with the St Jude's staff. I am informed that the outcome of his meeting was that Mr Veltman was very resistant to supported accommodation but did want to re-engage with a specific private community support service as he already had a relationship with them.

23 June 2020 – Mr Veltman expressed that he would like to live in Joondalup or Murdoch.

25 June 2020 – Mr Veltman appears more settled and is open to accommodation in Joondalup. Social worker to do home visit next week.

1 July 2020 – Mr Veltman expressed interest in returning to the Como property including paying bills there. The social worker would visit the Como house to review. I am informed that EMHS staff did not visit the Como house for reasons that include the impact the ongoing renovations had on the suitability of the residence, specifically Mr Veltman had been living in the shed.

4 July 2020 – The EMHS welfare officer and the social worker went with Mr Veltman to a property in Wilson. Mr Veltman was happy with that outcome. I am informed this was a private property, understood to be owned by Mr Veltman's family. Mr Veltman had a key, the house was clean, furnished with running water, gas and electricity. The house was set up as a share house where rooms appeared to be lockable and private, lodging style accommodation, although no one else appeared to be living there at the time.

7 July 2020 – The CTO records that Mr Veltman was discharged to a Wilson address. That is, he was discharged to 'own home' after home visit by social worker to ensure property safe for services to enter with guardian agreement. I am informed that the private community service provider Mr Veltman wanted to re-engage was to visit this property three times a week, being a service separate to EMHS.

76. As to question 4, the EMHS noted that Mr Veltman was not actually discharged to the Como property and that, in fact, he was discharged to reside at the Wilson property with a CTO condition that he inform the EMHS if he was to move from there.[51] Understandably, there were no efforts made by BHS to determine the suitability of the Como property as there had been no plan to have Mr Veltman discharged to that property.

[51] Letter from the EMHS to the Court dated 15 July 2024

77. I accept there was a difficult dilemma facing BHS when the decision was made that Mr Veltman no longer fitted the criteria for an involuntary inpatient. He had already been an inpatient for eight weeks and it is well known that extended hospital admissions for mental health patients can be counter-productive. Clearly, the best scenario for Mr Veltman in the community was supported accommodation. However, he was resistant to that proposition. I agree, as submitted by the EMHS, that when a treating practitioner is making a CTO they must consider the relevant provisions of the *Mental Health Act 2014* (WA), including the wishes of the patient.[52]

78. Although it was not ideal, I accept that in the circumstances, it was appropriate for BHS to discharge Mr Veltman to the Wilson address on 7 July 2020. In particular, I note that arrangements had been made for the private community service provider (which Mr Veltman was prepared to engage with) to visit this address three times a week. So there was a measure in place to monitor Mr Veltman. However, based on the information before me, I do not know the outcome of those visits.

Did the ECG on 15 July 2020 indicate Mr Veltman had an increased risk of a fatal ventricular arrhythmia?

79. An ECG is used to record the electrical activity of the heart and assists in the monitoring of heart conditions including cardiac arrhythmias. It operates as an automated reading machine, and Mr Veltman was given an ECG shortly after he was admitted to the ED at RPH. This took place at 5.41 am on 15 July 2020.[53] The ECG reading for Mr Veltman suggested that the QTc[54] was prolonged at 490 msec.[55] Associated Professor David Mountain (Professor Mountain) stated that a QTc under 440 msec was considered normal for males.[56] The question addressed at the inquest was whether an ECG reading of 490 msec meant that Mr Veltman had an

[52] Letter from the EMHS to the Court dated 15 July 2024, p.2
[53] Exhibit 1, Tab 13, Royal Perth Hospital medical records
[54] Due to the variation of QT interval with heart rate (higher heart rate has a shorter QT interval, lower heart rate has a longer QT interval), it is necessary to correct the QT interval for the heart rate; this is known as QTc
[55] msec is an abbreviation for millisecond
[56] Exhibit 1, Tab 17.1, Report from Associate Professor David Mountain dated 10 March 2023, p.4

increased risk of a fatal ventricular arrhythmia.[57] Mr Veltman's treating doctor in the ED at RPH regarded his ECG reading as normal.[58]

80. Professor Mountain explained that ECG machines are set up to "*over read, be very sensitive*" in order not to miss anything, and the Bazett's formula is generally used as a calculation which tends to overestimate the QTc.[59] Professor Mountain also noted that the American College of Psychiatry has suggested not using machine generated QTc readings because of this significant overestimation, preferring direct calculation using different formulae.[60]

81. However, to add to the complexity, there are at least six different formulae for QTc calculations, as well as a validated nomogram.[61] Of these seven different means for QTc calculations, Professor Mountain noted that for at least four of these calculation methods, the estimated QTc for Mr Veltman's ECG on 15 July 2020 would be within normal limits.[62]

82. Professor Mountain expressed the following opinion: "*Overall, I think the ECG was not grossly abnormal, although it would have been better to have documented why the machine generated QTc was felt to be erroneous.*" [63] However, Professor Mountain also noted the possibility that drugs like Acuphase could lead to a more prolonged QTc after the initial ECG.[64]

83. Professor Joyce indicated that Mr Veltman had four ECGs when he attended the ED at RPH on 21 and 22 March 2020, and 12 May 2020. He noted that the QTc reading on 15 July 2020 was higher than those readings from March and May 2020.[65] Although he noted that the ECG reading on 15 July 2020, "*did suggest a propensity to cardiac arrhythmias, which might then increase the risk from anti-psychotic drugs including Zuclopenthixol Acetate*",[66] Professor Joyce clarified at the inquest:[67]

[57] Ventricular arrhythmias are abnormal heart beats that originate in the lower heart chambers that may result in a cardiac arrest
[58] Ts 14.11.2023 (Dr de Baroid), p.23
[59] Exhibit 1, Tab 17.1, Report from Associate Professor David Mountain dated 10 March 2023, p.4
[60] Exhibit 1, Tab 17.1, Report from Associate Professor David Mountain dated 10 March 2023, p.4
[61] Exhibit 1, Tab 17.1, Report from Associate Professor David Mountain dated 10 March 2023, p.4
[62] Exhibit 1, Tab 17.1, Report from Associate Professor David Mountain dated 10 March 2023, p.4
[63] Exhibit 1, Tab 17.1, Report from Associate Professor David Mountain dated 10 March 2023, p.4
[64] Exhibit 1, Tab 17.1, Report from Associate Professor David Mountain dated 10 March 2023, p.4
[65] Exhibit 1, Tab 15.3, Report from Professor David Joyce dated 5 September 2022, p.10
[66] Exhibit 1, Tab 15.3, Report from Professor David Joyce dated 5 September 2022, p.10

> And at the end, the observation would have to be is that there was a little bit of stretching out of the QT interval in the very last ECG, the one that was done on the morning of 15 July, compared with some previous ones which had been, pretty much, unambiguously normal. But when we go and then do the specific measuring on it and we apply all the different forms of correction that different people have suggested, it only leaves us with the most faintly increased concern that those drugs might have caused an arrhythmia…

84. I also note that Dr Daithi de Baroid (Dr de Baroid), the RPH Emergency Physician in charge on 15 July 2020, was also of the view that the ECG on 15 July 2020, "*hadn't shown any abnormalities*".[68]

85. After a careful consideration of the relevant evidence, I am satisfied that the ECG reading on 15 July 2020 was appropriately considered to be within a normal range. It therefore need not have raised a concern that Mr Veltman had an increased risk of a fatal ventricular arrhythmia.

The delay in transferring Mr Veltman from RPH to BHS on 15 July 2020

86. Within a matter of hours of Mr Veltman's attendance to the ED at RPH, efforts were being made to transfer him to a mental health locked ward.[69] The EMHS Bed Blow Manager was responsible for finding the appropriate bed and the documentation suggests a bed was found in the locked ward at BMHS by 11.27 am.[70] However, Mr Veltman did not arrive at BMHS until 5.40 pm. This was 13 hours after he had been admitted to the ED at RPH.

