JURISDICTION	**:**	CORONER'S COURT OF WESTERN AUSTRALIA
ACT	**:**	CORONERS ACT 1996
CORONER	**:**	MICHAEL ANDREW GLIDDON JENKIN
HEARD	**:**	21 - 22 MAY 2024
DELIVERED	**:**	26 JUNE 2024
FILE NO/S	**:**	CORC 2901 of 2021
DECEASED	**:**	WILSON, PETER JAMES

Catchwords:
Nil

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

Cases:
Briginshaw v Briginshaw (1938) 60 CLR 336

Counsel Appearing:
Ms S Markham appeared to assist the coroner.

Mr G Stockton and Mr J Kirke appeared for the North Metropolitan Health Service.

Mr S Taylor of counsel (21 May 2024) and Ms K Reynolds (Avant Law) (22 May 2024) appeared for Dr A Juniper and Dr J Hahn.

Coroners Act 1996
(Section 26(1))

RECORD OF INVESTIGATION INTO DEATH

I, Michael Andrew Gliddon Jenkin, Coroner, having investigated the death of ***Peter James WILSON*** *with an inquest held at Perth Coroners Court, Central Law Courts, Court 85, 501 Hay Street, PERTH, on 21 - 22 May 2024, find that the identity of the deceased person was* ***Peter James WILSON*** *and that death occurred on 1 November 2021 at Fiona Stanley Hospital, 11 Robin Warren Drive, Murdoch, from complications in association with effects of fire, with terminal palliative care in the following circumstances:*

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INTRODUCTION

1. Mr Peter James Wilson (Mr Wilson) died on 1 November 2021 at Fiona Stanley Hospital from the effects of fire, after dousing himself with boat fuel and setting himself alight. He was 41-years of age.[1,2,3,4,5,6,7]

2. At the time of his death, Mr Wilson was subject to a community treatment order (CTO)[8] made under the *Mental Health Act 2014* (WA) (MHA).[9] Accordingly, immediately before his death he was an "*involuntary patient*" and thereby a "*person held in care*". As a consequence, his death was a "*reportable death*" and in such circumstances, a coronial inquest is mandatory.[10]

3. Where, as here, the death is of a "*person held in care*", I am required to comment on the quality of the supervision, treatment and care the person received while in that care.[11] I held an inquest into Mr Wilson's death on 21 - 22 May 2024, at which the following witnesses gave evidence:

i. Dr Christopher Hodgson (Consultant Psychiatrist);
ii. Dr Jayhee Hahn (Psychiatric Registrar);
iii. Dr Liana Suparare (Consultant Psychiatrist);
iv. Dr Asha Juniper, (Consultant Psychiatrist);
v. Dr Mark Warrington (Psychiatric Registrar);
vi. Dr Smitha Bhaduri (Director of Medical Services);
vii. Mr Darren Schwartz (Acting Chief Pharmacist); and
viii. Dr Adam Brett (Independent Consultant Psychiatrist).

4. The documentary evidence adduced at the inquest consisted of one volume and included reports from Mr Wilson's treating psychiatrists, medical notes, and letters from Mr Wilson's parents. The inquest focused on Mr Wilson's supervision, treatment and care while he was the subject of a CTO, and the circumstances of his death.

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[1] Exhibit 1, Vol. 1, Tab 1, P100 - Report of Death (13.04.23)
[2] Exhibit 1, Vol. 1, Tab 5, Death in Hospital form (01.01.22)
[3] Exhibit 1, Vol. 1, Tab 6.1, P92 - Identification of Deceased Person (03.11.21)
[4] Exhibit 1, Vol. 1, Tab 6.2, Affidavit - Sen. Const. S Dodge (03.01.22)
[5] Exhibit 1, Vol. 1, Tab 6.3, Affidavit - Sen. Const. K Asher (03.01.22)
[6] Exhibit 1, Vol. 1, Tab 6.4, Coronial Identification Report (03.01.22)
[7] Exhibit 1, Vol. 1, Tab 7.1, Supplementary Post Mortem Report (04.01.22)
[8] A CTO is an order under the MHA that requires a patient to submit to medical care and treatment in the community
[9] Exhibit 1, Vol. 1, Tabs 16.1 & 16.2, Form 5A - Community Treatment Orders signed by Dr D Smith and Dr M Warrington
[10] Section 21, *Mental Health Act 2014* (WA)
[11] Sections 3, 22(1)(a) & 25(3) *Coroners Act 1996* (WA)

MR WILSON

Background[12,13,14,15,16,17]

5. Mr Wilson was born on 27 August 1980, and he was 41 years of age when he died. He finished school at Year 10 and had worked as a mechanical fitter for a number of years. Mr Wilson had two siblings, and although he married when he was 18 years of age, there were no children of the union, and he divorced his wife about two years later.

6. Although Mr Wilson had his own accommodation in Kingsley, he had been living with his mother who assisted him with the management of his mental health and supervised his medication. Although Mr Wilson had been working as a car detailer, he had recently given up working, reportedly as a result of workplace bullying.

Contact with mental health services: 2000 - 2020[18,19,20,21,22,23,24]

7. Mr Wilson had a complex mental health history with an atypical presentation, and a history of polysubstance use including alcohol, cannabis and methylamphetamine. His first recorded interaction with mental health services occurred on 26 March 2000, when he was admitted to Joondalup Health Campus (JHC) and diagnosed with a manic episode with psychotic features and polysubstance use. Mr Wilson was admitted to the mental health unit at JHC and after treatment, he was discharged home on 1 May 2000.

8. On 13 March 2003, Mr Wilson presented to JHC again, and was diagnosed with insomnia, and possible depression. Mr Wilson does not appear to have had any further involvement with mental health services until 4 November 2010, when he presented to JHC, and was diagnosed with insomnia related to stimulant drug use.

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[12] Exhibit 1, Vol. 1, Tab 1, P100 - Report of Death (13.04.23)
[13] Exhibit 1, Vol. 1, Tab 2, Report - Ms C Vernon Coronial Investigation Squad (26.04.23), p5
[14] Exhibit 1, Vol. 1, Tab 24.1, Graylands Discharge Summary (18.09.21), p2
[15] Exhibit 1, Vol. 1, Tab 17.1, SAC1 Investigation Report (13.02.22), pp3-4
[16] Exhibit 1, Vol. 1, Tab 33, Report - Dr L Suparare (31.01.24), pp1-2
[17] Exhibit 1, Vol. 1, Tabs 14.1 & 14.2, Background information and Family association list
[18] Exhibit 1, Vol. 1, Tab 18, Report - Dr A Brett (17.10.23), pp2-6
[19] Exhibit 1, Vol. 1, Tab 29, Report - Dr C Hodgson (27.11.23), pp1-2 and ts 21.05..24 (Hodgson), pp7-22
[20] Exhibit 1, Vol. 1, Tab 31, Report - Dr M Warrington (19.01.24), p3
[21] Exhibit 1, Vol. 1, Tab 34, Report - Dr D Smith (27.03.24), p1
[22] Exhibit 1, Vol. 1, Tabs 26 & 28, Graylands Medical Records
[23] Exhibit 1, Vol. 1, Tab 27, NMHS Medical Records
[24] Exhibit 1, Vol. 1, Tab 25, Seacrest Medical Centre Medical Records

9. In 2016, Mr Wilson had several presentations to JHC in relation to drug induced psychosis. On 24 April 2016, Mr Wilson was admitted to the mental health unit at JHC under the provisions of the MHA, after his GP diagnosed him with drug-induced psychosis. Mr Wilson was taken to hospital by his mother, and he expressed paranoid delusions, including that he was being "*chased by bikies*", and that "*bikies were involved in the suicide death of his girlfriend*". He was treated as an involuntary patient on a locked ward, and prescribed the antidepressants aripiprazole and olanzapine.

10. Mr Wilson was discharged home as a voluntary patient on 16 May 2016, and referred to the Wanneroo Community Mental Health Service (the Service). His diagnoses on discharge were: "*bipolar affective disorder? + psychosis?, schizophrenia? and illicit substance use*", and Mr Wilson was managed by the Service from May 2016 until he was discharged in October 2020. It was noted that Mr Wilson was difficult to engage, and that he often failed to attend scheduled appointments. There is also evidence that he "*would independently alter doses of his various medications*", and that side effects, including weight gain of "*approximately 20 kg*" were documented.

11. A report of a clinical investigation after Mr Wilson's death (SAC1) noted that insomnia featured heavily during Mr Wilson's engagement with mental health services. It also appears that Mr Wilson's medication compliance issues were related to his attempts to manage side effects and insomnia and that "*Non-compliance with medication is a common cause of treatment failure and may have contributed to* (Mr Wilson's) *ongoing symptoms*".[25]

12. The SAC1 also noted that it appeared that deteriorations in Mr Wilson's mental health were preceded by his use of methylamphetamine, although he did manage long periods of abstinence. Although Mr Wilson was regularly offered referrals to drug rehabilitation services, he declined these referrals on each occasion.[26,27]

[25] Exhibit 1, Vol. 1, Tab 17.1, SAC1 Investigation Report (13.02.22), p4
[26] Exhibit 1, Vol. 1, Tab 17.1, SAC1 Investigation Report (13.02.22), p4
[27] See also: ts 21.05.24 (Hodgson), p11; ts 21.05.24 (Hahn), p33; and ts 21.05.24 (Juniper), pp74-75

13. In about 2019, Mr Wilson was referred to a neurologist to investigate possible tardive dyskinesia (a drug induced movement disorder), and when his sleep was identified as an issue, he was offered a sleep study. On 27 November 2019, Mr Wilson was reviewed by a consultant psychiatrist at the Service (Dr David Smith), following a referral from his GP. Dr Smith considered Mr Wilson had a mood disorder with psychotic features, and substance use disorder.[28]

14. Dr Smith noted that Mr Wilson had ceased using methylamphetamine, that his mood was "*stable*" and that Mr Wilson was "*looking forward to a new job*". Dr Smith gave Mr Wilson strategies to maintain a normal mood in the presence of a mood disorder, including controlling substance use, maintaining a regular sleep/wake cycle, "*developing psychological resilience*", and maintaining a healthy diet, regular exercise, and a daily routine. Dr Smith then discharged Mr Wilson back into the care of his GP.

15. Dr Smith says Mr Wilson subsequently ceased all of his medications "*because he believed they were not helping him*", and Dr Smith saw Mr Wilson at the Service on 27 March 2020, with a "*relapse of psychotic symptoms of auditory hallucinations of songs in his head*". Dr Smith saw Mr Wilson on several occasions and recommenced him on olanzapine, after an unsuccessful trial of lurasidone.

16. Dr Smith says that by 14 October 2020, Mr Wilson was "*doing well*" on a combination of paliperidone and olanzapine, and that Mr Wilson had said he did not want to go back on antidepressants. Mr Wilson's obsessive compulsive disorder (OCD) symptoms were not of concern to him, and Mr Wilson said he did not want to engage in case management. Dr Smith said that at no time in his care of Mr Wilson in the community "*was suicidality or self-harm an issue*" and when Mr Wilson was discharged from the Service into the care of his GP on 19 October 2020, his diagnoses were: mood disorder with psychotic episodes associated with substance use, and substance use disorder in remission.[29,30,31]

[28] Exhibit 1, Vol. 1, Tab 34, Report - Dr D Smith (27.03.24), p1
[29] Exhibit 1, Vol. 1, Tab 18, Report - Dr A Brett (17.10.23), p4
[30] Exhibit 1, Vol. 1, Tab 34, Report - Dr D Smith (27.03.24), p1
[31] See also: ts 21.05.24 (Hodgson), p19

Contact with mental health services: 2021[32,33,34,35,36,37,38,39]

17. On 27 June 2021, Mr Wilson was seen at JHC, and was diagnosed with depressive disorder, although he left before being reviewed by a psychiatrist. On 2 July 2021, Mr Wilson's mother contacted the Service and reported concerns about her son's mental health. An assessment was conducted, but on 11 July 2021, Mr Wilson was admitted to JHC after complaining of increasing anxiety, agitation, panic attacks, poor sleep, and worsening OCD behaviours.

