JURISDICTION	**:**	CORONER'S COURT OF WESTERN AUSTRALIA
ACT	**:**	CORONERS ACT 1996
CORONER	**:**	PHILIP JOHN URQUHART, CORONER
HEARD	**:**	17 JUNE 2025
DELIVERED	**:**	11 JULY 2025
FILE NO/S	**:**	CORC 1566 of 2023
DECEASED	**:**	GOMEZ, MONIQUE JACINTA

Catchwords:

Nil

Legislation:

Nil

Counsel Appearing:
Mr WJ Stops assisted the Coroner
Ms P A Femia appearing on behalf of the South Metropolitan Health Service
Mr M Williams appearing on behalf of Dr Vidya Narayanan
Ms K Reynolds appearing on behalf of Dr Andrew Roney

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

Nil

Coroners Act 1996
(Section 26(1))

RECORD OF INVESTIGATION INTO DEATH

I, Philip John Urquhart, Coroner, having investigated the death of ***Monique Jacinta GOMEZ*** *with an inquest held at Perth Coroners Court, Central Law Courts, Court 85, 501 Hay Street, PERTH, on 17 June 2025, find that the identity of the deceased person was* ***Monique Jacinta GOMEZ*** *and that death occurred on 29 May 2023 at Fiona Stanley Hospital, 11 Robin Warren Drive, Murdoch, from an intracerebral haemorrhage on a background of anticoagulation therapy for a recent embolic stroke in a woman with a mechanical aortic valve in the following circumstances:*

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INTRODUCTION

"I have schizophrenia. I am not schizophrenia. I am not my mental illness. My illness is a part of me."
Jonathan Harnisch - author

1 On 29 May 2023, Monique Jacinta Gomez (Ms Gomez) died from an intracerebral haemorrhage while receiving treatment at Fiona Stanley Hospital (FSH) for an embolic stroke and mental health issues. She was 48 years old.

2 At the time of her death, Ms Gomez was subject to a "*Form 6B - Inpatient Treatment Order in General Hospital*", pursuant to section 61(1)(a) of the *Mental Health Act 2014* (WA). She was therefore an involuntary patient as defined in that Act.[1]

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

4 In such circumstances, a coronial inquest is mandatory as Ms Gomez was, immediately before her death, "*a person held in care*".[3] Where the death is of a person held in care, I am required to comment on the quality of the supervision, treatment and care the person received while in that care.[4]

5 On 17 June 2025, I held an inquest into Ms Gomez's death at Perth. The following witnesses gave oral evidence:

i. Dr Andrew Roney (consultant psychiatrist at FSH);

ii. Dr Vidya Narayanan (consultant rehabilitation physician at FSH); and

iii. Dr Andrew Marshall (Director of Clinical Services, Fiona Stanley Fremantle Hospitals Group).

6 The documentary evidence at the inquest comprised of two volumes of the brief which were tendered by counsel assisting as exhibit 1 at the inquest's commencement.

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[1] *Mental Health Act 2014* (WA) ss 4 and 21(2)(a)
[2] *Coroners Act 1996* (WA) s 3
[3] *Coroners Act 1996* (WA) s 22(1)(c)
[4] *Coroners Act 1996* (WA) s 25(3)

7 At the completion of the inquest, I asked Ms Femia, counsel from the State Solicitor's Office appearing on behalf of the South Metropolitan Health Service (SMHS), to obtain a response from SMHS regarding a potential recommendation I was considering concerning the activation of body worn cameras by hospital security staff in non-Code Black situations when a patient was restrained. By email dated 30 June 2025, Ms Femia outlined the response from SMHS and attached the relevant policy that had been in place at SMHS since October 2023.

8 The inquest focused on the supervision, treatment and care Ms Gomez received after she was transferred from Sir Charles Gairdner Hospital (SCGH) to the State Rehabilitation Unit at FSH on 28 April 2023. Ms Gomez remained at FSH until her death just over one month later.