87. When asked if he considered this a delayed transfer, Professor Mountain stated: [71]

> Yes, it is a delay transfer, being well outside the four hours for ED access targets and beyond the eight hours that meets the definition of access block (delay to admission) by ACEM.[72]
>
> Any patient spending longer than 12 hours in an ED is severely delayed. This is now unfortunately, and for the last decade or more, a routine feature of the care of our sickest psychiatric patients due to the severe lack of capacity in our acute psychiatric hospital system. Delays of over five days have occurred in our system

[67] Ts 16.11.2023 (Professor Joyce), p.343
[68] Ts 14.11.2023 (Dr de Baroid) p.65
[69] Exhibit 4, Letter from Nigel Rogers to counsel assisting (undated), with attachments
[70] This was the time that the "*Form 4A - Transport Order*" had been completed
[71] Exhibit 1, Tab 17.1, Report from Associate Professor David Mountain dated 10 March 2023, p.5
[72] Australasian College for Emergency Medicine

> for psychiatric patients and delays of over 24 hours for psychiatric patients stuck in ED are not uncommon. It is symptomatic of a severely over capacity and failed system of care. The staff and hospitals involved are not able to manage patients expeditiously in the current environments because of the severe lack of beds and staff in our acute psychiatric system.

88. Sadly, the Court is only too familiar with these observations by Professor Mountain regarding the chronic shortage of mental health beds. It is almost trite to say that EDs with their bright lighting, and constant noise and activity are completely unsuitable for the care and treatment of patients experiencing psychotic episodes. Nevertheless, that is the environment where such patients frequently remain for prolonged periods of time.

89. The lack of beds in mental health wards provided the explanation for the evidence of Dr Meintjes that Mr Veltman's wait for a transfer was *"actually quite short*".[73] In his experience it was not uncommon for patients more agitated than Mr Veltman to be in the ED for 24 to 36 hours, and sometimes 48 hours.[74]

90. Dr de Baroid painted an even bleaker picture, stating that ED patients can be waiting for four to five days for a "*locked bed*".[75] With respect to available beds in locked mental health wards, Dr de Baroid explained:[76]

> It is normally – as I mentioned, 100% occupancy rate. There is very rarely an unoccupied bed in the State. And so there will regularly be a four or five person queue in each emergency department of all the tertiary sites awaiting one of these beds.

91. Even when a locked bed becomes available, Dr de Baroid explained that delays can then be experienced in arranging the transport as only one ambulance company has been given the contract to move patients. In addition, there is also a need to arrange a police escort for all involuntary patients.[77]

[73] Ts 14.11.2023 (Dr Meintjes), p.41
[74] Ts 14.11.2023 (Dr Meintjes), p.42
[75] Ts 14.11.2023 (Dr de Baroid), p.78
[76] Ts 14.11.2023 (Dr de Baroid), p.78
[77] Ts 14.11.2023 (Dr de Baroid), p.80

92. As of July 2020, RPH did not have an involuntarily inpatient mental health ward.[78] Consequently, Mr Veltman had to undergo a transfer to another hospital with a locked ward to receive treatment for his mental health. I accept Professor Mountain's opinion that a psychiatric patient spending longer than 12 hours in an ED is "*severely delayed*". However, given the prevailing circumstances, the time it took Mr Veltman to be transferred to BHS could not be the subject of any criticism. I therefore accept the submission by Mr Harwood, counsel for the EMHS, that the timing of the transfer was less than ideal but in context was not unreasonable. I also accept his submission that Mr Veltman was accepted at BHS relatively early and the further delay was most likely due to the unavailability of the actual transport, whether by the ambulance company or by police for the escort.[79]

Was all relevant information from RPH received at BHS?

93. It was not in dispute that part of the documentation from RPH to BHS should have included an up-to-date medication chart for Mr Veltman. However, the medication chart from RPH that was in Mr Veltman's medical records at BHS did not have a complete record of the medications given to Mr Veltman in the ED prior to his transfer. Significantly, it did not have an entry that the prescribed amount of 150 mg of Acuphase was actually given. It also did not have all the entries of when ketamine had been administered, with the last entry being at 8.28 am on 15 July 2020.[80] I accept that a reading of this medication chart would indicated that the Acuphase, although prescribed, had not been given to Mr Veltman.

94. An up-to-date medication chart would have shown that the Acuphase was actually given to Mr Veltman at 9.58 am on 15 July 2020 and that he received another 15 intravenous boluses of ketamine after 8.28 am, with the last being administered at 4.31 pm on 15 July 2020.[81]

95. I am satisfied that a medication chart was emailed to the BHS on the morning of 15 July 2020. This was at the time when RPH was seeking the transfer of Mr Veltman. Obviously, this medication chart only had a record

[78] Ts 14.11.2023 (Dr Meintjes), p.34
[79] Ts 17.11.2023 (closing submissions by Mr Harwood), p.411
[80] Exhibit 1, Tab 14, Bentley Health Service medical records, Medication Chart, pp.66-67
[81] Exhibit 1, Tab 13, Royal Perth Hospital medical records, Medication Chart , pp.47-48

of the medications given to Mr Veltman as at that time. However, once a transfer has been arranged and the patient is about to be taken to the other hospital, an up-to-date medication chart is to be photocopied and placed in an envelope that accompanies the patient.[82]

96. The person responsible for undertaking that task is the Psychiatric Liaison Nurse (PLN) in the ED at RPH. The PLN on duty at the relevant time was Lilian Mortimer (Ms Mortimer). Ms Mortimer's evidence at the inquest was the envelope that the up-to-date medication chart is placed into would not be sealed.[83] Understandably, Ms Mortimer did not have an independent recollection of placing an up-to-date medication chart into the envelope that accompanied Mr Veltman. Nevertheless, she was extremely firm in her recollection that she would have sent an up-to-date medication chart to BHS.[84]

97. I am unable to determine why it was that the up-to-date medication chart was not in Mr Veltman's medical records at BHS. At the inquest, Mr Harwood outlined the following explanations for what had happened:[85]

- The up-to-date medication chart was not placed into the envelope with the other relevant documents at RPH.
- The up-to-date medication chart was placed into the envelope at RPH and was misplaced during the transfer.
- The up-to-date medication chart was placed into the envelope at RPH and was misplaced at BHS.

98. Although I accept that one of these scenarios had occurred, I cannot be satisfied to the required standard which one was responsible for the absence of an up-to-date medication chart from RPH in Mr Veltman's medical records at BHS.

99. I am satisfied that given his level of agitation in the ED at RPH, it was necessary for Mr Veltman to be sedated with ketamine and Acuphase. I accept the following observations by Professor Mountain:[86]

[82] Ts 15.11.2023 (Ms Mortimer), p.240
[83] Ts 15.11.2023 (Ms Mortimer), p.240
[84] Ts 15.11.2023 (Ms Mortimer), pp.245-256
[85] Ts 15.11.2023 (Mr Harwood), p.239
[86] Exhibit 1, Tab 17.1, Report from Associate Professor David Mountain dated 10 March 2023, p.3

> The choice of medications showed both thought and care and were titrated to maintain some control without excessive sedation. The doses of ketamine used were large but titrated in sensible increments and appropriate to the circumstances. The use of Zuclopenthixol was also reasonable as it has a reasonable side effect profile, particularly in those with known underlying heart disease.

100. However, it was unfortunate that, for whatever reason, an incomplete medical chart which did not record the Acuphase had been administered and did not record all the ketamine boluses, was placed on Mr Veltman's medical records at BHS and was never subsequently updated.

Should the lack of an up-to-date medication chart been identified at BHS?