18. Mr Wilson's mental health had reportedly deteriorated after he had lost his job several weeks earlier. Although he was admitted to the mental health unit at JHC, Mr Wilson discharged himself against medical advice on 16 July 2021. Mr Wilson's mother contacted the Service the following day to report that her son had "*been discharged without medication and had decompensated*".

19. Mr Wilson was readmitted to JHC and complained of "*bizarre movements and abnormal motor movements*", which settled when he was given intravenous midazolam. He reportedly made inconsistent statements about his polysubstance use, and a urine sample tested positive for methylamphetamine, cannabis, and benzodiazepines. Mr Wilson was diagnosed with: "*psychiatric, mental and behavioural disorders due to sedative or hypnotic dependence, anxiety, and OCD*", although there was no explanation for his presenting complaint.

20. Mr Wilson was discharged on 19 July 2021, and seen daily by the Hospital in the Home service (HiTH) between 24 July 2021 and 9 August 2021. Although Mr Wilson had been discharged on quetiapine, this was switched to olanzapine due to his previous "*tardive dyskinesia like*" symptoms. During this period, Mr Wilson did not disclose any suicidal thoughts, and his insight and judgement were described as "*reasonable*.[40]

[32] Exhibit 1, Vol. 1, Tab 18, Report - Dr A Brett (17.10.23), pp2 & 5-10
[33] Exhibit 1, Vol. 1, Tab 29, Report - Dr C Hodgson (27.11.23), pp1-3
[34] Exhibit 1, Vol. 1, Tab 31, Report - Dr M Warrington (19.01.24), pp3-4
[35] Exhibit 1, Vol. 1, Tab 17.1, SAC1 Investigation Report (13.02.22), pp4-7
[36] Exhibit 1, Vol. 1, Tab 32, Report - Dr A Juniper (25.01.24), pp2-6
[37] Exhibit 1, Vol. 1, Tab 33, Report - Dr L Suparare (31.01.24), p2
[38] Exhibit 1, Vol. 1, Tab 30, Report Dr J Hahn (29.11.23) and ts 21.05.24 (Hahn), pp25-33
[39] Exhibit 1, Vol. 1, Tabs 26 & 28, Graylands Medical Records
[40] Exhibit 1, Vol. 1, Tab 29, Report - Dr C Hodgson 27.11.23), p2

21. Mr Wilson's clinical impression was documented as:

> Atypical OCD symptoms, ?OCD. Likely GAD (Generalised Anxiety Disorder) along with Cluster C personality type (avoidant predominantly) with recent deterioration in the context of workplace bullying, with recent admission and considerable improvement since the addition of diazepam. Long-term insomnia likely secondary to anxiety.[41]

22. On 17 August 2021, Dr Hahn reviewed Mr Wilson at the Service. He described an increase in "*OCD symptoms*" including repetitive shaving, although an examination of his face did not reflect this. Mr Wilson also complained restlessness and unsteadiness, although Dr Hahn did not notice any signs of "*agitation, tremor, abnormal facial or mouth movements, or restlessness*". Instead, Mr Wilson was seated calmly and engaging appropriately, and he was "*mobilising independently with a* "*normal gait*".[42]

23. Dr Hahn noted that Mr Wilson "*appeared to be focussed on Benzodiazepines to treat his problems*", but she explained that these medications have a high risk of addiction, and a plan to "*wean him off them*" was commenced. Dr Hahn noted that Mr Wilson had only started taking clomipramine three days earlier, despite it having been prescribed during his HiTH admission.[43]

24. Mr Wilson and his mother explained that "*they did not want too many changes to his medications*" and Dr Hahn clarified the medications Mr Wilson should be taking, and wrote this information on a piece of paper, which she handed to him. Mr Wilson denied any self-harm or suicidal ideation, and he engaged in a discussion on safety planning, which included ways to seek help if he needed it. Dr Hahn arranged a further review in four weeks, as neither Mr Wilson nor his mother wanted to see another doctor earlier.[44]

[41] Exhibit 1, Vol. 1, Tab 18, Report - Dr A Brett (17.10.23), para 43, p6
[42] Exhibit 1, Vol. 1, Tab 30, Report Dr J Hahn (29.11.23), p2
[43] Exhibit 1, Vol. 1, Tab 30, Report Dr J Hahn (29.11.23), p2
[44] Exhibit 1, Vol. 1, Tab 30, Report Dr J Hahn (29.11.23), p2

25. Dr Hahn's impression and diagnosis was: generalised anxiety disorder, cluster C personality disorder with some depressive features (but not a clear depression), and OCD with reported symptoms including spending time in front of the mirror and excessive grooming.[45]

26. On 26 August 2021, Mr Wilson presented to JHC but he reportedly considered his physical complaints were dismissed, and staff allegedly told him "*are you coming here again*". Mr Wilson was reportedly distressed by this comment, and he later said he contemplated suicide because he felt there was "*no help for him*" and he had "*intense feelings of hopelessness*".[46,47]

Management at SCGH: 27 August 2021 - 7 September 2021[48,49,50,51,52]

27. On 27 August 2021, Mr Wilson presented to JHC after ingesting drain cleaner (sodium hydroxide), and gave conflicting accounts as to why he had done so. After his physical injuries had been treated, Mr Wilson was subsequently admitted to Graylands Hospital (Graylands). In his report Dr Hodgson (who was Mr Wilson's treating psychiatrist at Graylands) made the following observations about Mr Wilson's ingestion of drain cleaner:

> Initially Mr Wilson reported that he wanted to end his life after experiencing a month of confusion, insomnia, his body moving oddly, and difficulty making decisions after licking the residue off his glass methylamphetamine pipe. Later in the admission he stated he had drunk the drain cleaner to alleviate his constipation reasoning that if it unblocked drains it might help to unblock his system. Given Mr Wilson's grossly disordered behaviour and thinking at the time of the ingestion, his prior history of Psychosis, and his recent methyamphetamine use, I suspected that Mr Wilson was psychotic at the time of the caustic ingestion.[53]

[45] Exhibit 1, Vol. 1, Tab 30, Report Dr J Hahn (29.11.23), p3
[46] Exhibit 1, Vol. 1, Tab 29, Report - Dr C Hodgson (27.11.23), p2 and ts 21.05.24 (Hodgson), pp22-23
[47] Exhibit 1, Vol. 1, Tab 33, Report - Dr L Suparare (31.01.24), p2
[48] Exhibit 1, Vol. 1, Tab 18, Report - Dr A Brett (17.10.23), pp2 & 6-7
[49] Exhibit 1, Vol. 1, Tab 29, Report - Dr C Hodgson (27.11.23), pp1-2
[50] Exhibit 1, Vol. 1, Tab 24.2, SCGH Discharge Summary (07.09.21)
[51] See also: Exhibit 1, Vol. 1, Tab 24.1, Graylands Discharge Summary (18.09.21), p1
[52] Exhibit 1, Vol. 1, Tab 17.1, SAC1 Investigation Report (13.02.22), pp5-6
[53] Exhibit 1, Vol. 1, Tab 29, Report - Dr C Hodgson (27.11.23), p2 and ts 21.05.24 (Hodgson), pp8-9

28. Mr Wilson was intubated due to swelling in his airway, and he was transferred to the intensive care unit at Sir Charles Gairdner Hospital (SCGH). A gastroscopy showed "*erosion and slough in his oesophagus*" but "*no necrosis or perforation*". During this admission, Mr Wilson was also treated for aspiration pneumonia and encephalopathy, which he developed. Although Mr Wilson disclosed daily methylamphetamine use, he declined a referral to community rehabilitation services when he was assessed by the drug and alcohol team.

29. On 6 September 2021, Mr Wilson had recovered sufficiently to be reviewed by consultant psychiatrist, Dr Liana Suparare. Mr Wilson said that prior to ingesting the drain cleaner he had not been able to sleep or go to the toilet, and that "*he should have admitted himself before his suicide attempt*". Mr Wilson's obsessive thoughts about his appearance were noted, but he had "*good insight about his condition and was willing to be admitted and treated*".[54,55]

30. Mr Wilson was diagnosed with generalised anxiety disorder, body dysmorphic disorder, OCD, and cluster C personality disorder - dependent type with avoidant traits. Although he was assessed as not being at acute risk of self-harm, it was determined he required further assessments given his recent, serious, impulsive behaviour.

31. When reviewed by Dr Suparare on 7 September 2021, Mr Wilson identified workplace bullying as a "*major stressor*", and he "*expressed regret for his suicidal behaviour*". Mr Wilson denied any recent polysubstance use, and he also identified his family as "*strong protective factors*" in relation to his risk of self-harm. Dr Suparare considered that Mr Wilson required further psychiatric assessments, given the serious nature of his actions in ingesting drain cleaner, and negotiated his admission to Graylands as a voluntary patient.[56,57,58]

[54] Exhibit 1, Vol. 1, Tab 18, Report - Dr A Brett (17.10.23), paras 48-49, pp6-7
[55] Exhibit 1, Vol. 1, Tab 33, Report - Dr L Suparare (31.01.24), p2 and ts 21.05.24 (Suparare), pp35-36
[56] Exhibit 1, Vol. 1, Tab 18, Report - Dr A Brett (17.10.23), para 51, p7
[57] Exhibit 1, Vol. 1, Tab 24.2, SCGH Discharge Summary (07.09.21)
[58] Exhibit 1, Vol. 1, Tab 33, Report - Dr L Suparare (31.01.24), pp2-3 and ts 21.05.24 (Suparare), pp38-43

Admission to Graylands Hospital: 7 September 2021[59,60,61,62]

32. Mr Wilson was transferred to Graylands as a voluntary patient on 7 September 2021. Because he lived in Banksia Hill, Mr Wilson would normally have been admitted to the mental health unit at JHC, but no beds were available, and in any case, Mr Wilson had previously indicated that he did not like being admitted to JHC.[63]

33. Mr Wilson was described as "*pleasant and settled*" on his arrival at Graylands, and he denied any self-harm or suicidal ideation. He disclosed a long-term history of polysubstance use (including methylamphetamine, alcohol, cannabis, and MDMA)[64], and although he said he had last used methyamphetamine four weeks earlier, it was thought likely he was intoxicated when he ingested drain cleaner, as to which his discharge summary from Graylands observed:

> It is apparent that (Mr Wilson) was undergoing psychotic phenomena at the time of his caustic ingestion with superimposed likely delirium upon awakening in ICU. We do not believe (Mr Wilson) had suicidal or deliberate self-harm intent at the time of ingestion. We believe this was an attempt to alleviate constipation.[65]

34. Mr Wilson appeared settled on the ward and was cooperative with his treatment plan. He was diagnosed with "*psychosis not otherwise specified*", and during his admission, the degree of his "*thought disorder, beliefs of body dysmorphia and perception*" improved and were "*not evident at the time of discharge*". Mr Wilson was granted periods of leave with his family, and this culminated in weekend leave, following which he was described as "*euthymic*" (i.e.: normal, tranquil mental state/mood).[66] Mr Wilson denied any suicidal ideation, and he was discharged into his mother's care on 18 September 2021.