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

10 I am also mindful to insert hindsight bias into my assessment of the actions taken by treating staff at FSH in their supervision, treatment and care of Ms Gomez. Hindsight bias is the tendency, after an event, to assume the event was more predictable or foreseeable that it actually was at the time.[5]

MS GOMEZ

Background [6]

11 Ms Gomez was born on 8 May 1975. She had a brother and a sister and at the time of her death, she was living with her mother in Karrinyup.

12 Ms Gomez was not employed and received the Disability Support Pension. She also had funding from the National Disability Insurance Scheme (NDIS).

13 Ms Gomez's mother supported many of her activities of daily living and Ms Gomez also had access to two NDIS support workers who visited two days a week to assist with going out into the community and shopping.

[5] Dillon H and Hadley M, *The Australasian Coroner's Manual* 2015 10
[6] Exhibit 1, Volume 1, Tab 2, Report of Coronial Investigator Anthony Brackenreg dated 6 March 2024

Ms Gomez's mental health [7]

14 Ms Gomez had been previously diagnosed with schizophrenia. However, by 2023, she had a diagnosis of schizoaffective disorder.

15 Schizoaffective disorder is related to schizophrenia and is diagnosed when a person meets the criteria for schizophrenia but also has features of an affective disorder in approximately equal proportions. Affective disorder refers to mood episodes in which people can present with depression or mania. Mania refers to a form of mood disorder characterised by significantly elevated mood to the point of disinhibition and grandiosity, insomnia, excess energy and increased libido.

16 The nature of Ms Gomez's mental illness was that of a chronic psychotic disorder, compounded by the fact she was treatment-resistant with an impairment of daily functioning. This meant she was not able to live independently.

17 For over a decade, Ms Gomez had been under the care of community mental health services and was prescribed the antipsychotic medication, clozapine. She had chronic negative symptoms from her mental health condition, prominently poor motivation. When unwell, Ms Gomez was paranoid about her mother, had disorganisation of thought and increased audio hallucinations of a derogatory content.

Ms Gomez's physical health [8]

18 Unfortunately, Ms Gomez also suffered from a number of physical health conditions. Most notable was an extended hospital admission in October 2021 where she received treatment for septicaemia with infective endocarditis. This required open heart surgery for a mechanical aortic valve replacement.

19 Following this surgery, Ms Gomez was prescribed warfarin (an anticoagulant medication in tablet form) to prevent blood clotting. This medication required regular blood tests to ensure the International Normalised Ratio (INR) was at a therapeutic level. Ms Gomez did not always take warfarin as prescribed nor was she complaint with the INR blood tests necessary to monitor the correct level of warfarin dosage.

[7] Exhibit 1, Volume 1, Tab 12, Report of Dr Andrew Roney dated 6 December 2024
[8] Exhibit 1, Volume 1, Tab 2, Report of Coronial Investigator Anthony Brackenreg dated 6 March 2024

Admission to Sir Charles Gairdner Hospital [9]

20 On the morning of 18 April 2023, Ms Gomez was watching a movie with her support worker when she suddenly became anxious and agitated. The support worker noticed Ms Gomez had left-sided weakness and called for an ambulance. Attending paramedics suspected Ms Gomez had had a stroke and she was transferred by ambulance under priority one conditions to Sir Charles Gairdner Hospital (SCGH).

21 Ms Gomez was admitted under the neurology team at SCGH and she was diagnosed with a right anterior cerebral artery ischaemic stroke. It was felt the stroke was cardioembolic in the context of non-adherence to her warfarin medication. Ms Gomez underwent a thrombectomy (a mechanical procedure to remove the blood clot); however, this was unsuccessful. Instead, she underwent a thrombolysis to dissolve the blood clot. To prevent further clotting, Ms Gomez was given injections of enoxaparin (an injectable blood thinner) and on 25 April 2023 warfarin was restarted.

22 The psychiatry team at SCGH was also involved with Ms Gomez's treatment as she had not been taking her clozapine medication in the days leading up to her stroke.