101. I have only considered this question with respect to staff at BHS. That is because I am not able to find whether or not an up-to-date medication chart was actually transferred to BHS. However, I am satisfied that such a medication chart did not find its way onto Mr Veltman's medical records with BHS, nor was it available to Dr Velure when she admitted Mr Veltman to BMHS. The handwritten entries by Dr Velure in Mr Veltman's Integrated Progress Notes stated: "*Given ketamine infusion. Chartered for Zuclopenthixol Acetate 150 mg by Consultant Psychiatrist, Dr Budrikis, not given according to medication chart*".[87]

102. However, there were other documents from RPH that were transferred and in Mr Veltman's medical records at BHS. One of those documents was the Mental Health Medical Handover (the Handover) which had been completed at 10.22 am on 15 July 2020 by Dr de Baroid.[88]

103. The front page of the Handover has a box headed "*Medications*". There is an entry within that box that stated: "*Recent: attach ED medication chart*". Alongside that entry, Dr de Baroid had written:[89]

> Ketamine boluses
> Acuphase

[87] Exhibit 1, Tab 14, Bentley Health Service medical records, Integrated Progress Notes, p.128
[88] Exhibit 1, Tab 14, Bentley Health Service medical records, Mental Health Medical Handover, p.33
[89] Exhibit 1, Tab 14, Bentley Health Service medical records, Mental Health Medical Handover, p.34

104. At the inquest, Dr de Baroid said he had made those entries to highlight: "*Two medications that are unusual and should forewarn whichever site might look after him next and inform their care.*"[90]

105. In her evidence at the inquest, Dr Velure said that the Handover, "*should have been there and I should have read it … but I can't remember specifically seeing it.*"[91]

106. When shown the Handover at the inquest and asked whether it would have given her cause to contact RPH or raise any questions for her, Dr Velure answered: "*Well it would confirm that it* [Acuphase] *definitely was considered. I – but the medication chart does trump something like that.*"[92] Dr Velure then added: "*So to me, looking at it* [the Handover] *now, that does not confirm that Acuphase has been given.*"[93]

107. When I asked that if in fact the Acuphase had not been given, why would the Handover have it written down as being a recent medication, Dr Velure replied: "*Well, I can't tell you exactly why, but sometimes these things are written in advanced.*"[94]

108. I struggle with the logic of that answer as it related to Dr de Baroid's entries. It would make no sense for Dr de Baroid to make the effort of writing down on the Handover that Acuphase was a recent medication given to Mr Veltman if it was not. Furthermore, he had also written down that ketamine was a recent medication given to Mr Veltman. As Dr Velure was aware of that fact from the medication chart that BHS had, it would logically follow that the same applied to the Acuphase which was written immediately below "ketamine" by Dr de Baroid.

109. I also asked Dr Velure these questions at the inquest:[95]

> However, if there is a contradiction between one document, in this case the medical handover, and the medication chart, isn't it a case of it being your responsibility to clarify which document is the more accurate one?---Yes. It is my responsibility to – yes – to admit the patient and – yes – clarify. I guess I can only

[90] Ts 14.11.2023 (Dr de Baroid), p.63
[91] Ts 14.11.2023 (Dr Velure), p.125
[92] Ts 14.11.2023 (Dr Velure), p.96
[93] Ts 14.11.2023 (Dr Velure), p.96
[94] Ts 14.11.2023 (Dr Velure), pp.96-97
[95] Ts 14.11.2023 (Dr Velure), p.99

> say that I was so convinced he didn't have Acuphase and if he had had Acuphase, it wouldn't have been a problem for me because there are very strict protocols for Acuphase.
>
> Which leads me to my next question. It [Acuphase] is a particular medication that people in your position need to know about. Is that fair to say?---Yes.

110. Dr Velure then accepted, with the benefit of hindsight, she should have made a call to RPH to clarify whether Acuphase had been administered to Mr Veltman.[96]

111. I readily appreciate that given the passage of time, Dr Velure would not be expected to have specifically remembered seeing the Handover. However, it clearly was on the BHS medical records. I am therefore satisfied to the required standard that the Handover was available to Dr Velure and it should have been read by her. For whatever reason, Dr Velure failed to pick up on the fact the Handover recorded that Acuphase had been administered to Mr Veltman. If for some reason the Handover was not available to Dr Velure, her evidence at the inquest was that: "*Generally if I think we definitely do need to have more information, then I would generally ask, like the senior nurse to try and get that*".[97]

112. I am not satisfied Dr Velure required the benefit of hindsight in order to have clarified the situation with RPH.

113. The sedating effect of the ongoing boluses of ketamine until about 4.30 pm would have worn off by the time Mr Veltman was transferred to BHS.[98] In contrast, the Acuphase Mr Veltman had received "*is designed to release the drug at a rate to reach peak concentrations at around one to 1½ days after injection*".[99]

114. Having carefully considered all the available information, and having applied the ***Briginshaw*** principle and being mindful not to inset hindsight bias, I am satisfied that Dr Velure erred in failing to note that Acuphase had been administered to Mr Veltman on the day that she was admitting him into BMHS. To use her own words, Dr Velure was aware of the "*very*

[96] Ts 14.11.2023 (Dr Velure), p.100
[97] Ts 14.11.2023 (Dr Velure), p.93
[98] Exhibit 1, Tab 17.1, Report from Associate Professor David Mountain dated 10 March 2023, p.3
[99] Exhibit 1, Tab 15.3, Report from Professor David Joyce dated 5 September 2022, p.9

strict protocols"[100] for the supervision and monitoring of patients who have been medicated with Acuphase. Due to her oversight, those protocols were not put in place for Mr Veltman following his admission to the locked ward at BMHS. Dr Velure ought to have identified the discrepancy between the medication chart and the Handover as to whether the prescribed Acuphase had actually been administered. And if she had any doubt, then contact ought to have been made with RPH.

115. I am also satisfied to the required standard that something more than just a cursory glance at the medication chart from RPH would have alerted the reader to the fact that it was not up-to-date. The medication chart showed that no medication had been given to Mr Veltman for over eight hours, and that the ketamine which had been intravenously administered four times between 7.00 am and 8.30 am, had seemingly abruptly stopped.[101] A contention that it had stopped because it must have had the effect of calming Mr Veltman does not fit with his highly agitated presentation at BMHS later in the day. Nor does it fit with the Acuphase having been prescribed later that morning.

116. These were obvious "red flags" that should have alerted Dr Velure to the fact this medication chart was not up-to-date. And when the Handover actually specified that Acuphase had been given, the red flags demanding further enquiries to be made became not only larger but began flapping vigorously.

Failure by BHS to apply the Acuphase post-injection monitoring

117. Dr Velure was correct in her recollection regarding the protocols in place for patients who had been medicated with Acuphase. These protocols are set out in a document titled: "*Zuclopenthixol Acetate (Clopixol Acuphase) Intramuscular Injection SOP*" (the Acuphase SOP[102]). As of July 2020, the Acuphase SOP applied to all mental health areas in the EMHS.[103]

118. The Acuphase SOP defines the drug as: "*An intermediate acting psychotic injection indicated for acute psychosis and acute mania where other*

[100] Ts 14.11.2023 (Dr Velure), p.99
[101] Exhibit 1, Tab 14, Bentley Health Service medical records, Medication Chart, pp.66-67
[102] Standard Operational Procedure
[103] Letter from Dr Vinesh Gupta to the Court dated 30 May 2024, p.6

treatment modalities have been ineffective."[104] Professor Joyce gave a similar description of Acuphase, stating that it has a "*particular utility in managing psychotic illness with prominent agitation, aggression or manic manifestation*".[105]

119. The Acuphase SOP also notes that it is a drug that can cause prolongation of QT interval and has been associated with life-threatening arrhythmia.[106] Under the heading "*Purpose*", the Acuphase SOP states that its aim is "*to ensure the safe prescription, administration and monitoring of consumers*" following an intramuscular injection of Acuphase.[107]

120. The Acuphase SOP clearly specifies there is a need for careful monitoring of patients post-injection. Vital signs are to be documented on the Adult Observation and Response Chart (AORC) and a record made on the provided Post Acuphase Monitoring Checklist (the Checklist) which is to be placed in the patient's Integrated Progress Notes. The patient's level of consciousness must also be monitored.[108] Amongst the other required documentation is for mental state observations to be recorded in the patient's Integrated Progress Notes.[109]