[59] Exhibit 1, Vol. 1, Tab 18, Report - Dr A Brett (17.10.23), pp2 & 7-8
[60] Exhibit 1, Vol. 1, Tab 29, Report - Dr C Hodgson (27.11.23), pp1-3 and ts 21.05..24 (Hodgson), pp7-22
[61] Exhibit 1, Vol. 1, Tab 24.1, Graylands Discharge Summary (18.09.21)
[62] Exhibit 1, Vol. 1, Tab 17.1, SAC1 Investigation Report (13.02.22), pp5-6
[63] See for example: Exhibit 1, Vol. 1, Tab 24.2, SCGH Discharge Summary (07.09.21), p2
[64] MDMA is the abbreviation for 3,4-Methylenedioxymethamphetamine, commonly known as Ecstasy
[65] Exhibit 1, Vol. 1, Tab 24.1, Graylands Discharge Summary (18.09.21), p2
[66] Exhibit 1, Vol. 1, Tab 24.1, Graylands Discharge Summary (18.09.21), p2

35. Following Mr Wilson's discharge, ongoing support was to be provided by his GP and the Service. Mr Wilson's discharge diagnoses were documented as: psychosis, obsessional personality disorder with OCD traits, Cluster C (avoidant) personality disorder, and generalised anxiety disorder.

36. Mr Wilson's discharge medications included drugs to treat constipation (docusate, lactulose, Movicol, and senna), frusemide (a diuretic for oedema), pantoprazole (an antacid), and paracetamol for pain relief. He was also prescribed olanzapine and diazepam "*as prophylaxis against psychosis and anxiety, and to aid sleep*".[67,68]

37. Dr Hahn reviewed Mr Wilson at the Service on 30 September 2021, with his interim case manager and his mother. Mr Wilson said his admission to Graylands had been helpful and he seemed brighter than at his previous review. In relation to drinking drain cleaner, Mr Wilson denied it had been a suicide attempt. He claimed he had been sitting on the toilet when he saw the drain cleaner, and had consumed it because he thought it would help with his constipation.[69]

38. Dr Hahn spent a significant portion of the review discussing Mr Wilson's medications with him, and Mr Wilson denied any rumination or "*fixations on his facial features*". He also said he had been keeping busy, and that his mental state was stable. Dr Hahn did not note any features of OCD, and Mr Wilson denied any symptoms of psychosis or self-harm ideation. Although Dr Hahn suggested a further review in two weeks, Mr Wilson's mother requested an appointment in three weeks, so an appointment was scheduled for 22 October 2021.[70]

39. Dr Hahn also gave Mr Wilson instructions for his medications, and wrote a letter to his GP to update them on progress. Although Dr Hahn encouraged Mr Wilson to engage with drug rehabilitations services and see a psychologist, Mr Wilson declined, saying "*did not feel he needed either at this time*".[71]

[67] Exhibit 1, Vol. 1, Tab 29, Report - Dr C Hodgson (27.11.23), para 15, p3
[68] Exhibit 1, Vol. 1, Tab 18, Report - Dr A Brett (17.10.23), para 56, p8
[69] Exhibit 1, Vol. 1, Tab 30, Report Dr J Hahn (29.11.23), p3
[70] Exhibit 1, Vol. 1, Tab 30, Report Dr J Hahn (29.11.23), p3
[71] Exhibit 1, Vol. 1, Tab 30, Report Dr J Hahn (29.11.23), p3

Psychiatric review - 14 October 2021[72,73,74,75]

40. On 14 October 2021, Mr Wilson's mother contacted the Service and requested an urgent review. She and her former husband had become very concerned about Mr Wilson's welfare, and were unable to manage his level of risk at home. Although Dr Hahn was fully booked, she arranged to see Mr Wilson, and he attended the Service with both of his parents. Dr Hahn observed that Mr Wilson was "*objectively low*" compared to his previous with her, and she noted thought disorder, and apparent symptoms of psychosis. Mr Wilson also claimed his skin was "*peeling off*", but Dr Hahn could not see this for herself.

41. Although Mr Wilson said he did not want to go to hospital, Dr Hahn was unconvinced that he would refrain from attempting suicide. Mr Wilson's parents agreed that a hospital admission was needed. They also said they were not coping with Mr Wilson's level of risk and felt the need to "*monitor him constantly*". Mr Wilson was described as experiencing low mood, poor concentration, isolation, and psychomotor retardation and was expressing feelings of feelings of hopelessness/worthlessness.

42. In view of Mr Wilson's perceived risk of self-harm, Dr Hahn determined that it was appropriate to place him on a Form 1A under the MHA (which required him to be taken to an authorised hospital and undergo a review by a psychiatrist). Mr Wilson's parents did not want Mr Wilson admitted to JHC, "*due to previous poor experiences there*", and so Dr Hahn arranged for Mr Wilson to be admitted to SCGH. Mr Wilson's parents were able to transport him to SCGH immediately, and Dr Juniper (the clinical lead at the Service) subsequently agreed that Dr Hahn's treatment plan was appropriate.

43. Dr Hahn called the psychiatric liaison nurse and a psychiatric registrar at SCGH to discuss her concerns about Mr Wilson's presentation and to explain he was an "*out of area*" patient. A clinical nurse specialist from the Service also contacted the emergency department at SCGH to alert them to Mr Wilson's imminent arrival.

[72] Exhibit 1, Vol. 1, Tab 18, Report - Dr A Brett (17.10.23), p8
[73] Exhibit 1, Vol. 1, Tab 30, Report Dr J Hahn (29.11.23), pp3-4 and ts 21.05.24 (Hahn), pp30-32
[74] Exhibit 1, Vol. 1, Tab 31, Report - Dr M Warrington (19.01.24), p2
[75] Exhibit 1, Vol. 1, Tab 17.1, SAC1 Investigation Report (13.02.22), pp5-6

44. However, despite these very sensible communications and the genuine reasons behind Mr Wilson's referral to SCGH, Dr Hahn received an email from Dr Anne O'Sullivan (consultant psychiatrist at SCGH's mental health observation area) at 1.31 pm on 14 October 2021 raising concerns that Mr Wilson had been referred to SCGH rather than to JHC. Dr O'Sullivan also asserted that because Mr Wilson had been driven to SCGH by his parents, "*he did not require the MHA as he had attended voluntarily*", and that in any case, a referral of this nature would require arrangement from the heads of service.[76]

45. Dr Juniper (who had been copied in to the email) responded to Dr O'Sullivan's concerns, and Mr Wilson was admitted to the Mental Health Observation Area at SCGH. It was documented that Mr Wilson's "*long standing delusions of skin peeling (secondary to long-term amphetamine use)* were "*still present*", and he was diagnosed with possible schizophrenia and started on the antipsychotic, zucopenthixol.

46. The Form 1A which initiated Mr Wilson's presentation at SCGH was revoked due to there being "*no evidence of acute psychosis*" and Mr Wilson not being suicidal "*despite low mood*". Following his assessment at SCGH, Mr Wilson was transferred to Graylands on 15 October 2021, as a voluntary patient, and admitted under the care of Dr Smith.[77,78]

Transfer to Graylands Hospital: 15 October 2021[79,80,81,82,83]

47. On his admission to Graylands, Mr Wilson was initially reviewed by Dr Suparare, who was "*on call*" at Graylands at the time. Dr Suparare noted that Mr Wilson had been discharged from Graylands on 18 September 2021, with a diagnosis of "*psychosis*" and that he had been followed up by the Service thereafter.[84]

[76] Exhibit 1, Vol. 1, Tab 30, Report Dr J Hahn (29.11.23), p4
[77] Exhibit 1, Vol. 1, Tab 30, Report Dr J Hahn (29.11.23), p4
[78] Exhibit 1, Vol. 1, Tab 18, Report - Dr A Brett (17.10.23), p8
[79] Exhibit 1, Vol. 1, Tab 18, Report - Dr A Brett (17.10.23), pp2-6
[80] Exhibit 1, Vol. 1, Tab 29, Report - Dr C Hodgson (27.11.23), pp1-2
[81] Exhibit 1, Vol. 1, Tab 28, Graylands Integrated Patient Records (16-29.10.21)
[82] Exhibit 1, Vol. 1, Tab 31, Report - Dr M Warrington (19.01.24) and ts 21.05.24 (Warrington), pp49-72
[83] Exhibit 1, Vol. 1, Tab 17.1, SAC1 Investigation Report (13.02.22), pp6-7
[84] Exhibit 1, Vol. 1, Tab 33, Report - Dr L Suparare (31.01.24), p3

48. On assessment, Mr Wilson reported feeling depressed, and was experiencing "*psychomotor retardation, had socially isolated himself, and was experiencing insomnia, poor concentration and feelings of hopelessness and worthlessness*". Dr Suparare noted that Mr Wilson was agreeable to an admission as a voluntary patient, and his care plan included routine observations, and a bowel chart and soft diet "*as per the gastroenterologist's recommendations*".[85]

49. When Mr Wilson was reviewed by the "*duty consultant*" on 16 October 2021, he was reported to be somewhat preoccupied with "*somatic delusions about his skin peeling*", and constipation. He gave an unclear history of medication compliance and recent polysubstance use, and a urine screen was requested. Mr Wilson was placed on routine observations and given escorted grounds access.

50. Despite Mr Wilson's complaints of insomnia, a sleep chart maintained during his admission found "*almost all entries indicate the client was asleep at hourly checks*".[86] Mr Wilson was given medication to treat his reported constipation, and he was regularly reviewed by medical staff. Records indicate that Mr Wilson and his mother were involved in "*assessments and care planning*", and in addition to Dr Smith, Mr Wilson's treating team included Dr Mark Warrington, who was then a supervised medical officer in his first year.

51. In his report to the Court, Dr Smith said that during this admission, he developed concerns for Mr Wilson's long-term safety, and "*did not see evidence that the risk was short term*". Dr Smith said he was aware of Mr Wilson's "*on again off again*" engagement with the Service, the deterioration in his functioning, and Mr Wilson's intermittent substance use "*of varying intensity*". Dr Smith said he formed the clinical opinion that Mr Wilson had a major mental health illness, "*either schizophrenia or schizoaffective disorder bipolar type*", and considered the best management was long-lasting depot injections of paliperidone, a medication which Mr Wilson had responded well to in the past.[87]

[85] Exhibit 1, Vol. 1, Tab 33, Report - Dr L Suparare (31.01.24), pp3-4
[86] See also: ts 22.05.24 (Schwartz), pp116-117
[87] Exhibit 1, Vol. 1, Tab 34, Report - Dr D Smith (27.03.24), pp1-2 and ts 21.05.24 (Warrington), pp52-54

52. Key aspects of Mr Wilson's treatment and care during his admission to Graylands include:

a. *18 October 2021*: Mr Wilson was reviewed by Dr Smith and Dr Warrington and said that prior to this admission he had thoughts ingesting drain cleaner again, but that he was not currently experiencing suicidal thoughts. Mr Wilson's response to questions was brief, and it was thought likely he had a primary psychotic illness (i.e.: schizoaffective disorder/schizophrenia).