23 A decision was made to transfer Ms Gomez from the neurology team at SCGH to the neuro-rehabilitation ward at FSH for ongoing rehabilitation. The referral email from SCGH specified the need for, "*an MDT*[10] *approach in considering the disposition challenges going forward*."[11]

MS GOMEZ'S TREATMENT AT FSH [12]

24 On admission to FSH, Ms Gomez had a multidisciplinary assessment with the medical team, nursing team, physiotherapist, occupational therapist, speech therapist and social worker. It was noted she had left-sided weakness (upper and lower limb) due to her stroke. It was also noted she had global cognitive deficits, including reduced insight into her condition, attention and working memory. With her consent, Ms Gomez was commenced on a suppository regime for optimising her bowel functions.

[9] Exhibit 1, Volume 2, Tab 2, Sir Charles Gairdner Hospital records
[10] Abbreviation for "Multi-Disciplinary Team".
[11] Exhibit 1, Volume 1, Tab 12, Report of Dr Andrew Roney dated 6 December 2024, p.3
[12] Exhibit 1, Volume 1, Tab 11, Report of Dr Vidya Narayanan dated 11 December 2024; Exhibit 1, Volume 1, Tab 12, Report of Dr Andrew Roney dated 6 December 2024

25 Ms Gomez's clozapine medication was increased from 150 mg to 200 mg daily with blood testing confirming that a therapeutic range was achieved by 5 May 2023.

26 In so far as her mental health was concerned, Ms Gomez appeared to be "*doing okay*" for the first three weeks of her admission to FSH.[13] However, on 19 May 2023, Ms Gomez inadvertently had a suppository inserted in her vagina. Gynaecology staff were consulted and nursing staff were advised there were no clinical concerns due to the dissolvable nature of the suppository. Saline flushing was recommended and this was subsequently undertaken by nursing staff.

27 On 21 May 2023, nursing staff noted a new vaginal discharge from Ms Gomez. A vaginal infection was suspected and Ms Gomez was commenced on a course of antibiotics. On that same day, Ms Gomez's behaviour began escalating and she refused to take her clozapine and warfarin medications.

28 On 22 May 2023, Ms Gomez assaulted a phlebotomist who was attempting to collect blood for INR monitoring and a Code Black was called.[14] By this stage she was also refusing routine observations such as blood pressure and heart rate monitoring.[15]

29 A review by Dr Natalie Ghosh (Dr Ghosh) on the same day noted that Ms Gomez was paranoid, believing medical staff to be working with unknown people to harm her. She also thought that her food could be poisoned and continued to refuse taking her medications. Ms Gomez denied having a psychotic disorder and was verbally abusive towards Dr Ghosh.

30 Dr Ghosh's clinical impression was that Ms Gomez had suffered an acute psychotic relapse and she subsequently placed Ms Gomez on a "*Form 1A - Referral for Examination by Psychiatrist*" at 10.24 am on 22 May 2023.[16]

[13] Ts (Dr Roney) p.12
[14] A Code Black is a call for assistance when a staff member is personally threatened or subjected to harm or violence from a patient.
[15] Ts (Dr Narayanan) p.36
[16] Exhibit 1, Volume 1, Tab 9, Form 1A - Referral for Examination by Psychiatrist dated 22 May 2023

31 Dr Andrew Roney (Dr Roney), a consultant psychiatrist at FSH, assessed Ms Gomez on 23 May 2023. An earlier attempt by Dr Roney to assess Ms Gomez the previous day did not take place due to her heightened state of distress.

32 During Dr Roney's assessment, Ms Gomez said she would not take her antipsychotic medication, explaining that it was not a replacement for food. Ms Gomez told Dr Roney that people were attempting to control her body and actions, and that she felt trapped in a battle between good and evil. When Dr Roney raised the subject of her clozapine prescription, Ms Gomez became highly agitated and threw water at the doctor which required the attendance of hospital security staff. Ms Gomez was offered olanzapine, an alternative psychotic medication, which she agreed to take.