121. Relevant to when Mr Veltman was admitted to BMHS,[110] from six hours to 12 hours post-injection, the Checklist required two-hourly observations of the patient and then for every four hours.[111]

122. When the patient is asleep, the Acuphase SOP required monitoring of the patient's respiratory function on an hourly basis, including respiratory rate, rise and fall of chest, and noting any sounds suggestive of obstructive or impaired breathing such as snoring.[112]

123. On those occasions when he was asleep from 7.00 pm on 15 July 2020 to 1.00 pm on 16 July 2020, Mr Veltman's respiratory rates were recorded as

[104] Exhibit 6.3, Acuphase SOP, p.1
[105] Exhibit 1, Tab 15.3, Report from Professor David Joyce dated 5 September 2022, p.9
[106] Exhibit 6.3, Acuphase SOP, p.1
[107] Exhibit 6.3, Acuphase SOP, p.1
[108] Exhibit 6.3, Acuphase SOP, p.4
[109] Exhibit 6.3, Acuphase SOP, p.4
[110] Which was about seven hours after the Acuphase was given
[111] Exhibit 6.3, Acuphase SOP, Appendix 1, p.9
[112] Exhibit 6.3, Acuphase SOP, p.5

between 16 to 20.[113] Had the Acuphase SOP been applied, this would not have raised any alarms as it states it is only when the patient's respiratory rate is less than 10 breaths per minute that action should be taken.[114] I am also satisfied that the observations being made of Mr Veltman during his time in the BMHS did accord with the Checklist and, in fact, exceeded what it specified.

124. However, Mahmud Abubakar (Mr Abubakar), the nursing co-ordinator on 16 July 2020, was asked if he would have done anything differently if he knew Mr Veltman had previously been given Acuphase. He answered: "*It makes all the difference in the world*".[115] Mr Abubakar went on to explain:[116]

> That would have prompted me to be more proactive. One piece of information can make a big difference in care.
>
> It is a different risk rating now because he is a new admission, he is diabetic, he has got medical issues in obesity and cardiovascular history, sleeping deeply and he has had Acuphase; that makes a difference in how you look after them.
>
> I might not have allocated [Mr Veltman] to Nurse Kong[117] in these circumstances. If I did, I would have checked the patient myself as well.
>
> When Nurse Kong told me [Mr Veltman] was not waking up, I would have said let's go and have a look at him, just to make sure he's fine. It doesn't hurt to just walk across and have a look.
>
> There are also post Acuphase observations. There was a checklist that we usually put on the board inside the nurses' station.
>
> The checklist will also be a reminder for me to remember to go to [Mr Veltman] to check on him myself. I tend to do that as nurse co-ordinator especially if I have allocated a junior nurse

125. I accept this explanation from Mr Abubakar and am satisfied the monitoring of Mr Veltman by nursing staff at BMHS would have been greater had they been aware he had received Acuphase at RPH before his transfer.

126. Given that Acuphase can cause QT prolongation, the Acuphase SOP also specifies that an ECG at 24 hours post-injection is required to check for

[113] Statement of Mahmud Abubakar dated 31 May 2024, Attachment MA3
[114] Exhibit 6.3, Acuphase SOP, p.5
[115] Statement of Mahmud Abubakar dated 31 May 2024, pp.25-26
[116] Statement of Mahmud Abubakar dated 31 May 2024, p.26
[117] At the time Mr Kong was regarded as a junior nurse, having only commenced working as a nurse five months earlier: Ts 15.11.17 (Mr Kong), p.177

QT prolongation.[118] For Mr Veltman that would have been at or about 10.00 am on 16 July 2020. However, as no staff member at BHS had become aware he had been given Acuphase the previous day, no consideration was given to performing an ECG at this time.

127. I accept that Mr Kong had unsuccessfully (and coincidentally) tried to wake Mr Veltman up for his physical observations at 10.00 am on 16 July 2020 (and at other times after that).[119]

128. Mr Abubakar remembered that Mr Kong had told him that Mr Veltman was sleeping and that this was around 10.00 am or 11.00 am. Mr Abubakar recalled:[120]

> I remember I was not worried that [Mr Veltman] was still asleep. When patients come in, they are very unwell at the time they are needing to come to a locked ward. Whatever has bought them in takes a toll on them mentally and physically. One of our practices is that we let them catch up on sleep if they appear to need it. Especially on the first day we will let them sleep in a little bit. That said, if we have concerns for their physical or mental health, we will wake them up.

129. However, if Mr Abubakar had been aware of the Acuphase given to Mr Veltman the previous day, he may have taken a different approach. As he explained: [121]

> If a patient is sleeping, you are allowed to write that on the post Acuphase checklist. However, if you have concerns, you can assess and escalate to senior staff or medical team.
>
> I might have had a chat with the doctor or with the BeSAFE team and asked them what they think if the patient is sleep when the 24-hour ECG is due and I'm trying to wake them up but breathing and everything else seems fine.
>
> If you're thinking about it then that means the risk is high, so you're leaning more towards a Code Blue. The BeSAFE team attend the Code Blue and do a three lead ECG.

130. I am satisfied that if staff at BMHS had been aware Mr Veltman received the Acuphase injection at RPH, they would have applied a higher level of monitoring to him in accordance with the Acuphase SOP. But even if staff had this awareness, I am not able to say that if Mr Veltman was woken up

[118] Exhibit 6.3, Acuphase SOP, p.5
[119] Exhibit 1, Tab19, Statement of Matthew Kong dated 1 November 2023, p.5
[120] Statement of Mahmud Abubakar dated 31 May 2024, pp.19-20
[121] Statement of Mahmud Abubakar dated 31 May 2024, p.27

at or about 10.00 am on 16 July 2020, an ECG would have necessarily been performed. That is because the consent of a patient is required before an ECG can be carried out. How Mr Veltman behaved regarding previous attempts at physical examinations (including ECGs) may provide an indication of what would have happened if he was awakened on the morning of 16 July 2020.

131. On 19 and 20 May 2020, during his penultimate admission at BHS, Mr Veltman was uncooperative during physical examinations, and an ECG was not completed on 20 May 2020 due to his non-compliance. On 5 June 2020, Mr Veltman threatened staff after he was given Acuphase and refused post-Acuphase observations.[122] As he was also uncooperative on 15 July 2020 in the ED at RPH and then at BHS regarding physical observations, this pattern of behaviour makes it questionable whether he would have agreed to an ECG on 16 July 2020.

132. Based on all the information available to me, I am also unable to determine whether a closer monitoring of Mr Veltman at BMHS would have prevented his death. In drawing that conclusion, I have relied on the following observation by Professor Joyce:[123]

> Sudden death seems to be unexpectedly common among people who are admitted to psychiatric institutions with uncontrolled psychosis that includes protracted (typically days) of uncontrolled agitation and unremittent physical activity, unbroken by unaffected sleep, fluid intake or food and where obesity, sleep apnoea and heart or lung disease coexist. The role of exhaustion is not characterised, simply because we have no clinical methods for measuring exhaustion, no clear understanding of its physiology and biochemistry and no means to quantitate any links between exhaustion and risk of dying.