Dr Warrington had a lengthy conversation with Mr Wilson's mother about "*Mr Wilson's potential for primary psychotic illness*", and his medication regime. Dr Warrington also discussed Mr Wilson's likely timeframe for admission, and indicated there would be further liaison with her, and likely a family meeting. During a multidisciplinary meeting later that day, Dr Smith confirmed he had previously treated Mr Wilson successfully in the community with paliperidone. A long-lasting depot injection of paliperidone was planned due to uncertainty about Mr Wilson's medication compliance, and Dr Smith expressed the view that Mr Wilson would benefit from being placed on a Community Treatment Order (CTO) under the MHA when he was discharged, to provide "*assertive follow up*" and to ensure compliance with medication.[88]

b. *19 October 2021*: Mr Wilson was reviewed by Dr Warrington and started on a low oral dose of paliperidone, with a view to him receiving his "*first depot loading dose*" on 21 October 2021. Mr Wilson was noted to be displaying some "*abnormal lip smacking/jaw movements*" that were suggestive of tardive dyskinesia, and his olanzapine dose was subsequently reduced.[89]

c. *20 October 2021*: Dr Smith told Mr Wilson he believed that he (Mr Wilson) had a primary psychotic illness and that his mental health issues were not simply drug induced. Dr Smith also discussed the planned depot paliperidone injection, and that a CTO would be beneficial. Although Mr Wilson seemed "*superficially agreeable to this plan*", he expressed concern about "*potential side effects*".[90]

[88] Exhibit 1, Vol. 1, Tab 31, Report - Dr M Warrington (19.01.24), pp4-5 and ts 21.05.24 (Warrington), p67
[89] Exhibit 1, Vol. 1, Tab 31, Report - Dr M Warrington (19.01.24), p5
[90] Exhibit 1, Vol. 1, Tab 31, Report - Dr M Warrington (19.01.24), p5

d. *21 October 2021*: Mr Wilson consented to receive his first depot loading dose of paliperidone, and Dr Warrington spent about 40 minutes with Mr Wilson's mother discussing the treatment plan and the clinical impression which was being developed. Dr Warrington arranged a family visit for the following day so that Mr Wilson's care could be further discussed.[91]

e. *22 October 2021*: a family meeting was conducted, attended initially by Mr Wilson's treating team, and his mother, who expressed concerns about side effects from her son's antipsychotic medication. It was explained that Mr Wilson appeared to have a primary psychotic illness and that he would require ongoing treatment with antipsychotic medication. Dr Smith also noted that Mr Wilson had previously responded well to paliperidone.

   Mr Wilson then joined the meeting and when he expressed concerns about possible side effects from his medication, Dr Smith highlighted the "*ongoing psychotic phenomena Mr Wilson may experience*" without treatment, and how this might lead to "*further gestures where Mr Wilson may try to end his life again*". Ultimately it was agreed that Mr Wilson would receive a lower monthly dose of 75 mg of paliperidone, and the plan to discharge him on a CTO was discussed. Mr Wilson was given day leave with his family over the weekend.[92]

f. *25 October 2021*: Mr Wilson was reviewed by Dr Smith and Dr Warrington, and said day leave with his family had gone well. Mr Wilson expressed "*ongoing anxiety*" about side effects from his depot medication, but other than a "*mild fine tremor*", no obvious physical side effects were noted. Mr Wilson's tardive dyskinesia symptoms were noted to be "*improving*", and he was encouraged to engage in daytime ward activities rather than sleeping in order to "*ameliorate his sleep/wake cycle*".[93]

g. *26 October 2021*: when reviewed by Dr Smith, Mr Wilson expressed concern about weight gain caused by olanzapine, which was ceased in favour of quetiapine to help with sleep. Mr Wilson was again encouraged to engage in daytime ward activities.[94]

[91] Exhibit 1, Vol. 1, Tab 31, Report - Dr M Warrington (19.01.24), p5 and ts 21.05.24 (Warrington), p67
[92] Exhibit 1, Vol. 1, Tab 31, Report - Dr M Warrington (19.01.24), p6 and ts 21.05.24 (Warrington), pp66-67
[93] Exhibit 1, Vol. 1, Tab 31, Report - Dr M Warrington (19.01.24), p6
[94] Exhibit 1, Vol. 1, Tab 31, Report - Dr M Warrington (19.01.24), p6

h. *27 October 2021*: when Mr Wilson was reviewed by Dr Smith and Dr Warrington, and he appeared "*more reactive and less blunted*". He disclosed he had not opened his bowels for five days, and was given some aperient medication prior to going out with his family for coffee.

Dr Warrington had a discussion with Mr Wilson's mother about medication, and highlighted the importance of "*reasonable control of psychotic symptoms to manage (Mr Wilson's) risk and distress*". It was agreed that Mr Wilson's reduced depot of paliperidone would go ahead the following day, and his mental state was assessed as "*sufficiently stable to allow for registrar-led discharge*", which was planned for 29 October 2021.[95]

i. *28 October 2021*: Mr Wilson consented to receive his second depot-loading dose of paliperidone (i.e.: 75 mg).[96]

j. *29 October 2021*: when reviewed by Dr Warrington prior to his discharge, Mr Wilson's mental state was assessed as stable, and he continued to deny any suicidal or self-harm ideation. Mr Wilson was assessed as "*reactive*" and "*generally pleasant to engage with*", and he did not demonstrate any signs of side effects.

Mr Wilson said he was looking forward to going home, and when Dr Warrington spoke with Mr Wilson's mother, she "*reported that she felt ready to take him home and thanked us for our care of him*".[97]

53. In his report, Dr Smith confirmed that Mr Wilson had received two depot injections of paliperidone (which he said "*are known to lead to better outcomes*"), and he had chosen paliperidone because Mr Wilson had reacted well to this medication in the past. Dr Smith noted that during his admission at Graylands, Mr Wilson had indicated he did not want to continue with olanzapine, and he (Dr Smith) also noted it was not in Mr Wilson's interests to continue with benzodiazepines, explaining why Mr Wilson's dose of diazepam was titrated down during his admission and then ceased.[98]

[95] Exhibit 1, Vol. 1, Tab 31, Report - Dr M Warrington (19.01.24), pp6-7 and ts 21.05.24 (Warrington), pp61-62 & 68
[96] Exhibit 1, Vol. 1, Tab 31, Report - Dr M Warrington (19.01.24), p7
[97] Exhibit 1, Vol. 1, Tab 31, Report - Dr M Warrington (19.01.24), p7 and ts 21.05.24 (Warrington), p68
[98] Exhibit 1, Vol. 1, Tab 34, Report - Dr D Smith (27.03.24), p1 and see also: ts 21.05.24 (Warrington), p61

54. In his report, Dr Smith made the following observations about Mr Wilson's presentation at the time of discharge:

> (Mr Wilson) was future focussed, in reasonable spirits, reasonably reactive and smiling on occasions. I interviewed him on several occasions including immediately prior to discharge and there was no indication of mental state changes that were of concern to me about self-harm or behaviours motivated by psychotic phenomena that might lead to harm as had occurred prior to the previous admission. If there had been such a concern I would not have discharged him from hospital. Because of my worry for his welfare, I placed (Mr Wilson) on a Community Treatment Order to increase the changes of his meaningful engagement with community services and to ensure he regularly received his depot medication.[99]

Transfer of Mr Wilson's care to the Service[100,101,102]

55. As noted, when Mr Wilson was discharged, he was placed on a CTO by Dr Smith because of ongoing concerns about Mr Wilson's risk of self-harm, and as a mechanism to ensure medication compliance. The CTO was confirmed by Dr Warrington, and although the plan was that Mr Wilson was to receive follow-up care in the community from the Service, there were issues with his transfer.

56. For a start, because Mr Wilson was an out of area patient, he had not been discussed during the weekly video conferences between Graylands clinicians, and its local community mental health service.[103] This meant that the Service had no formal notification of Mr Wilson's transfer into their care prior to his discharge.

57. At the inquest, Dr Hodgson explained that the usual practice for discharging an out of area patient from Graylands was that the treating clinician would telephone the relevant consultant psychiatrist at the patient's receiving community mental health service to discuss the referral, and the patient's on-going treatment and care.[104]

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[99] Exhibit 1, Vol. 1, Tab 34, Report - Dr D Smith (27.03.24), p2
[100] Exhibit 1, Vol. 1, Tab 31, Report - Dr M Warrington (19.01.24), p7 and ts 21.05.24 (Warrington), pp62-64 & 70-72
[101] Exhibit 1, Vol. 1, Tab 17.1, SAC1 Investigation Report (13.02.22), p7
[102] Exhibit 1, Vol. 1, Tab 32, Report - Dr A Juniper (25.01.24), pp6-7 and ts 21.05.24 (Juniper), pp75-91
[103] Exhibit 1, Vol. 1, Tab 29, Report - Dr C Hodgson (27.11.23), para 17.1, p3
[104] ts 21.05.24 (Hodgson), pp16-21 and See also: ts 21.05.24 (Juniper), pp75-76

58. In Mr Wilson's case, although Dr Smith called Dr Juniper (who was to be Mr Wilson's treating psychiatrist at the Service) on 29 October 2021, she was unavailable as she was on leave that day. In her statement to the Court, Dr Juniper confirmed that Dr Smith telephoned the Service and says she was later told that Dr Smith advised an administrative officer that:

> The CTO had been discussed with me (Dr Juniper) and that I had accepted it, he (Dr Smith) also requested the appointment for (Mr Wilson) to see me, which (the administrative officer) scheduled for (Mr Wilson).[105]

59. In her report (and at the inquest), Dr Juniper confirmed that contrary to Dr Smith's assertion, she did not discuss the CTO with him and that she "*had not accepted the CTO, as I did not know about it*".[106] In his report, Dr Smith says that when he called the Service, he was told that Dr Juniper "*did not work Fridays*" that "*no alternative was made available*". Dr Smith also said he was aware that Dr Juniper had informally discussed Mr Wilson's care with Dr Vanda Smith (who was the Head of Service at Graylands and also Dr Smith's wife).[107]

60. Dr Smith says that during her conversation with Dr Vanda Smith, Dr Juniper had expressed "*broad agreement with diagnosis and transfer on CTO*", and that both Mr Wilson and his family were "*keen for discharge*". Mr Wilson had completed a successful period of leave the previous weekend, and Dr Smith explained his rationale for discharging Mr Wilson without speaking first with Dr Juniper in these terms:

> I was leaving the employment at the hospital that day. I did not want (Mr Wilson) to go through the process of getting to know another consultant, I did not perceive any acute risk issues, so I chose to discharge him. I could have put him on leave but that would have given the responsibility to the next consultant.[108]

[105] Exhibit 1, Vol. 1, Tab 32, Report - Dr A Juniper (25.01.24), p7 and ts 21.05.24 (Juniper), p76
[106] Exhibit 1, Vol. 1, Tab 32, Report - Dr A Juniper (25.01.24), p7 and ts 21.05.24 (Juniper), pp75-79
[107] Exhibit 1, Vol. 1, Tab 34, Report - Dr D Smith (27.03.24), p2
[108] Exhibit 1, Vol. 1, Tab 34, Report - Dr D Smith (27.03.24), p2