33 After his assessment, Dr Roney placed Ms Gomez under a "*Form 6B - Inpatient Treatment Order in General Hospital*" at 10.28 am on 23 May 2023. Dr Roney recorded:[17]

> Chronic treatment resistant schizophrenia for which she is prescribed clozapine, currently in hospital following stroke due to intermittent adherence to anticoagulant medications. Currently presenting with passivity phenomena, paranoid and guarded with unpredictable behaviours which have included verbal and physical assault of others - punched a phlebotomist and thrown water over staff.
>
> She has no insight into her diagnosis of schizophrenia or the need for medication, stating that she does not need any. She is unable to demonstrate understanding in terms of her need for admission or weigh information with regards to treatment for her mental illness and therefore lacks capacity to consent to treatment at the current time which out of necessity needs to provide for PRN medication[18] in case of distress and agitation with subsequent risk to both self and others. She therefore requires treatment under the *Mental Health Act* at the current time.

34 By 22 May 2023, Ms Gomez was refusing to take her warfarin medications and have blood tests to monitor her anticoagulation levels. She was also refusing enoxaparin injections and behaving aggressively towards FSH staff. Without anticoagulation therapy, Ms Gomez was at a high risk of having a further stroke. Without appropriate monitoring of her warfarin medication she was at risk of an intracerebral bleed if she was over-anticoagulated. Without antipsychotic medication, her

[17] Exhibit 1, Volume 1, Tab 9.1, Form 6B - Inpatient Treatment Order in General Hospital dated 23 May 2023, p.3
[18] A medication to be administered "when required" or "as needed".

mental health would continue to deteriorate and potentially entrench her refusal to take any medications.

35 Consequently, I am satisfied that it was appropriate for Dr Ghosh to refer Ms Gomez for a psychiatrist examination on 22 May 2023 and I am also satisfied that it was appropriate for Dr Roney to make her an involuntary patient on the following day.

36 Although it was initially thought that the misplaced suppository on 19 May 2023 may have been the cause of Ms Gomez's mental health deterioration, blood test levels from 19 May 2023 became available on 24 May 2023 which demonstrated that was not the case. These levels showed that Ms Gomez had been non-compliant with her clozapine medication in the days before 19 May 2023. I am therefore satisfied that the suppository incident was not the cause of Ms Gomez's mental health deterioration which, coincidentally, had occurred at the same time.

EVENTS LEADING TO MS GOMEZ'S DEATH [19]

37 From 23 May 2023, the medical teams treating Ms Gomez regularly discussed their treatment plans with Ms Gomez's mother who was her next of kin.

Anticoagulation treatment [20]

38 Unfortunately, there was always a risk of a catastrophic outcome for Ms Gomez whether she was or was not treated with anticoagulant medication. As Dr Narayanan explained:[21]

> … without anticoagulation there was significant risk of Ms Gomez developing a clot and suffering another stroke (the cause of her initial presentation to SCGH) and with anticoagulation there was a risk of a bleed in the brain (or any other part of the body). [Ms Gomez's mother] was informed that either of these events could be catastrophic. I emphasised that the least restrictive path and avoiding the use of restraints would be utilised by the team if it was possible. It was an extremely challenging clinical situation, and I acknowledged [Ms Gomez's mother] difficult situation as the substitute decision maker.

[19] Exhibit 1, Volume 2, Tab 3, Fiona Stanley Hospital records
[20] Exhibit 1, Volume 1, Tab 11, Report of Dr Vidya Narayanan dated 11 December 2024
[21] Exhibit 1, Volume 1, Tab 11, Report of Dr Vidya Narayanan dated 11 December 2024, pp.4-5

39 As Ms Gomez was refusing to take warfarin tablets, the decision was made to administer injectable enoxaparin twice daily.

40 Ms Gomez had her first injection of enoxaparin on the night of 24 May 2023. Given her aggressive behaviour, security staff had to be involved to restrain Ms Gomez by her legs so that nurses could safely administer the injection. Thereafter, however, Ms Gomez was compliant with these injections until her death and required no restraining.[22]

41 I am satisfied it was appropriate for Ms Gomez to be prescribed anticoagulant medications during her admission at FSH. I am also satisfied that appropriate measures were taken by FSH hospital staff to monitor the levels of these medications.