Adequacy of resuscitation efforts

133. In his report to the Court, Professor Mountain was critical of the resuscitation upon Mr Veltman on 16 July 2020.[124]

134. However, subsequent to Professor Mountain's report, the Court received additional information from medical staff who were either part of the MET

[122] Exhibit 1, Tab 14, Bentley Health Service medical records, Discharge Summary dated 7 July 2020, p.2
[123] Exhibit 1, Tab 15.3, Report from Professor David Joyce dated 5 September 2022, p.14
[124] Exhibit 1, Tab 17.1, Report from Associate Professor David Mountain dated 10 March 2023, pp.7-8

that attended to Mr Veltman or who assisted in the resuscitation efforts.[125] Dr Linda Vu (Dr Vu), the attending medical officer for the MET, also gave oral evidence at the inquest.[126]

135. This evidence clarified the concerns raised by Professor Mountain and I am now satisfied that the resuscitation efforts were appropriate. This conclusion was not in dispute at the inquest with Ms Allan-McConchie submitting: "*Upon the clarification of the correct equipment being available, it certainly appears that all efforts were utilised.*"[127]

Mr Veltman's need for a CPAP machine

136. The medical records for Mr Veltman at BHS frequently refer to his sleep apnoea, his use of a CPAP machine and the fact that he had one. Being a locked ward, ward 6 at BMHS does not have CPAP machines available to patients.[128]

137. The question arose at the inquest as to whether Mr Veltman ought to have been provided with either his own CPAP machine or one from BHS following his admission to BMHS on 15 July 2020.

138. Dr Velure did not make any attempts to organise a CPAP machine for Mr Veltman during his admission.[129] In fact, on the information available to me, no consideration was given to whether Mr Veltman required a CPAP machine during his final admission to BHS.

139. At the inquest, Professor Mountain was given the hypothetical scenario where Mr Veltman had access to a CPAP machine and he utilised it as he slept on 16 July 2020. The question was asked whether that would have had any impact on the ultimate outcome. Professor Mountain responded:[130]

> No not certainly … We don't really know whether it was sleep apnoea and hypoxia or a primary arrhythmia that caused his death. But if he had been willing to have the CPAP machine on and kept it on then, yes, it would have probably improved his breathing; reduced the amount of time he was likely to be very

[125] Exhibit 1, Tab 22, Statement of Dr Linda Vu dated 5 November 2023, Exhibit 1, Tab 23, Statement of Fiona Bolingbroke dated 6 November 2023, Exhibit 3, Statement of Thomas Ansell dated 13 November 2023
[126] Ts 15.11.2023 (Dr Vu), pp.186-194
[127] Ts 17.11.2023 (closing submissions by Ms Allan-McConchie), p.383
[128] Ts 15.11.2023 (Dr Velure), p.124
[129] Ts 15.11.2023 (Dr Velure), p.116
[130] Ts 16.11.2023 (Professor Mountain), pp.300-301

> hypoxic and desaturated. And that clearly would, you know, decrease the stress on his heart. That is quite hypothetical though. Because, I think it's unlikely that he would have been willing.

140. There is a sound basis for Professor Mountain's observation that Mr Veltman would unlikely be willing to use a CPAP machine. At his prior admission to BHS, there had been poor compliance with the CPAP machine which led to its removal from Mr Veltman at one stage.[131] Consequently, there is some force to this submission from Mr Harwood:[132]

> Now there was a pathway to access a CPAP for Mr Veltman if staff or Mr Veltman or indeed Dr Veltman [Mr Veltman's brother] had wanted to initiate that process, and the clinicians at Bentley Hospital on that night and that morning might well have not considered this to be an urgent matter for another reason ...
>
> And that is that Mr Veltman was not in a position to use the CPAP at that point in time. So he had refused all attempts on this admission to Bentley Hospital at assessment or vital signs. He was uncooperative at this point in time. This is no criticism of Mr Veltman who was obviously suffering an acute episode of his mental illness.
>
> The usual path for Mr Veltman was his condition would become more under control as he spent some time as an inpatient, and as that progressed, he may well be in a position to utilise a CPAP. But in that first 12 to 18 hours of his admission at Bentley, he was not in a position to do so, and so it is not surprising that this wasn't a top priority for the staff.

141. It is also relevant to note that the respiratory rates which had been monitored hourly when Mr Veltman was asleep were normal.[133] Nor was there any recording of Mr Veltman experiencing laboured breathing.

142. I am satisfied that it was not inappropriate for BHS to have not followed up Mr Veltman's requirement of a CPAP machine so soon after his admission. I am satisfied that this matter would have likely been explored in more detail once Mr Veltman's levels of agitation had subsided. This could have potentially been done at the medical review that was planned for 1.40 pm on 16 July 2020.

143. Had there been a passage of days rather than a number of hours prior to Mr Veltman's death without the question of a CPAP machine being

[131] Exhibit 1, Tab 14, Bentley Health Service medical records, Discharge Summary dated 7 July 2020, p.3
[132] Ts 17.11.2023 (closing submissions by Mr Harwood), p.436
[133] Exhibit 1, Tab 14, Bentley Health Service medical records,

addressed by BHS staff, then my finding in this area may well have been very different.

Mr Veltman's next of kin

144. There was conflicting information in Mr Veltman's medical records at RPH and BHS as to the identity of his next of kin.

145. The Mental Health Assessment form from RPH dated 15 July 2020 that was completed by Dr Meintjes listed Ms Veltman as the next of kin.[134]

146. However, an entry into RPH's Emergency Department Information System made at 3.47 pm on 15 July 2020 listed Mr Veltman's brother as the next of kin.[135] The Client Management Plan from BHS dated 4 July 2020 refers to Mr Veltman's brother as the next of kin who had been informed of Mr Veltman's discharge.[136]

147. As to 15 and 16 July 2020, I am satisfied of the following:

- Ms Veltman was not notified by RPH that Mr Veltman had been admitted to the ED at RPH;
- Ms Veltman was not notified by BHS after Mr Veltman had been transferred to BHS;
- Ms Veltman was not notified by BHS of Mr Veltman's death.[137]

148. I understand, given her close bond with Mr Veltman, that not being advised of these events would have been extremely distressing for Ms Veltman in the aftermath of her brother's death. I also accept this distress would have been magnified as it was only shortly before Mr Veltman's death that Ms Veltman had contacted his guardian expressing her concern that he would die if he was to be continually discharged into the community from mental health wards.[138]

149. However, I am satisfied that Mr Veltman's brother (as the other listed next of kin) was aware Mr Veltman was going to be taken to the ED at RPH.

[134] Exhibit 1, Tab 13, Mental Health Assessment, p.1
[135] Exhibit 4, Screen shot of the Emergency Department Information System entry
[136] Exhibit 1, Tab 14, Bentley Health Service medical records, Client Management Plan dated 4 July 2020, p.2
[137] Exhibit 1, Tab 27, Statement of Frances Veltman dated 9 November 2023
[138] Exhibit 1, Tab 27, Statement of Frances Veltman dated 9 November 2023, p.9

I am also satisfied that as he collected Mr Veltman's personal belongings from the ED at RPH on the afternoon of 15 July 2020, he would have been aware of Mr Veltman's transfer to BHS.[139] I am also satisfied that the consultant psychiatrist on duty at BMHS notified Mr Veltman's brother as the next of kin within a reasonable time after his death.[140]

150. Ms Veltman was Mr Veltman's legal guardian from 2004 to sometime in 2016 or 2017.[141] After that time, the Public Advocate became Mr Veltman's guardian (although it was not Ms Veltman's intention that this situation would be permanent).[142]

151. Thereafter, it was the understanding of Ms Veltman that she was listed as his next of kin. That understanding was well-founded. I accept this account from Ms Veltman: "*I played a very active role in* [Mr Veltman's] *management and his life until the time of his death, prior to and after the period of time I was his legal guardian*".[143]

152. This role was a very important one. I also accept Ms Veltman's account that whenever she was notified of Mr Veltman's admission to a hospital, she would always explain his special needs including his heart disease, diabetes and the requirement of his CPAP machine.[144]

153. During one of the COVID-19 lockdowns in 2020, Ms Veltman described contacting BHS in an effort to locate him. This was when she was first informed she was not listed as the next of kin. As a result, Ms Veltman was not even told whether her brother was a patient at BHS.[145]

154. During Mr Veltman's penultimate admission to BHS,[146] Ms Veltman outlined that she again contacted the hospital to provide information regarding her brother's comorbidities, including his requirement for a CPAP machine. She informed the Court that during this conversation, she