61. After calling the Service on 29 October 2021, Dr Smith also sent Dr Juniper an email at 11.46 am, in which he said:

> Dear Asha,
>
> I have put (Mr Wilson) on a CTO. Vanda told me you were in agreement with this and with the diagnosis of schizophrenia and treatment with depot paliperidone. He is only on a dose of 75 mg to start after the loading dose as he has had problems with EPSE in the past and I wanted to start low. It likely won't be enough long term. His parents are concerned with diagnosis and treatment but I assured them of its necessity. Sharon gave me an appointment for you to see him on 4 Nov at 1.30 pm. I will no longer be in the service when you get this and Mark Warrington the registrar can answer any queries.[109]

62. In his report, Dr Warrington confirmed the plan was that he was to make a follow up call to the Service on Monday, 1 November 2021, to discuss Mr Wilson's referral to the Service on a CTO. Dr Warrington confirmed that "*the CTO would be issued on the discharge date regardless*", and that he confirmed the CTO. Dr Warrington also said he had instructed the RMO to forward Mr Wilson's discharge summary (which the RMO was responsible for drafting) to the Service, but that "*this did not occur on this date*".[110]

63. As to her purported "*broad agreement*" to Mr Wilson's diagnosis and his transfer to the Service on a CTO, at the inquest Dr Juniper conceded that she had spoken with Dr Vanda Smith about Mr Wilson at a "*work function*" on 28 October 2021. However, Dr Juniper denied this was a "*formal discussion*", and also said that at that time:

> I hadn't formally accepted the CTO, and I certainly didn't feel I had enough information at that point to do so. I anticipated there would be further formal discussion with Dr David Smith.[111]

[109] Exhibit 1, Vol. 1, Tab 26, Graylands Medical Records - Email Dr D Smith to Dr A Juniper (11.46 am, 29.10.21)
[110] Exhibit 1, Vol. 1, Tab 31, Report - Dr M Warrington (19.01.24), p7
[111] ts 21.05.24 (Juniper), pp78 & pp89-91

64. It is clearly unfortunate there was miscommunication about Mr Wilson's discharge, and that Dr Smith was not able to speak with Dr Juniper (or another consultant psychiatrist at the Service), before Mr Wilson was discharged from Graylands.[112] It is also unfortunate Mr Wilson's discharge summary was not forwarded to the Service on 29 October 2021. However, the question of whether any of these failures had any direct impact on Mr Wilson's clinical journey is an entirely different matter.

65. The SAC1 concluded that although Mr Wilson was assessed as "*low risk*" when he was discharged from Graylands on 29 October 2021, "*given that the discharge occurred on a Friday, the panel felt is was appropriate to alert and request follow up by after-hours/weekend (Service) staff of the client on discharge*".[113]

66. Further, in an email she sent to Dr Wojnarowska and others on 1 November 2021, Dr Juniper noted "*the main concern here in relation to this man's safety is around communication on discharge - for example perhaps weekend follow up from our afterhours team could have been helpful*".[114,115] With the benefit considerable of hindsight, the views expressed by the SAC1 and Dr Juniper are clearly sensible.

67. However, at the inquest Dr Juniper agreed that even if Mr Wilson's transfer to the Service been dealt with in the usual way, he would not have been reviewed by her until his appointment on 4 November 2021. Whilst there was a possibility Mr Wilson may have been contacted by a mental health nurse on 1 November 2021, had the Service been aware of his referral on a CTO, that is as far as the evidence before me can go.[116]

68. In my view, perhaps the more pressing failure in Mr Wilson's discharge care from Graylands was the fact that neither Mr Wilson nor his mother were provided with any information about his diagnosis or his new medication regime.

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[112] ts 21.05.24 (Juniper), p91
[113] Exhibit 1, Vol. 1, Tab 17.1, SAC1 Investigation Report (13.02.22), p10
[114] Exhibit 1, Vol. 1, Tab 27, Email - Dr Juniper to Dr Wojnarowska and others (01.11.21)
[115] ts 21.05.24 (Juniper), pp85-86
[116] ts 21.05.24 (Juniper), pp78-79

69. In my view, the reason this is so significant is because both Mr Wilson and his mother had repeatedly expressed concerns about the potential side effects of his antipsychotic medication, and because Mr Wilson had only recently been started on a depot of paliperidone.

70. The SAC1 noted that it had been advised by the Pharmacy at Graylands that on discharge, the patient should be provided with written information on all new medication introduced during the admission. Although this is usually done by the pharmacist, other staff (mainly medical), are also expected to provide information on any new medications.[117]

71. In a letter to the Court dated 6 June 2024, Mr Greg Stockton (counsel for NMHS) provided copies of information pamphlets relating to paliperidone, and noted that:

> The A/Chief Pharmacist, Mr Darren Schwartz, has advised that the usual practice of pharmacy staff at Graylands is to provide a copy of one of the drug specific information leaflets available on the Department of Health's Choice and medication website[118]. Different leaflet formats and styles are available to match the reader's health literacy level. **Attached** to this letter are three of the current leaflets available for paliperidone as a long-acting injection. Unfortunately, no record is available of what information was provided to Mr Wilson or his mother about paliperidone before Mr Wilson was discharged from Graylands Hospital on 29 October 2021.[119] (Original emphasis)

72. The pamphlets attached to Mr Stockton's letter contain a great deal of information about paliperidone depot injections, including an explanation of what paliperidone medication is and why it helps. The pamphlets also outline the likely timeframe for the medication to have an effect, and the possible side effects including the more common (e.g.: akathisia, movement disorders, pain at the injection site), and the less common (for which a doctor should be consulted, namely priapism, and neuroleptic malignant syndrome.[120]

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[117] Exhibit 1, Vol. 1, Tab 17.2, SAC1 Investigation Report Addendum (09.09.22), p3
[118] See: https://www.choiceandmedication.org/wadoh/printable-leaflets/
[119] Exhibit 1, Vol. 1, Tabs 40.1-40.4, Letter - State Solicitors Office to Court & attachments e paliperidone (06.06.24)
[120] See for example: Exhibit 1, Vol. 1, Tabs 40.2, Paliperidone palmitate monthly long-action injection

73. The other notable failure in relation to Mr Wilson's discharge plan from Graylands was the fact that his discharge summary was not forwarded to the Service at the time he was discharged (i.e: 29 October 2021). The reason this was potentially significant was that if Mr Wilson had been seen by the Service's after-hours team over the weekend after his discharge from Graylands, attending clinicians would not have had confirmation of Mr Wilson's latest clinical summary, diagnosis, and medication regime.[121]

74. It appears to be standard procedure that one of the roles of junior doctors, such as RMOs, is the drafting of discharge summaries. In Mr Wilson's case, although Dr Warrington had instructed the RMO to do so, the discharge summary was not forwarded in accordance with the procedure. At the inquest, Dr Warrington noted that that at the relevant time, he was responsible to two consultant psychiatrists, each of whom had a case load of seven patients.[122]

75. Thus Dr Warrington, and probably the RMO as well, each had 14 patients they were in some sense responsible for. In that context, the RMO's failure to forward Mr Wilson's discharge summary to the Service on 29 October 2021, whilst regrettable, is perhaps understandable.

EVENTS LEADING TO MR WILSON'S DEATH

Observations 30 - 31 October 2021

76. During the weekend after Mr Wilson was discharged from Graylands, Mr Wilson's mother says that her son was having trouble breathing and she was "*forced to call a doctor*". She also says that "*after a few days he* (Mr Wilson) *had such bad tremors that he could not do the simplest tasks*", and that these side effects "*were never evident before*".[123]

77. According to Mr Wilson's father, after Mr Wilson was discharged from Graylands, he seemed "*very different*" and was "*quiet and withdrawn*".

[121] ts 22.05.24 (Bhaduri), p101
[122] ts 21.05.24 (Warrington), p49
[123] Exhibit 1, Vol. 1, Tab 10, Statement - Ms A Wilson (02.11.21)

Mr Wilson's father also says that he and his ex-wife "*attributed this to the new medication that he* (Mr Wilson) *was on*".[124]

78. However, I note that although Mr Wilson's parents described him experiencing side effects after his release from Graylands, there is no evidence that either of them observed any signs that Mr Wilson was displaying behaviours which suggested he was at acute risk of suicide or self-harm.

79. It is well known that a person's suicide risk can fluctuate wildly on a relatively short time frame, and that people who take their lives often show no signs or symptoms before doing so. In his report, Dr Hodgson referred to a comprehensive review of suicide research published in the American Psychological Association, in which the lead author (Professor Joseph Franklin of Harvard University) commented that:

> Our analysis showed that science could only predict future suicidal thoughts and behaviours about as well as random guessing. In other words, a suicide expert who conducted in-depth assessment of risk factors would predict a patient's future suicidal thoughts and behaviours with the same degree of accuracy as someone with no knowledge of the patient who predicted based on a coin flip.[125]

Mr Wilson's visit with father - 1 November 2021[126,127,128,129]

80. In a statement he gave on 2 November 2021, Mr Wilson's father says that at about 10.30 am on 1 November 2021, he was at his home in Padbury, when his ex-wife (Mr Wilson's mother), dropped Mr Wilson off for a visit. He and Mr Wilson went out and did some shopping, and on their return, he (Mr Wilson's father) made them some lunch, and they watched a movie on TV.[130]

81. During the movie, Mr Wilson went outside for a cigarette, and his father followed him outside and asked if he wanted some music put on. When

[124] Exhibit 1, Vol. 1, Tab 9, Statement - Mr S Wilson (02.11.21), paras 8-9
[125] Exhibit 1, Vol. 1, Tab 29, Report - Dr C Hodgson (27.11.23), p6 and ts 21.05.24 (Hodgson), p22
[126] Exhibit 1, Vol. 1, Tab 2, Report - Ms C Vernon Coronial Investigation Squad (26.04.23), pp2-4
[127] Exhibit 1, Vol. 1, Tab 3, Memorandum - FC Const. S McGrady (01.11.21)
[128] Exhibit 1, Vol. 1, Tab 4, Memorandum - Sen. Const. L Woolfe (02.11.21)
[129] Exhibit 1, Vol. 1, Tab 12, WA Police Incident Report LWP21110100822579 (01.11.21)
[130] Exhibit 1, Vol. 1, Tab 9, Statement - Mr S Wilson (02.11.21), paras 10-13

Mr Wilson replied: "*OK*", his father went inside and put on some music, before going to the back shed to fetch some weed spray.[131]

82. In a subsequent undated letter (which I read out at the inquest at his request), Mr Wilson's father says after he made Mr Wilson some lunch, they went into the backyard and he tried to engage Mr Wilson in some gardening. However, Mr Wilson had "*no coordination*" and "*even the simplest thing was an extreme effort*" so instead, he wandered around the backyard having a cigarette. Mr Wilson's father says he "*sat (Mr Wilson) down at the patio table*" before he went to the back shed for some spray.[132]

83. Either way, Mr Wilson's father was only gone a matter of moments, and as he approached the tap at the back of his house he could hear a "*roaring sound*". As he looked around the corner from the tap, Mr Wilson's father saw to his horror that Mr Wilson was squatting in the garage, covered with flames. It appears that in the few moments he was alone, Mr Wilson went into the garage and doused himself with fuel from a jerry can labelled "*boat fuel*", before setting himself alight.[133,134,135,136]