Antipsychotic medication [23]

42 Given Ms Gomez's non-compliance with her clozapine oral medication, consideration was given by the psychiatry team to the administering of an intramuscular antipsychotic medication as an alternative. Again, Ms Gomez's mother was informed of this intention and she was supportive of the use of paliperidone as an intramuscular medication instead of an oral antipsychotic medication.

43 Ms Gomez was subsequently injected with an intramuscular dose of 150 mg of paliperidone on 24 May 2023.

44 At Ms Gomez's last psychiatric review on 26 May 2023, there was an apparent improvement in her mental state and she had accepted her prescribed antipsychotic medication that morning.

45 I am satisfied of the steps taken by Ms Gomez's psychiatry team to ensure she was given appropriate dosages of antipsychotic medications during her admission at FSH. I am also satisfied that it would have been difficult for nursing staff to have noticed Ms Gomez was not taking her clozapine tablets in the days before 19 May 2023. As Dr Roney explained at the inquest:[24]

[22] Ts (Dr Narayanan) pp.39-40
[23] Exhibit 1, Volume 1, Tab 12, Report of Dr Andrew Roney dated 6 December 2024
[24] Ts (Dr Roney) p.11

> I think that's difficult to say [whether nursing staff could ensure Ms Gomez was swallowing her medication] because this is a general hospital, there weren't any concerns at that time about her being non-adherent. So there wouldn't necessarily be any reason to check. We have to remember treating patients in the general hospital is very different to treating them if they've already been admitted to a mental health ward.

Ms Gomez's sudden deterioration

46 Despite Ms Gomez's improving health, at 1.30 am on 28 May 2023, a medical emergency team (MET) call was made when nursing staff found her unresponsive in bed. Ms Gomez was intubated and transferred to the Intensive Care Unit (ICU) where a CT head scan revealed a massive intracranial haemorrhage (brain bleed), which was found to be a non-salvageable brain injury.

47 On 29 May 2023, formal brain stem testing confirmed brain death and Ms Gomez was declared deceased at 2.50 pm.[25]

CAUSE AND MANNER OF DEATH [26]

Cause of death

48 Dr Victoria Keuppers (Dr Keuppers), a forensic pathologist, conducted an external post mortem examination and CT scan upon Ms Gomez's body on 15 June 2023. The Court had accepted Dr Keuppers' opinion that a review of Ms Gomez's medical records, in conjunction with an external post mortem examination and CT scan, meant that an internal post mortem examination was not required.

49 A toxicological analysis of blood samples from Ms Gomez detected medications in keeping with her hospital treatment.

50 At the conclusion of the external post mortem examination and after considering the medical records, Dr Keuppers expressed the opinion that the cause of death was an intracerebral haemorrhage on a background of anticoagulation therapy for a recent embolic stroke in a woman with a mechanical aortic valve.

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[25] Exhibit 1, Volume 1, Tab 3, Death in Hospital form

[26] Exhibit 1, Volume 1, Tabs 6 and 6.1 - 6.5, Amended Post Mortem Report dated 15 August 2024, Emails between the Court and Dr Keuppers, Supplementary Post Mortem Report dated 19 February 2024, Final Post Mortem Report dated 15 June 2023, Interim Post Mortem Report dated 15 June 2023 and Pathologist's Recommendation for External Post Mortem dated 15 June 2023; Exhibit 1, Volume 1, Tab 7, Toxicology Report dated 31 January 2024

51 I accept and adopt the opinion expressed by the forensic pathologist as to the cause of Ms Gomez's death.

Manner of death

52 Initially, Dr Keuppers expressed the view she was not able to say whether Ms Gomez's death was due to natural causes as she could not, "*ascertain to what degree the anticoagulation therapy may have contributed to the brain bleed*."[27]

53 The Court subsequently sought clarification from Dr Keuppers as to whether the intracerebral haemorrhage may have been caused by trauma as Ms Gomez's stroke had occurred on the other side of her brain. Dr Keuppers responded:[28]

> I have reviewed the case file and I can find no indication to suggest a traumatic origin of the large left intracerebral bleed, either in medical records or my PM[29] report. I would favour a spontaneous IC[30] bleed in the setting of anticoagulant use.