[139] Ts 16.11.2023 (Dr Gupta), pp.285-286
[140] Exhibit 1, Tab 14, Bentley Health Service medical records, Integrated Progress Notes
[141] Exhibit 1, Tab 27, Statement of Frances Veltman dated 9 November 2023, pp.1 and 6
[142] Exhibit 1, Tab 27, Statement of Frances Veltman dated 9 November 2023, p.6
[143] Exhibit 1, Tab 27, Statement of Frances Veltman dated 9 November 2023, p.7
[144] Exhibit 1, Tab 27, Statement of Frances Veltman dated 9 November 2023, p.7
[145] Exhibit 1, Tab 27, Statement of Frances Veltman dated 9 November 2023, p.8
[146] From 13 May to 7 July 2020

was again told that as she was not listed as the next of kin, they would not speak to her or listen to any relevant medical information that she had.[147]

155. In his evidence at the inquest, Dr Gupta provided a possible explanation as to why no contact was made with Ms Veltman on 15 July 2020, despite her name and her contact number appearing as next of kin on the Mental Health Assessment form. He said that if he was the treating doctor and he became aware that a family member of the patient, who was also a doctor,[148] knew of the hospital admission then he would not necessarily feel the need to contact another family member.[149] Nevertheless, Dr Gupta also acknowledged that with respect to the notification process in this instance: "*I completely agree, there have been things that could have been done better*".[150] That concession was properly made.

156. The EMHS does not have specific family liaison staff. Social workers will often perform the role of communicating with family members. In addition, the treating team (including psychiatrists and registrars) must also be in communication with family members throughout a relative's treatment in accordance with the EMHS policy, "*Rights of Carers and Personal Support Persons*".[151] This policy uses the term "*close family member*" as defined in section 281 of the *Mental Health Act 2014* (WA) rather than "*next of kin*".

157. I am satisfied that appropriate notifications were made to Mr Veltman's brother in his capacity as a "*close family member*". I also note that the *Mental Health Act 2014* (WA) permits fulfilment of a requirement if there is compliance with at least one close family member.[152]

158. I am not aware how it came about that Ms Veltman was removed as the next of kin (at least from the medical records at BHS) sometime in the period before Mr Veltman's death. However, what I am able to say is it was an unfortunate outcome, as on all the information available to me, it was Ms Veltman who provided the most assistance to the hospitals

[147] Exhibit 1, Tab 27, Statement of Frances Veltman dated 9 November 2023, p.8
[148] Mr Veltman's brother is a doctor
[149] Ts 16.11.2023 (Dr Gupta), p.286
[150] Ts 16.11.2023 (Dr Gupta), p.286
[151] Letter from Nigel Rogers, EMHS senior medico legal officer, to the Court (undated), p.2
[152] *Mental Health Act 2014* (WA) s 283(2)

regarding her brother's extensive medical needs, including the need for his CPAP machine.

QUALITY OF MR VELTMAN'S SUPERVISION, TREATMENT AND CARE

At the ED of RPH on 15 July 2020

159. Professor Mountain described the quality of Mr Veltman's care in the ED at RPH as follows:[153]

> Overall, the care in RPH ED was of a high standard throughout with care and thought with treatment decisions, potential complications and balancing medical and psychiatric needs shown throughout his stay.

160. The only issues raised by Professor Mountain was the out-of-date medication chart that BHS received, and a lack of documentation as to why the ECG on 15 July 2020 was described as normal.

161. With respect to the first of these issues, as I have outlined above, I cannot be satisfied to the required standard where the fault lay for BHS not having an up-to-date medical chart for Mr Veltman. As to the second issue, I am satisfied it had no impact on the treatment and care provided to Mr Veltman as Professor Mountain was not critical of the ECG being described in this way.

162. I agree with Professor Mountain's opinion that, overall, the care of Mr Veltman at RPH was of a high standard. I am therefore satisfied that the supervision, treatment and care of Mr Veltman in the ED at RPH was appropriate.

At BHS on 15 and 16 July 2020

163. The level of Mr Veltman's supervision, treatment and care at BMHS was impeded by the lack of knowledge that Mr Veltman had received an Acuphase injection less than eight hours before he was admitted. Although I am satisfied that at the time of his admission to BMHS, the admission doctor did not have an up-to-date medication chart for Mr Veltman, there was other material available to her (namely the Handover) which clearly indicated he had been given Acuphase at RPH. I have therefore found that

[153] Exhibit 1, Tab 17.1, Report from Associate Professor David Mountain dated 10 March 2023, p.2

if it was unclear whether Acuphase had been administered to Mr Veltman there should have been a follow up with the ED at RPH to clarify when and how much Acuphase had been injected.

164. I am satisfied it was a significant oversight not to do this as it meant the protocols for the Acuphase post-injection monitoring of Mr Veltman were not followed.

165. Although I have not found that this oversight contributed to Mr Veltman's death, it was an unfortunate blight on what would have otherwise been an adequate level of supervision, treatment and care at BHS.

IMPROVEMENTS SINCE MR VELTMAN'S DEATH [154]

166. As would be expected of all government entities, the EMHS is always on the pathway of continual improvement with respect to the treatment and care of those requiring its services. Given there is ordinarily a gap of some duration between the date of the death requiring a mandatory inquest and the inquest's date, entities connected to the death will often implement changes that are designed to improve practices and procedures before the inquest is heard.

167. In addition, when the death occurs in a hospital setting, a SAC1 investigation is usually completed well before the inquest has commenced. SAC1 investigations will frequently make recommendations designed to make improvements.

168. The SAC1 investigation into Mr Veltman's death made recommendations in the following three areas:

- Clinical handover and transfer of care process and procedures
- Recognising and responding to clinical deterioration
- Monitoring following the administration of high-risk medications

169. I will now address what has been done by way of improvements in these areas.

[154] Exhibit 1, Tab 12, SAC1 Clinical Incident Investigation Report dated 23 September 2020, Report from Dr Vinesh Gupta dated 30 May 2024

Clinical handover and transfer of care processes and procedures

170. A recommendation was made by the SAC1 investigation in the above area as it found there had been insufficient clinical handover processes from the ED at RPH to BHS. It recommended a working group be established with representatives from emergency departments and mental health.

171. On 3 August 2021, a EMHS Emergency Department and Mental Health Interface Collaborative Working Group was formed (the Working Group). As Dr Gupta explained at the inquest:[155]

> So it is attended by the medical director of emergency department as well as myself as medical director – medical co-director of mental health. Which is also attended by the head of department of emergency department. There are occasions when the operational co-director of mental health is part of that as well. And it is to look at making sure that we are ensuring the best possible holistic care for our patients. Discussing things like bed flow, movement of patients from ED, medical clearances, issues around management of aggression and suicidality, for example. Providing education to each of them around some of those issues, because ED – some of the ED staff have a better understanding of managing things like acute intoxication. But from a mental health point of view, we might educate and work with them on capacity assessment. So if, for example, some patient has been in the ED for a prolonged period of time, the ED consultant can directly contact me and they can escalate it to me … so it can be directly escalated.

172. On advice from the Working Group, the Mental Health Division is currently working on a mental health specific standard operating policy for admission, discharge and transfer. This will encompass the many individual mental health ward-based guidelines and ensure there is continuity throughout.

173. The EMHS "*Clinical Handover Policy*" has been reviewed and updated including the addition of an appendix titled "*Medical Handover Process for Mental Health Inpatient Services*" which includes procedures for the handover of a "*patient of concern*". There now exists more detailed guidance for patients of concern who are mental health patients that have received intravenous or intramuscular sedation in the previous 24 hours.

174. Since 2022, the procedure for transfers within the Royal Perth Bentley Group is that all "ACTIVE" documents[156] (including medication charts and care plans) are delivered in original form with the patient, without

[155] Ts 16.11.2023 (Dr Gupta), p.328

[156] Documents that are currently in use at the patient's bedside (not including the integrated patient record)

photocopying any of these documents. This process should avoid the circumstance of an out-of-date medication chart being used as an updated record.