84. On seeing his son ablaze, Mr Wilson's father rushed to the garage and used his coat to smother the flames engulfing Mr Wilson, before fetching a garden hose to do the same. Mr Wilson's father's actions in these appalling circumstances were incredibly brave, and he injured his hand after he placed it over the burning opening of the jerry can, which he feared was about to explode.[137,138]

85. As Mr Wilson's father was calling emergency services, his ex-wife arrived, and they used the garden hose to cool Mr Wilson while they waited for an ambulance. A short time later police arrived and assisted

[131] Exhibit 1, Vol. 1, Tab 9, Statement - Mr S Wilson (02.11.21), paras 14-17
[132] Exhibit 1, Vol. 1, Tab 36.1, Letter - Mr S Wilson (undated)
[133] Exhibit 1, Vol. 1, Tab 9, Statement - Mr S Wilson (02.11.21), paras 18-26
[134] Exhibit 1, Vol. 1, Tab 36.1, Letter - Mr S Wilson (undated)
[135] Exhibit 1, Vol. 1, Tab 11, Photographs of red jerry can labelled "*boat fuel*"
[136] Exhibit 1, Vol. 1, Tab 2, Report - Ms C Vernon Coronial Investigation Squad (26.04.23), pp3-4
[137] Exhibit 1, Vol. 1, Tab 9, Statement - Mr S Wilson (02.11.21), paras 21-23
[138] Exhibit 1, Vol. 1, Tab 36.1, Letter - Mr S Wilson (undated)

with first aid, before being joined by ambulance officers who took over Mr Wilson's management and transported him to JHC.[139,140,141,142,143]

Transfer to hospital and management[144,145,146,147,148,149]

86. At JHC, Mr Wilson was assessed as having "*full thickness burns*" to 60 - 70% of his body. After his condition was stabilised, Mr Wilson was transferred to Fiona Stanley Hospital (FSH) by ambulance. At FSH Mr Wilson was taken to theatre and assessed by two burns consultants, who confirmed Mr Wilson had very severe burns involving about 60% of his body.

87. Mr Wilson was admitted to the intensive care unit where he underwent various specialist reviews. It was determined that Mr Wilson's injuries were non-survivable, and following discussions with his family, it was decided to treat Mr Wilson palliatively. Mr Wilson was kept comfortable until he died at 6.58 pm on 1 November 2021.[150,151,152]

CAUSE AND MANNER OF DEATH[153,154]

88. A forensic pathologist (Dr Ong), conducted an external post mortem examination of Mr Wilson's body on 4 November 2021 and reviewed CT scans. Dr Ong also reviewed FSH medical notes, which confirmed Mr Wilson had sustained full thickness burns to 60% of his body.[155]

89. Dr Ong's external examination noted "*widespread thermal injuries the body surface and evidence of medical intervention*", whilst CT scans showed no evidence of significant skeletal injuries.[156]

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[139] Exhibit 1, Vol. 1, Tab 9, Statement - Mr S Wilson (02.11.21), paras 24-25
[140] Exhibit 1, Vol. 1, Tab 36.1, Letter - Mr S Wilson (undated)
[141] Exhibit 1, Vol. 1, Tabs 15.1, St John Ambulance Patient care records - Crew JOO42DD (02.11.21)
[142] Exhibit 1, Vol. 1, Tabs 15.2, St John Ambulance Patient care record - Crew WAR22D2 (02.11.21)
[143] Exhibit 1, Vol. 1, Tabs 15.3, St John Ambulance Patient care records - Crew CSN01D2 (02.11.21)
[144] Exhibit 1, Vol. 1, Tab 23.1, JHC - Emergency Department Triage/Nursing Assessment (01.11.21)
[145] Exhibit 1, Vol. 1, Tab 23.2, JHC - Emergency Department Trauma Record (01.11.21)
[146] Exhibit 1, Vol. 1, Tab 22.1, FSH - Discharge Summary (01.11.21)
[147] Exhibit 1, Vol. 1, Tab 22.2, FSH 0 Adult Triage Nursing Assessment (01.11.21)
[148] Exhibit 1, Vol. 1, Tab 23.2, JHC Emergency Department Trauma Record (01.11.21)
[149] Exhibit 1, Vol. 1, Tabs 15.1-15.3, St John Ambulance Patient care records (02.11.21)
[150] Exhibit 1, Vol. 1, Tab 22.1, FSH - Discharge Summary (01.11.21)
[151] Exhibit 1, Vol. 1, Tab 5, FSH - Death in Hospital Form (01.11.21)
[152] Exhibit 1, Vol. 1, Tab 6, P92 - Identification of Deceased Person (03.11.21)
[153] Exhibit 1, Vol. 1, Tab 7.1, Supplementary Post Mortem Report (04.01.22)
[154] Exhibit 1, Vol. 1, Tab 7.2, Post Mortem Report (04.11.21)
[155] Exhibit 1, Vol. 1, Tab 7.1, Supplementary Post Mortem Report (04.01.22)
[156] Exhibit 1, Vol. 1, Tab 7.1, Supplementary Post Mortem Report (04.01.22)

90. Toxicological analysis found medications in Mr Wilson's system that were consistent with his medical care. Alcohol and other common drugs were not detected.[157]

91. At the conclusion of his external post mortem examination, Dr Ong expressed the opinion that the cause of Mr Wilson's death was "*complications in association with effects of fire, with terminal palliative care*".[158]

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

93. Further, in view of all of the circumstances, I find that Mr Wilson's death occurred by way of suicide.

OTHER ISSUES RAISED BY THE EVIDENCE

Side effects

94. The evidence establishes that Mr Wilson regularly complained of side effects which he attributed to his medication. These side effects included constipation, insomnia, tremors, odd body movements and weight gain. Mr Wilson's mother also regularly raised concerns about the potential side effects of her son's various medications.

95. At the inquest, Dr Hodgson (with whom Dr Warrington agreed) said that the true extent of Mr Wilson's side effects was difficult to assess because Mr Wilson often reported side effects that were not observed by his treating clinicians. For example, Mr Wilson often reported insomnia, but during his last admission, a sleep chart recording hourly observations at night showed that he was almost always asleep.[159,160]

96. In his report, Dr Brett made the following comments about Mr Wilson's side effects:

[157] Exhibit 1, Vol. 1, Tab 8.1, Final Toxicology Report (24.12.21)
[158] Exhibit 1, Vol. 1, Tab 7.1, Supplementary Post Mortem Report (04.01.22)
[159] ts 21.05.24 (Hodgson), pp9-10 and ts 21.05.24 (Warrington), pp51, 56 & 69-70
[160] See also: Exhibit 1, Vol. 1, Tab 30, Report Dr J Hahn (29.11.23), pp2 & 3 and ts 21.05.24 (Hahn), pp27-28

> There is good evidence that Mr Wilson was experiencing debilitating side effects from his medications following discharge. The description was consistent with akathisia. Mr Wilson had also experienced unusual neurological side effects (mild ataxia and dysdiadochokinesis) that would have benefitted from further investigation.[161]

97. At the inquest Mr Schwartz agreed that some long-term psychiatric patients attribute side effects to their medications which their treating clinicians are unable to see, and which may be related to their mental illness rather than manifesting physically.[162] In any case, regardless of the actual severity of Mr Wilson's side effects, there seems to be little doubt that Mr Wilson found aspects of his medication regime troubling, and the fact that he was trialled on a variety of medications during his mental health journey may have added to these concerns.

Paliperidone[163,164,165]

98. In his report to the Court, the Acting Chief Pharmacist at Graylands (Mr Schwartz) explained that paliperidone is a second generation (or atypical) antipsychotic. This medication can be given orally or by way of long lasting depot injections. Mr Schwartz said that paliperidone is "*indicated in the treatment of schizophrenia and bipolar disorder*", and its depot form, which is the most prescribed long acting injection in Western Australia, is used when medication compliance may be an issue.

99. Mr Schwartz noted that although the usual initial dose for a depot of paliperidone is 150 mg on "*Day 0*" followed by 100 mg on "*Day 8*", Mr Wilson received 150 mg on 21 October 2021, followed by 75 mg on 28 October 2021. As I have explained, the reason for this lower second dose was that both Mr Wilson and his mother had expressed concerns about side effects, although as noted Mr Wilson had used this medication successfully in the past.

[161] Exhibit 1, Vol. 1, Tab 18.1, Report - Dr A Brett (17.10.23), para 18, p14 and ts 21.05.24 (Brett), pp126-129
[162] ts 22.05.24 (Schwartz), pp115-116 and see also: ts 21.05.24 (Juniper), p82 and ts 21.05.24 (Brett), pp125-126
[163] Exhibit 1, Vol. 1, Tab 35, Report - Mr D Schwartz (07.05.24) and ts 22.05.24 (Schwartz), pp113-121
[164] Exhibit 1, Vol. 1, Tab 17.2, SAC1 Investigation Report Addendum (09.09.22), pp2-4
[165] See Also: and ts 21.05.24 (Warrington), pp69-70

100. As Mr Schwartz explained, antipsychotics can provoke extrapyramidal side effects (EPSE) such as tremor, dystonia (a movement disorder where muscles contract), and akathisia (an inability to sit still) in some patients by the dopamine blocking effects on dopamine receptors.

101. Mr Schwartz noted that Mr Wilson had been given several antipsychotic medications before the paliperidone depot and his dose of diazepam had been progressively reduced before being ceased. However, Dr Schwartz also noted that although paliperidone does carry the risk of EPSE including akathisia:

> [I]t is rare for akathisia to set in immediately after the initiation of a depot (long acting injection) simply because the initial release and build-up of antipsychotic levels takes much longer when a long acting injection is used. Akathisia is far more common with oral medication than with depot medication.[166]

102. In an addendum to the SAC1, which was published following a family meeting with Mr Wilson's parents in June 2022, the panel noted:

> Pharmacy further advised that although rare, akathisia can be induced shortly after a paliperidone depot injection is administered. This side effect is not common with depot antipsychotics as it would be with short acting ones. Pharmacy advised it is less likely that (Mr Wilson) suffered side effects from paliperidone that from the total amount of medications given during the admission, however, it is unlikely side effects from the medications would have caused (Mr Wilson) to self-immolate.[167]

103. In the addendum, the panel also noted that Mr Wilson had a history of dystonic reactions to typical and atypical antipsychotic medications and had experienced EPSE. In this case, Mr Wilson had successfully used paliperidone in the past, and at the inquest, Dr Brett said that patients are often started on antipsychotic depot injections in the community.[168]

[166] Exhibit 1, Vol. 1, Tab 35, Report - Mr D Schwartz (07.05.24) and ts 22.05.24 (Schwartz), pp117-119
[167] Exhibit 1, Vol. 1, Tab 17.2, SAC1 Investigation Report Addendum (09.09.22), p3
[168] ts 21.05.24 (Brett), p145

104. Mr Wilson received his first two depot doses of paliperidone at Graylands, although the second dose was given the day before his discharge. When reviewed by Dr Warrington on 29 October 2021 prior to his discharge, Mr Wilson's mental state was stable and he denied any suicidal ideation. Dr Warrington also said Mr Wilson "*did not demonstrate any side effects from his medication during this review*".[169]

105. Mr Schwartz reviewed a letter from Mr Wilson's mother and spoke to one of the consultants on the SAC1 panel, before observing:

> [I]t seems likely that Mr Wilson was suffering from significant side effects from the medications used. Having said that, Dr Brett points out the lack of research in the area associating akathisia (or other EPSE) with suicide. Although medication side effects could contribute to the impetus to make a suicide attempt, I would be reluctant to attribute a single cause such as medication side effects as the sole prompt for a suicide attempt.[170,171]

Cessation of diazepam

106. Diazepam is a benzodiazepine medication that can be useful in controlling some side effects of antipsychotic medications, including reducing the effects of akathisia. However, long-term use of diazepam can be problematic due to issues of dependence, and the risk of unwanted side effects including cognitive impairment, memory problems and mood swings.