54 Dr Keuppers also expressed the view that a finding of misadventure was therefore open.[31]

55 In those circumstances, I am satisfied that the intracerebral haemorrhage occurred in the setting of anticoagulant medication that was given to Ms Gomez.

56 Accordingly, I find that death occurred by way of misadventure.

57 To make it abundantly clear, this finding is not a criticism of the decision by Ms Gomez's treating team at FSH to prescribe her anticoagulant medication. I accept Dr Narayanan's observation in her report to the Court, "*with anticoagulation there was a risk of a bleed in the brain.*"[32] As I have already stated, I am satisfied this course of treatment was appropriate.

[27] Exhibit 1, Volume 1, Tab 6, Amended Post Mortem Report dated 15 August 2024, p.1
[28] Exhibit 1, Volume 1, Tab 6.1, Emails between the Court and Dr Keuppers, p.1
[29] Abbreviation for "post mortem".
[30] Abbreviation for "intracerebral".
[31] Exhibit 1, Volume 1, Tab 6.1, Emails between the Court and Dr Keuppers, p.3
[32] Exhibit 1, Volume 1, Tab 11, Report of Dr Vidya Narayanan dated 11 December 2024, p.2

ISSUE RAISED BY THE EVIDENCE

The administering of enoxaparin to Ms Gomez when she was restrained on 24 May 2023 [33]

58 FSH has authorised and non-authorised sections as defined under the *Mental Health Act 2014* (WA) (the Act).

59 The ward where Ms Gomez was a patient was a non-authorised section of FSH. Consequently, the administration of non-psychiatric medication and treatment, and the conditions under which that occurred was a matter for the individual treating team.

60 As outlined above, on the evening of 24 May 2023, Ms Gomez was briefly restrained by security staff and administered enoxaparin.

61 Sections 177 and 178 of the Act provide that an involuntary patient can be given treatment without informed consent. The definition of "*treatmen*t" is set out in section 4 of the Act:

> The provision of a psychiatric, medical, psychological or psychosocial intervention intended (whether alone or in combination with one or more other therapeutic interventions) to alleviate or prevent the deterioration of a mental illness or a condition that is a consequence of a mental illness, and does not include bodily restraint, seclusion or sterilisation.

62 The definition of "*treatment*" therefore contemplates treatment that is non-psychiatric (i.e. "*medical*") which is intended to alleviate or prevent the deterioration of a condition that is a consequence of a mental illness.

63 On the information before me, I am satisfied that the administering of enoxaparin to Ms Gomez on 24 May 2023 without her consent was appropriate, as her refusal to take anticoagulant medication posed a risk of blood clotting leading to another stroke and that her refusal was a consequence of her schizoaffective disorder.

64 I am also satisfied it was appropriate for Mr Gomez's legs to be restrained by FSH security staff for a brief time while the enoxaparin was administered. In so finding, I agree with the conclusion reached by Dr Andrew Marshall, Director of Clinical Services, Fiona Stanley Fremantle Hospitals Group.[34]

[33] Exhibit 1, Volume 1, Tab 20, Statement of Dr Andrew Marshall dated 6 June 2025
[34] Exhibit 1, Volume 1, Tab 20, Statement of Dr Andrew Marshall dated 6 June 2025, p.18

CHANGES SINCE MS GOMEZ'S DEATH [35]

65 Relevant to the restraining of Ms Gomez on 24 May 2023, two documents have been created since her death.

66 One of those documents is the "*Chief Psychiatrist's Guideline issued under Sections 547(3) and 548 of the Mental Health Act 2014: Use of Detention and Restraint in Non-Authorised Healthcare Settings*".[36]