175. Since 2021, a "Safe Transition of Care" six monthly audit process takes place in order to identify compliance with expected processes. Reports from the audit are provided to relevant organisational committees. As Dr Gupta explained:[157]

> This is an audit which was implemented soon after Mr Veltman's death, where it's a six monthly cycle to audit the transition of care from Royal Perth Hospital site to Bentley site or the other way around as well. So it is to look at the quality of information that is transferred between the two sites. It's an ongoing cycle which helps us identify any ongoing issues, deficits or gaps, and what we need to do to improve them. And, as I was mentioning earlier, so when I'm talking about what's happening now, that's not that nothing has been done in the last two or three years. So what's happening now is that these audits and compliance measures that have been put in place have helped us make changes over the last three years and we keep on identifying more or better ways of doing those things.

Recognising and responding to clinical deterioration

176. The SAC1 investigation noted that the clinical handover process for Mr Veltman, including the identification of him as a "patient of concern" was insufficient.

177. As a result, in April 2021, the EMHS policy, "*Recognising and Responding to Acute Deterioration*", came into effect. This policy directly addressed how to use an AORC to appropriately escalate concerns about a patient's deterioration.

178. In 2021, other relevant changes were made by the EMHS that included:

- Having the BeSAFE team review all patients of concern who are transferred to BHS
- Having a medical officer review all patients of concern within two hours of arrival at BHS

[157] Ts 16.11.2023 (Dr Gupta), p.327

- Having all patients on the locked ward at BHS managed on 15 minute observations until they have been reviewed by their treating doctor

Monitoring following the administration of high-risk medications

179. The SAC1 investigation noted that there was an absence of a consistent hospital-wide Acuphase SOP which resulted in insufficient monitoring and recording of Mr Veltman. It was recommended that a hospital-wide SOP for the use of Acuphase be developed.

180. At the time of Mr Veltman's death, the Acuphase SOP was only in use in mental health areas within the EMHS. On 7 August 2020, an email was sent to all RPH leadership groups and nursing staff that directed them to use the Acuphase SOP. This email also offered education opportunities regarding it. On 15 December 2020, amendments were made to the Acuphase SOP to expressly include application in all patient areas. The Checklist appended to the Acuphase SOP was significantly amended. It was also given a "medical record" number which meant it became a hospital-wide form and became part of the official medical record for the patient.

181. Included in the changes to the Acuphase SOP is that an early medical, SAFE,[158] or BeSAFE review should be considered for obese patients and\or those patients with known or suspected obstructive sleep apnoea.[159] Another change is that where there is evidence of airway obstruction (such as snoring sounds or central cyanosis) then attempts are to be made to reposition the patient's airway or encourage the patient to reposition themselves. If the airway obstruction is not resolved then a medical review is to be sought and a Code Blue initiated if there is difficulty in rousing the patient.[160] A third change is that a flowchart has been attached to the Checklist which provides easy to understand instructions regarding the ECG and vital observations.[161]

[158] SAFE is the RPH equivalent of the BeSAFE team at BHS
[159] Ts 16.11.2023 (Dr Gupta), p.316, Exhibit 6.1, Acuphase SOP (updated version), p.7
[160] Ts 16.11.2023 (Dr Gupta), p.317, Exhibit 6.1, Acuphase SOP (updated version), p.8
[161] Exhibit 6.1, Acuphase SOP (updated version), p.12

Providing CPAP machines to patients in locked mental health wards

182. As the cords to CPAP machines can be used to self-harm, they are not stocked or readily made available within locked mental health wards.

183. Should a CPAP machine be required for a patient in a locked mental health ward then that patient would be subject to continual observation by a member of the nursing staff whilst the CPAP machine is being used.

184. Following the death of Mr Veltman and the issues raised regarding the absence of a CPAP machine for him, the following changes were made.

185. In those circumstances where a patient has needed a CPAP machine previously and there is a likelihood they might need it again, the process now in place is for nursing staff to escalate the matter to the relevant medical staff member who, depending on their assessment, would escalate it to the treating team consultant. If that consultant forms the view that a CPAP machine is required then the matter is forwarded to a respiratory physician. If the respiratory physician determines a CPAP machine is necessary it is provided by the respiratory department or an arrangement is made for the patient to have their own CPAP machine delivered to them.[162]

186. Where there is an acute and unexpected deterioration in an inpatient's breathing at BHS, then the BeSAFE team is contacted and an assessment is made. The situation is then managed on site, including the use of a CPAP machine. Alternatively, a transfer of the patient can be made to RPH for further management, either in the ED, ICU or respiratory department.[163]

The addition of a locked mental health ward at RPH

187. As I have already noted above, there was no locked mental health ward for involuntary patients at RPH in July 2020. That has now changed. In 2022, a 12-bed locked mental health ward at RPH became available.

188. Sadly, however, this has not resulted in a reduction in time for transfers of involuntary patients from the ED at RPH to a mental health ward. This has

[162] Ts 16.11.2023 (Dr Gupta), p.283
[163] Ts 16.11.2023 (Dr Gupta), p.283

been due to a 40% increase in mental health hospital presentations since COVID-19.[164]

189. Given Mr Veltman's physical comorbidities, this ward would have been more suitable for him than BMHS as there exists a higher level of physical and medical health facilities at RPH compared to BHS.[165]

My comments relating to the improvements since Mr Veltman's death

190. Very appropriately, Dr Gupta acknowledged the shortcomings in Mr Veltman's care and treatment. He accepted that with respect to the handover from RPH to BHS, "*there are things that should have and could have been done better*."[166] As to the absence of an up-to-date medication chart at BHS, Dr Gupta conceded: *"Irrespective, wherever it went missing, it's not acceptable.*"[167]

191. Dr Gupta also accepted that the staff treating Mr Veltman at BHS were not aware of all his physical health issues and that they should have been. As to who was responsible for that lack of awareness, he said it was "*a joint responsibility of everyone*".[168]

192. I am satisfied with the improvements that have been made following Mr Veltman's death. The implementation of these improvements should help in reducing the risk of a death of someone in a similar situation to that of Mr Veltman's.

RECOMMENDATIONS

193. During the course of Dr Gupta's evidence at the inquest, two matters arose that were potential recommendations in my finding. The first concerned the introduction of a virtual monitoring system for mental health patients and the second concerned the creation of a unit at RPH that combined medical and psychiatric care.

[164] Ts 16.11.2023 (Dr Gupta), p.263
[165] Ts 16.11.2023 (Dr Gupta), pp.264-265
[166] Ts 16.11.2023 (Dr Gupta), p.269
[167] Ts 16.11.2023 (Dr Gupta), p.270
[168] Ts 16.11.2023 (Dr Gupta), p.276

Virtual monitoring of mental health patients

194. Mr Veltman's refusal to have his physical observations taken is a frequent occurrence for hospital staff trying to treat patients who are mentally unwell. If a patient does not consent to these observations then they simply cannot take place. Vital observations can therefore be very difficult to make, and often for an extended period.

195. Dr Gupta has undertaken the task of exploring other options in this area. One of those options has been infrared monitoring of a patient's vital observations.[169] However, an issue with this monitoring is that the data would have to be stored in England where the company providing the infrastructure is based. That has raised confidentiality issues.[170]

196. Another option is the installation of cameras in patients' bedrooms which are able to monitor observations of the patients. A monitor is set up in the nurses' station and if there are any changes in a patient's breathing or vital observations then the monitor will set off an alarm.[171]

197. A third option that has been explored by Dr Gupta and his team are mattresses that are designed to monitor vital observations. Dr Gupta was of the view this is the best option as these mattresses are able to monitor respiratory and heart rates, and body temperature. However, as these mattresses have cords, there would be a difficulty in using them in locked mental health wards due to the ligature risk. [172]

Establishing of a unit at RPH jointly operated by mental health and medical staff

198. As to this concept, Dr Gupta stated:[173]

> The second thing that we are discussing is actually having the ward or the unit within Royal Perth Hospital, which is jointly managed and clinically covered by a combination of mental health and medical workforce, including nursing staff, as well as both psychiatrists and medical physicians. So that is also being looked at and the working group is being formed and is already in progress.