107. Mr Wilson's diazepam dose was gradually reduced during his last admission at Graylands so that by the time he was discharged it had been completely withdrawn. At the inquest, Dr Hodgson and Mr Schwartz both said that the cessation of Mr Wilson's diazepam was managed appropriately. Further, despite Ms Wilson's firm views to the contrary, there is no evidence before me that the cessation of Mr Wilson's diazepam had anything to do with his death.[172,173]

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[169] Exhibit 1, Vol. 1, Tab 31, Report - Dr M Warrington (19.01.24), p7
[170] Exhibit 1, Vol. 1, Tab 35, Report - Mr D Schwartz (07.05.24), pp3-4 and ts 22.05.24 (Schwartz), pp119-120
[171] ts 22.05.24 (Brett), p140
[172] ts 2x.05.24 (Hodgson), p10; ts 21.05.24 (Schwartz), pp114 & 117; and see also: ts 22.05.24 (Brett), p129
[173] Exhibit 1, Vol. 1, Tab 10, Statement - Ms A Wilson (02.11.21)

Transfer of patients on CTO

108. As I have outlined, Mr Wilson's discharge from Graylands on 29 October 2021 was marred by miscommunication between Graylands and the Service, and by the failure to provide Mr Wilson and his mother with relevant information about his diagnosis and his new medication regime.

109. The information which clearly should have been provided to Mr Wilson and his mother should also have included the potential side effects of Mr Wilson's medication (including paliperidone) and the signs to look out for which would indicate that Mr Wilson's mental was deteriorating. There should also have been an indication of the pathway back into care if Mr Wilson's mental state was noted to be deteriorating.

110. Since Mr Wilson's death, relevant clinical staff have been reminded of the policy requirement that all patient discharges under the MHA involving a CTO require: "*verbal consultation between associated Consultant Psychiatrists*" before the patient is discharged.[174][175]

QUALITY OF SUPERVISION, TREATMENT AND CARE

SAC1 findings[176]

111. The SAC1 noted that Mr Wilson's mental state had "*deteriorated significantly*" in the four or five months prior to his death. Although Mr Wilson had reportedly stopped using illicit substances and received treatment from mental health professionals during this period, he continued to complain of issues with insomnia and constipation, and he appeared to develop symptoms of a depressive disorder and psychosis.

112. The SAC1 expressed the following conclusions about Mr Wilson's treatment and care:[177]

a. *Diagnosis*: the panel considered that Mr Wilson's treatment was impacted by "*lack of clarity regarding his diagnosis*", and

[174] Exhibit 1, Vol. 1, Tab 38, NMHS Inpatient Mental Health Services Admission to Discharge, p7
[175] ts 22.05.24 (Bhaduri), p108
[176] Exhibit 1, Vol. 1, Tab 17.1, SAC1 Investigation Report (13.02.22)
[177] Exhibit 1, Vol. 1, Tab 17.1, SAC1 Investigation Report (13.02.22), pp9-10

that this had also affected the development of his risk management plan;[178]

b. *Medication management*: the panel noted Mr Wilson's medication management was complicated by issues of non-compliance, his history of using illicit substances, and by his proclivity to alter the dosages of his medication to manage perceived side effects, without first obtaining any input from his treating team;

c. *Assessments*: the panel found Mr Wilson's inpatient and community assessments were comprehensive and had been informed by collateral information obtained from his mother. The panel also noted that information (including discharge summaries) had been provided to Mr Wilson's GP;[179]

d. *Transfers*: the panel noted that although there was evidence of communication between inpatient and community teams early in 2021, there was no documented evidence of communication during Mr Wilson's last two admissions;[180]

e. *Case conferences*: the panel considered that collaborative case conferences would have been of benefit given "*the complexity of managing this client*". However, as I have noted, Mr Wilson was an "*out of area*" patient at Graylands and so he was not discussed at weekly video-conferences between Graylands and its local community mental health service.

f. *Referral to after-hours team*: as noted earlier, the panel considered that although Mr Wilson was assessed as "*low risk*" when he was discharged from Graylands on 29 October 2021, he should have been followed up by the Service's after hours/weekend team.

g. *Interaction with Dr Smith*: the panel noted Ms Wilson had forwarded a letter about Dr Smith's communication style and Mr Wilson's treatment plan.[181,182] At the inquest, Dr Brett noted that communication issues of this nature can sometimes

[178] See also: and ts 22.05.24 (Bhaduri), pp105-106
[179] Although as noted, Mr Wilson's discharge summary was not forwarded to the Service on 29 October 2021
[180] However, see Dr Smith's email to Dr Juniper on 29 October 2021, to which I have referred
[181] Exhibit 1, Vol. 1, Tab 10, Letter - Ms A Wilson to Chief Psychiatrist (undated)
[182] Exhibit 1, Vol. 1, Tab 36.1, Letter - Ms A Wilson (02.11.21)

> simply be a matter of the "*fit*" between the patient, their carer(s) and the relevant clinician.[183]
>
> Although this issue is outside the scope of this inquest, I note that NMHS[184] wrote to Ms Wilson to advise that although Dr Smith was no longer employed by the service, staff had been asked to provide "*clearer communication when relaying treatment regimes and options*".[185]

113. The SAC1 identified two "*system gaps*" in relation to Mr Wilson's care that were caused by a "*lack of continuous education of staff*". The first system gap related to a lack of collaborative case conferencing and care planning between inpatient and community mental health services, which "*may have contributed to fragmented care between settings and a lack of timely follow up*". The second system gap related to inadequate assessment of Mr Wilson at "*different contacts with mental health services*" which "*may have contributed to ambiguity of diagnosis*".[186]

114. The panel also made three recommendations for improvement. The first was aimed at reminding staff of the need to comply with relevant polices relating to admission and discharge. The second focussed on ensuring mandatory education was completed and that staff skills are identified and assessed, while the third dealt with identifying and promoting training resources in relation to the MHA.[187]

Dr Brett's assessment[188]

115. In his report to the Court, Dr Brett (an experienced consultant psychiatrist) reviewed Mr Wilson's case, and his observations included:

a. *Diagnosis*: Dr Brett noted Mr Wilson's presentations were atypical, and that there was disagreement about his diagnosis. Dr Brett said he had "*no doubt that Mr Wilson was suffering a severe mental disorder at the time of his death*", but expressed some concern about the diagnosis of schizophrenia, noting he could not find the "*rationale for*

[183] ts 21.06.24 (Brett), p144 and see also: ts 22.05.24 (Bhaduri), p99
[184] NMHS is the abbreviation for North Metropolitan Health Service, the entity responsible for Graylands
[185] Exhibit 1, Vol. 1, Tab 36.2, Letter - Dr G Wojnarowska to Ms A Wilson 1(6.09.22)
[186] Exhibit 1, Vol. 1, Tab 17.1, SAC1 Investigation Report (13.02.22), p10
[187] Exhibit 1, Vol. 1, Tab 17.1, SAC1 Investigation Report (13.02.22), pp13-14
[188] ts 21.05.24 (Brett), pp130-147

the diagnosis". Dr Brett said he would like to have seen evidence of a comprehensive developmental history, a review of Mr Wilson's previous presentations, and "*a formulation of the recent decline and multiple presentations to hospital*". Dr Brett also said he would have expected a more thorough assessment of Mr Wilson's "*personality characteristics and his coping mechanisms*", and raised the possibility Mr Wilson may have had autism spectrum disorder, although this was discounted by Dr Hodgson in his report.[189,190]

b. *Care from July 2021*: Dr Brett said Mr Wilson's care during the four month period prior to his death was "*suboptimal*", and there had not been a coordinated approach to his care. Dr Brett said there should have been increased liaison between Mr Wilson's hospital and community treating teams, and there was an "*inconsistent formulation regarding his suicide attempt*". Dr Brett also said there should have been a case conference between Graylands and the community team, and I have already canvassed the miscommunications that occurred during Mr Wilson's final discharge from Graylands.[191]

c. *Risk assessments*: Dr Brett said he did not believe appropriate risk assessments and that the risk assessment process used was "*unvalidated, not standardised, and not contemporary*". Dr Brett said that Mr Wilson required a risk formulation "*explaining his previous suicide attempt and how his risk had changed*". Dr Brett said Mr Wilson also required a risk management plan "*addressing his risk factors and a plan if he deteriorated*".[192]

d. *Engagement with family*: Dr Brett said he did not believe there was sufficient engagement with Mr Wilson's family during his final admission, and that it would have been appropriate for the team social worker "*or a specific carer support worker*" to be involved. While I take Dr Brett's point about the use of a social worker and/or carer support worker, I note that a family meeting attended by Mr Wilson's mother was conducted, and that during Mr Wilson's final admission to Graylands, she had several detailed conversations with Dr Warrington about his diagnosis and medication regime.[193,194]

[189] Exhibit 1, Vol. 1, Tab 18.1, Report - Dr A Brett (17.10.23), pp11-15
[190] Exhibit 1, Vol. 1, Tab 29, Report - Dr C Hodgson (27.11.23), para 17.2, p5 and ts 21.05.24 (Hodgson), p12
[191] Exhibit 1, Vol. 1, Tab 18.1, Report - Dr A Brett (17.10.23), p14
[192] Exhibit 1, Vol. 1, Tab 18.1, Report - Dr A Brett (17.10.23), pp14-15 and ts 22.05.24 (Brett), pp141-142
[193] Exhibit 1, Vol. 1, Tab 31, Report - Dr M Warrington (19.01.24), pp5-7

116. In relation to Mr Wilson's care during the period before his death, Dr Brett expressed the following opinion:

> I believe that in the final months of his life, (Mr Wilson's) management was suboptimal. There did not appear to be a united approach to his formulation and management. It seems that there were a number of issues that were not properly addressed or considered.[195]

Dr Hodgson's observations

117. In his report, Dr Hodgson referred to Mr Wilson's complex personality structure and his various diagnoses including anxiety, bipolar affective disorder, obsessive compulsive disorder, schizoaffective disorder, and schizophrenia.[196] Drawing on his lengthy experience in managing patients like Mr Wilson in the community, Dr Hodgson made these observations about the management of Mr Wilson's mental health:

> Mr Wilson's complex mental illness, his ongoing drug use, his sensitivity to medications, and his reluctance to accept the supports offered, made community management very difficult and meant that his prognosis was poor.[197]

118. Dr Hodgson said he suspected that Mr Wilson had experienced cognitive decline and associated social and occupational decline "*secondary to his longstanding drug use*", and noted that Mr Wilson's "*episodes of psychosis and mania*" appeared to be related to his "*ongoing use of illicit substances (mainly methylamphetamine)*".[198]

119. Dr Hodgson also noted that despite the obvious impact that Mr Wilson's substance use was having on his mental health, he routinely declined referrals to drug rehabilitation services. Mr Wilson also declined