67 Effective from January 2024, it sets out the legislative requirements for the lawful use of detention and restraint in a non-authorised healthcare setting, with a human rights and best practice based framework. It is designed to help all health service providers, including support staff such as security officers, to "*understand and manage their obligations to provide a safe, therapeutic culture and environment for consumers, carers and staff.*"[37]

68 The second document is from the Department of Health and is titled: "*Use of Restrictive Practices in Non-Authorised Healthcare Settings Policy*" which came into effect on 19 July 2024.[38] This document outlined the minimum requirements for the safe and lawful use of restrictive practices on patients in a non-authorised healthcare setting and specified that restrictive practices, including restraint, must only be used as a last resort after exhausting all other strategies, and when there is an imminent risk to actual health or safety.

69 The Office of the Chief Psychiatrist and the Department of Health are to be commended for the drafting of these documents.

QUALITY OF MS GOMEZ'S SUPERVISION, TREATMENT AND CARE

70 Ms Gomez presented as a considerable challenge for her treating teams at FSH. She had a number of pre-existing health conditions which were compounded when she had an ischaemic stroke on 18 April 2023. The difficulties surrounding her care were heightened by her reluctance to take anticoagulant medication to prevent further blood clotting and antipsychotic medication to treat her schizoaffective disorder. By 24 May 2023, her non-adherence with her medications and aggressive

[35] Exhibit 1, Volume 1, Tab 20, Statement of Dr Andrew Marshall dated 6 June 2025
[36] Exhibit 1, Volume 1, Tab 20, Statement of Dr Andrew Marshall dated 6 June 2025, Annexure E
[37] Exhibit 1, Volume 1, Tab 20, Statement of Dr Andrew Marshall dated 6 June 2025, Annexure E, p.5
[38] Exhibit 1, Volume 1, Tab 20, Statement of Dr Andrew Marshall dated 6 June 2025, Annexure D

behaviour meant a consultant psychiatrist at FSH had no option other than to make her an involuntary patient.

71 Sadly, only days later and just when it appeared her physical and mental health were improving, Ms Gomez suffered an intracerebral haemorrhage which proved to be fatal.

72 Having carefully considered all of the information available, I am satisfied that the supervision, treatment and care provided to Ms Gomez during her admission to FSH from 28 April 2023 to 29 May 2023 was appropriate.

A POTENTIAL RECOMMENDATION

73 One matter I raised at the inquest that could be the subject of a recommendation was the activation of body worn cameras worn by security staff in non-Code Black situations when a patient is being restrained by them. I considered such footage may provide important evidence should a complaint be made by a patient or a member of their family that they were inappropriately restrained. Through its counsel, Ms Femia, I invited SMHS to provide its views regarding such a recommendation.

74 The response from SMHS was set out in an email from Ms Femia to the Court dated 30 June 2025. Attached to that email was a document produced by SMHS titled "*Body Worn Cameras Policy*" dated 13 October 2023. This policy helpfully set out the discretionary activation of a body worn camera where it is appropriate to do so or where an activity applicable to an operational matter may require transparency of actions.

75 Having reviewed this document I am satisfied that the existing SMHS policy on body worn cameras already provides sufficient discretionary options for the recording of non-Code Black situations, including when a patient is restrained.

76 In those circumstances I have not deemed it necessary to make a recommendation in this area.

CONCLUSION

77 Ms Gomez was a mental health patient with complex care needs. She had been diagnosed with schizoaffective disorder and was not always compliant with her antipsychotic medication. In addition, open heart surgery she had in October 2021 meant she was required to take anticoagulant medication to prevent blood clotting. Unfortunately, Ms Gomez was also not compliant with that medication nor did she undergo the required blood tests to monitor this medication's dosages. This non-compliance was a likely explanation for the ischaemic stroke she suffered on 18 April 2023. Sadly, she was to remain in hospital from that date until her death on 29 May 2023.

78 As I have outlined above, I was satisfied that the supervision, treatment and care Ms Gomez received at FSH in the final month before her death was appropriate.

79 I extend my condolences to the family of Ms Gomez, particularly her mother, for their sad loss.

PJ Urquhart
Coroner
11 July 2025