[169] Ts 16.11.2023 (Dr Gupta), p.278
[170] Ts 16.11.2023 (Dr Gupta), p.281
[171] Ts 16.11.2023 (Dr Gupta), p.278
[172] Ts 16.11.2023 (Dr Gupta), p.278
[173] Ts 16.11.2023 (Dr Gupta), p.279

199. With the high number of mental health patients with complex physical comorbidities, the establishment of a unit as outlined by Dr Gupta would significantly improve the care and treatment of these patients.

Dr Gupta's update regarding these two matters

200. Towards the completion of his oral evidence, Dr Gupta agreed to provide the Court with an update as to the progress that has been made in these two areas which I regard are of significant importance in enhancing the care and treatment of mental health patients. This update was to be provided shortly before I had finalised my finding.

201. Dr Gupta provided the Court with a progress of these matters on 15 July 2024.

202. As to the use of remote observation technology, Dr Gupta advised that a collaborative program within the EMHS titled "Community and Virtual Care" (CVC) has been exploring technology-based solutions to record continuous observations of the physical health of mentally unwell patients.[174] Dr Gupta provided compelling reasons why this technology would improve the health care for mental health patients:[175]

- Continuous monitoring of vitals through an artificial intelligence platform including analysis of real time data and immediate alerts as needed;
- Improved information and therefore care, for the physical health of mentally unwell patients, who statistically have a lower health expectancy, have side effects from mental health medications and may have reduced voluntary engagement with their doctors;
- Removing the need to wake a patient to conduct routine observations, which increases the risk of agitation in the patient, impacts their health and increases risks of safety to staff;
- Removing the need to conduct routine physical observations, in the longer term, can improve safety and morale for staff who are then able to attend to other tasks; and
- There is also potential for use of the technology in the community, down the track.

[174] Letter from Dr Vinesh Gupta to the Court dated 15 July 2024, p.1
[175] Letter from Dr Vinesh Gupta to the Court dated 15 July 2024, p.1

203. CVC is to apply for funding to develop a prototype device for the EMHS. This project has a working title of "Sensibles". As outlined by Dr Gupta: "*The objective is for a prototype to remotely monitor vital signs of respiratory and heart rates, to begin with. Once a prototype has been developed then a pilot program will be conducted.*"[176]

204. As to the establishment of a unit at RPH jointly operated by mental health and medical staff, Dr Gupta confirmed that the three areas within RPH where patients receive specialised psychiatric care are all mental health facilities within a general hospital setting, and from a clinical governance perspective are run as mental health facilities only.[177] Dr Gupta advised that since the inquest, he has addressed executive members from the EMHS of the need to improve the physical care of mentally unwell patients by developing a service staffed by clinicians trained in both mental health and physical health. This concept has been supported.[178]

205. However, the road ahead is a long one. As outlined by Dr Gupta:[179]

> As I understand it, perhaps the most challenging aspect will involve the bringing together of the otherwise separate clinical governance and regulation of mental health as well as upskilling staff accordingly.
>
> Given the early stages of the work of the Royal Perth Bentley Group Head of Clinical Services, I am not in a position to offer any suggested recommendations for the Court's consideration.

206. In those circumstances, I will refrain from making a recommendation in this area. However, as progress continues to be made, I anticipate the Court may make recommendations in future inquest findings that embrace the development of a unit that is jointly operated by mental health and medical staff.

207. As to the other matter, I am firmly of the view that the use of remote observation technology will immeasurably improve the monitoring of mentally unwell patients. Accordingly, I make the following recommendation suggested by Dr Gupta:

[176] Letter from Dr Vinesh Gupta to the Court dated 15 July 2024, p.2
[177] Letter from Dr Vinesh Gupta to the Court dated 15 July 2024, p.2
[178] Letter from Dr Vinesh Gupta to the Court dated 15 July 2024, p.2
[179] Letter from Dr Vinesh Gupta to the Court dated 15 July 2024, p.3

Recommendation

In order to provide an improved standard of physical care for mental health patients, that funding sought for the Community and Virtual Care's "Sensibles" project be provided by the Future Health Research and Innovation Fund with the Department of Health, so that technology that enables patient observations to be taken remotely can be developed and made available through a secure and confidential system.

CONCLUSION

208. All too frequently the Coroner's Court encounters intelligent, compassionate and thoughtful people who are afflicted with the terrible scourge of a major mental illness which is treatment-resistant. When these people suffer a relapse of their mental illness, they can behave as completely different people, and are frequently in mental health wards for extended periods of time. Sadly, because of these relapses and the strain it places on their bodies, and in combination with their other extensive comorbidities, it is not uncommon for these people to die when in hospital care. Sadly, Mr Veltman has become another person to be added to this lengthy list.

209. Although having only been discharged from BHS eight days earlier, Mr Veltman's schizoaffective disorder had considerably worsened. After behaving erratically at a supermarket in the early hours of 15 July 2020, he was taken by police to the ED at RPH. Due to his agitation, Mr Veltman had to be sedated in the ED with ketamine and an injection of the anti-psychotic medication, Acuphase.

210. By late that afternoon, Mr Veltman had been transferred as an involuntary patient to the locked ward at BMHS. Regrettably, an up-to-date medication chart from RPH did not find its way to Mr Veltman's medical file at BHS. Consequently, staff at BHS and BMHS did not become aware that Acuphase had been given to Mr Veltman in the ED at RPH, and monitoring protocols for patients who have been given Acuphase were not put in place.

211. Due to his lack of sleep in the previous 24 hours, Mr Veltman was allowed to remain asleep in his bedroom at BMHS during the morning of 16 July 2020. At about 1.40 pm, when staff entered his room for a medical review, Mr Veltman was found unresponsive. Despite prompt resuscitation efforts by medical staff, Mr Veltman could not be revived.

212. I was satisfied that the supervision, treatment and care provided to Mr Veltman in the ED at RPH was of a high standard. This was so notwithstanding the absence of an up-to-date medication chart from RPH making its way to BHS during Mr Veltman's transfer. Based on the information available, I was unable to find whether RPH or BHS was responsible for that oversight.

213. As to the supervision, treatment and care provided to Mr Veltman by BHS, I found that there was a significant oversight by the admission doctor at BHS in not identifying Mr Veltman had been given an injection of Acuphase at RPH. Despite the absence of an up-to-date medication chart recording the administration of Acuphase, there was another document from RPH that was in the possession of BHS which indicated Acuphase had been given to Mr Veltman.[180] This had an impact on the adequacy of the level of supervision, treatment and care provided to Mr Veltman in BMHS as he was not subsequently monitored as a patient who had received Acuphase.

214. I am satisfied that following Mr Veltman's death, the EMHS has implemented changes and improvements that should lead to a higher standard of monitoring and care for mental health patients; particularly those who have been given sedating medications in hospital.

215. I have made one recommendation that I hope will assist the efforts of EMHS to introduce significant improvements in the supervision, treatment and care of mental health inpatients who are non-compliant with the taking of physical observations.

216. I conclude with these words from Mr Veltman's sister:[181]

[180] Exhibit 1, Tab 14, Bentley Health Service medical records, Mental Health Medical Handover, p.34
[181] Exhibit 1, Tab 27, Statement of Frances Veltman dated 9 November 2023, p.13

> Phillip was dearly loved by our whole family and was an integral part of our family. He was particularly close to me and my children. He was (when his mood swings were controlled) a kind, gentle man of good humour and the children adored him.

217. On behalf of the Court, and as I did at the conclusion of the inquest, I extend my condolences to the family of Mr Veltman for their sad loss.

PJ Urquhart
Coroner
19 July 2024