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[194] Exhibit 1, Vol. 1, Tab 18.1, Report - Dr A Brett (17.10.23), p15 and ts 22.05.24 (Brett), pp143-144
[195] Exhibit 1, Vol. 1, Tab 18.1, Report - Dr A Brett (17.10.23), para 22, p15
[196] Exhibit 1, Vol. 1, Tab 29, Report - Dr C Hodgson (27.11.23), para 18.2, p5
[197] Exhibit 1, Vol. 1, Tab 29, Report - Dr C Hodgson (27.11.23), para 20, p6
[198] Exhibit 1, Vol. 1, Tab 29, Report - Dr C Hodgson (27.11.23), paras 18.2-18.3, p5

psychological input, and/or services aimed at reducing his social isolation offered by a step down facility, and the Men's Shed program.[199]

120. Although Dr Hodgson noted that Mr Wilson had supportive parents who were happy for him to live with them, Dr Hodgson considered Mr Wilson "*may have benefitted from a long-term placement in a supported community residential unit*" although Dr Hodgson felt *"he would have been reluctant to accept such placement*".[200]

Dr Bhaduri's observations

121. Dr Bhaduri (Director of Medical Services, NMHS) said that after reviewing relevant medical records, in her view the decision to place Mr Wilson on a CTO was justifiable. Dr Bhaduri noted Mr Wilson had six inpatient admissions in a four month period which indicated a "*risk of rapid relapse*", and there was evidence of non-compliance with medication. Mr Wilson had also been diagnosed with a serious mental illness "*characterised by psychotic symptoms, mood problems and substance use*" and Dr Bhaduri noted "*there was evidence that without ongoing treatment and support, Mr Wilson was at risk of significant harm to himself*".[201]

122. Dr Bhaduri highlighted the lack of direct communication with the "*community consultant*" regarding Mr Wilson's transfer on a CTO, and noted this lapse had occurred because Mr Wilson's discharge coincided with Dr Smith's impending retirement and Dr Juniper's "*non-working day*". Dr Bhaduri also noted that "*it is possible the retiring consultant aimed to minimise transitions in consultants and honoured Mr Wilson's request for discharge on that day*".[202]

123. Dr Bhaduri commented on the findings and recommendations of the SAC1, and made the following observation about the current situation at Graylands:

[199] Exhibit 1, Vol. 1, Tab 29, Report - Dr C Hodgson (27.11.23), paras 18.2-18.3, p5
[200] Exhibit 1, Vol. 1, Tab 29, Report - Dr C Hodgson (27.11.23), para 18.5, pp5-6
[201] Exhibit 1, Vol. 1, Tab 37, Report - Dr S Bhaduri (15.05.24), pp1-2 and ts 22.05.24 (Bhaduri), pp95-96
[202] Exhibit 1, Vol. 1, Tab 37, Report - Dr S Bhaduri (15.05.24), pp1-2 and ts 22.05.24 (Bhaduri), pp96

> If Mr Wilson presented at Graylands Hospital today, improvements in communication between inpatient and community mental health teams would likely enhance his care, particularly in discharge planning and CTO utilisation. Revised policies now mandate verbal consultation between consultant psychiatrists, facilitating better understanding of clinical perspectives and risks.[203]

124. Dr Bhaduri noted there "*increased consideration*" of using after-hours teams, and the HiTH to address the concerns such as those raised by Mr Wilson and his family "*regarding medication side effects and insomnia*". Dr Bhaduri also noted that the Brief Risk Assessment (consistently criticised by Dr Brett as "*unvalidated, not standardised and not contemporary*")[204] has been replaced by a risk assessment and management plan that "*offers flexibility to develop a risk formulation*".[205]

125. Dr Bhaduri acknowledged that Mr Wilson faced challenges with various treatments and "*sensitivities to medications*", and this was compounded by his serious mental illness characterised by several "*somatic*"[206] concerns "*which overlapped with some of his side effects, and needed to be treated*.[207]

126. Dr Bhaduri said that with "*sincere regard for the unfortunate outcome*", in her opinion, Mr Wilson's treating team had "*mostly shown inclusivity and responsiveness*" to Mr Wilson and his family in relation to "*medication side effects, effectiveness, and preferences*. Dr Bhaduri concluded her report with the following observation:

> From my perspective, clinicians attempted to navigate these challenging complexities by balancing the necessity of treating (Mr Wilson's) condition with his anxiety surrounding medication and the associated side effects.[208,209]

[203] Exhibit 1, Vol. 1, Tab 37, Report - Dr S Bhaduri (15.05.24), pp1-2 and ts 22.05.24 (Bhaduri), pp97-100
[204] Exhibit 1, Vol. 1, Tab 18, Report - Dr A Brett (17.10.23), para 20, pp14-15
[205] Exhibit 1, Vol. 1, Tab 37, Report - Dr S Bhaduri (15.05.24), pp1-2 and ts 22.05.24 (Bhaduri), pp102-103 & 108-109
[206] Relating to, or affecting the body, as distinct from the mind
[207] Exhibit 1, Vol. 1, Tab 37, Report - Dr S Bhaduri (15.05.24), pp1-2
[208] Exhibit 1, Vol. 1, Tab 37, Report - Dr S Bhaduri (15.05.24), p3 and ts 22.05.24 (Bhaduri), pp104-105
[209] See also: 21.05.24 (Hodgson), p9 concerning Mr Wilson's chronic anxiety and his proclivity to report side effects

Conclusion on standard of supervision, treatment and care

127. In assessing the quality of Mr Wilson's supervision, treatment and care, I have applied the standard of proof set out in the High Court's decision in ***Briginshaw v Briginshaw***[210] (the Briginshaw principle) which requires consideration of the nature and gravity of the conduct when deciding whether a finding adverse in nature has been proven on the balance of probabilities.

128. I have also been mindful not to insert hindsight bias into my assessment. Hindsight bias is the tendency after an event, to assume that the event was more predictable or foreseeable than it actually was at the relevant time.[211]

129. After carefully reviewing the available evidence, I have concluded that the decision to place Mr Wilson on a CTO prior to his discharge from Graylands on 29 October 2021 was appropriate. The CTO was justified because of ongoing concerns about Mr Wilson's ongoing risk of suicide, and doubts about whether he would comply with his depot medication.

130. I have also concluded that Mr Wilson's treatment at Graylands during his last admission was appropriate, and that his medication regime (including the commencement of a paliperidone depot, and the reduction and then cessation of his dose of diazepam) was appropriate.

131. Although Mr Wilson's discharge from Graylands on 29 October 2021 was justified given the improvement in his mental state, and his desire to return home, his discharge plan was compromised. That was because prior to Mr Wilson's discharge his consultant psychiatrist at Graylands did not speak directly with the consultant psychiatrist at the Service who would be assuming Mr Wilson's care in the community. Although Dr Warrington was to contact the Service on 1 November 2021 to discuss Mr Wilson's CTO and his ongoing management, Mr Wilson died before this contact could occur.[212]

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[210] (1938) 60 CLR 336, per Dixon J at pp361-362
[211] Dillon H and Hadley M, *The Australasian Coroner's Manual (2015)*, p10
[212] ts 22.05.24 (Brett), pp144-145

132. It is also unfortunate that Mr Wilson's Graylands discharge summary (which contained important information about the management of his mental health) was not sent to the Service on the day Mr Wilson was discharged. Whilst the reason for this lapse has not been explained, it may have been due to workload pressures on the RMO who was responsible for preparing the summary.[213]

133. It is also regrettable that Mr Wilson and his mother were not given basic information about his diagnosis of schizophrenia, or his medication regime, including the depot injections of paliperidone he had recently been started on.[214] Notwithstanding their familiarity with the mental health system, it is my view that Mr Wilson and his mother should also have been given information about the likely, or potential side effects of Mr Wilson's medication, and concerning signs and symptoms to watch out for, as well as the pathway back to care should Mr Wilson's mental state deteriorate.

134. As to whether Mr Wilson's death could have been prevented, I note that at the time of his discharge, his risk of suicide had been assessed as "*low*". Further, although Mr Wilson did appear to be experiencing some side effects from his medication after his discharge from Graylands on 29 October 2021, there is no evidence that Mr Wilson was experiencing any thoughts of suicide or self-harm, or that there were any signs he was at any acute risk in the period between his discharge and his death.

135. This lack of any apparent advance warning is perhaps not surprising given it is impossible to predict a person's future risk of suicide. I have already referred to the review of suicide research referred to in Dr Hodgson's report, where the study's lead author (Professor Franklin) concluded that science could predict a person's future suicidal thoughts and behaviours about as well as random guessing, before observing: "*This was extremely humbling - after decades of research; science had produced no meaningful advances in suicide prediction*".[215,216,217]

[213] ts 21.05.24 (Warrington), p63
[214] Exhibit 1, Vol. 1, Tab 10, Statement - Ms A Wilson (02.11.21)
[215] Exhibit 1, Vol. 1, Tab 29, Report - Dr C Hodgson (27.11.23), para 19, p6
[216] See also: ts 21.05.24 (Warrington), p63, where Dr Warrington says Mr Wilson's action were a complete shock
[217] See also: ts 22.05.24 (Bhaduri), p104 and ts 21.05.24 (Brett), pp134-135

136. In her report, Dr Juniper made the following observations about factors that made Mr Wilson's care and treatment more difficult to provide:

> I consider that this is a complex and largely a systemic issue related to resourcing and community demand for mental health services in WA, Globally, there are also challenges associated with care and treatment where multiple clinicians are involved, including clarity around diagnosis clear communication with all parties. To that end, I consider that better communication from Graylands Hospital on 29 October 2021 prior to discharge would have been optimal but that it may not have necessarily prevented (Mr Wilson's) death by suicide.[218]

137. However, I note that at the inquest, Dr Juniper agreed that on reflection, it would have been better to have expressed the following view: "*it is impossible to know whether or not it* (i.e.: better communication from Graylands) *would have changed the outcome in Mr Wilson's case*".[219]

138. After carefully considering the available evidence, and having regard to the Briginshaw principle, and to the phenomenon of hindsight bias, I have been unable to conclude (to the relevant standard) that any defect in Mr Wilson's discharge planning was causative of his death.[220] The reason why Mr Wilson chose to take his life in the manner he did must remain a mystery, and this no doubt adds to the pain that his death has caused to his family and loved ones.

CONCLUSION

139. Mr Wilson was a dearly loved family member, who was 41-years of age when he died from the effects of fire on 1 November 2021. It is impossible for me to imagine the impact of this appalling tragedy on Mr Wilson's family and loved ones, and the ongoing pain and trauma they continue to experience as a result of his death.

[218] Exhibit 1, Vol. 1, Tab 32, Report - Dr A Juniper (25.01.24), p7 and ts 21.05.24 (Juniper), pp79-80
[219] ts 21.05.24 (Juniper), p81
[220] See also: ts 21.05.24 (Juniper), p91; ts 22.05.24 (Bhaduri), p97; and ts 21.05.24 (Brett), pp135-136

140. Mr Wilson's case highlights the difficulties of managing someone with a complex and atypical presentation, characterised by multiple diagnoses, non-compliance with medication, and intermittent polysubstance use. Mr Wilson's death also highlights the ever-changing risk of self-harm and suicide associated with some mental health illnesses, and the challenges in managing those risks.[221]

141. As I did at the conclusion of the inquest, I wish to again convey to Mr Wilson's family and friends, on behalf of the Court, my very sincere condolences for their terrible loss.

MAG Jenkin
Coroner
26 June 2024

[221] ts 21.05.24 (Hodgson), p15