JURISDICTION	**:**	CORONER'S COURT OF WESTERN AUSTRALIA
ACT	**:**	CORONERS ACT 1996
CORONER	**:**	SARAH HELEN LINTON, ACTING STATE CORONER
HEARD	**:**	2 JULY 2025
DELIVERED	**:**	5 DECEMBER 2025
FILE NO/S	**:**	CORC 11 of 2024
DECEASED	**:**	LINTON, LESLIE CHARLES

Catchwords:

Nil

Legislation:

Nil

Counsel Appearing:

Ms S Markham assisted the Coroner.
Ms C A Lakewood (SSO) appeared on behalf of the East Metropolitan Health Service.

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

Nil

Coroners Act 1996
(Section 26(1))

RECORD OF INVESTIGATION INTO DEATH

I, Sarah Helen Linton, Acting State Coroner, having investigated the death of ***Leslie Charles LINTON*** *with an inquest held at Perth Coroners Court, Central Law Courts, Court 85, 501 Hay Street, PERTH, on 2 July 2025, find that the identity of the deceased person was* ***Leslie Charles LINTON*** *and that death occurred on 30 December 2023 at Royal Perth Hospital, Victoria Square, Perth, from acute myocardial infarction, coronary artery atherosclerosis in the following circumstances:*

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INTRODUCTION

1. Leslie Linton died on 30 December 2023 at Royal Perth Hospital from a heart-related condition.

2. Mr Linton was an involuntary psychiatric patient, pursuant to the *Mental Health Act 2014* (WA) at the time of his death, so he came within the definition of a 'person held in care' under the *Coroners Act 1996* (WA) and a coronial inquest into his death was mandatory. I held an inquest on 2 July 2025. At the inquest, a significant amount of documentary evidence was tendered and two witnesses involved in Mr Linton's medical care at Royal Perth Hospital were called to give evidence in relation to certain aspects of his medical treatment immediately prior to his death.[1]

3. Following the inquest, I am required to comment on the quality of the treatment, supervision and care given to Mr Linton while he was held in care as an involuntary patient leading up to his death.[2]

BRIEF BACKGROUND

4. Leslie Linton was born in Myanmar (Burma) on 22 March 1959. He came to Australia with extended family at the age of 10 years and settled in Perth. He attended school until Year 9. He left school at the age of 16 years and began working with the hope of becoming a motor mechanic. He then joined the Army at 19 years of age. He continued to be based in Perth and during his army service he completed his Year 12 equivalent and obtained a diploma in architecture, which qualified him to work as a draftsman. He eventually chose to leave the military after 9 years of service.[3]

5. Mr Linton married and had two children, a son and a daughter. In 2010, following the breakdown of his marriage and in the context of the demands of caring for his mother, Mr Linton appears to have experienced some mental health issues and he made an impulsive decision to take his mother's car and drive to Queensland. He lived in Queensland for approximately the next 12 years and had limited contact with his family during this time, despite their attempts to keep in contact. The evidence indicates Mr Linton struggled personally and financially while living in Queensland and experienced homelessness, along with physical and mental health issues.[4]

6. Between 26 April to 3 May 2023 Mr Linton was admitted to the Cairns Hospital after suffering a myocardial infarction (heart attack). Tests revealed that he had severe triple-vessel coronary artery disease. It was recommended he undergo coronary artery bypass graft surgery, but he declined to undergo the surgery. Mr Linton was started on a number of medications to try to manage his cardiovascular risk factors

[1] Section 22(1)(a) *Coroners Act 1996* (WA).
[2] Section 25(3) *Coroners Act 1996* (WA).
[3] Exhibit 1, Tab 11.
[4] Exhibit 1, Tab 11.

and he was discharged from hospital. The evidence indicates Mr Linton was not compliant with his medication regime after discharge.[5]

7. Mr Linton's family in Perth became aware of his hospital admission and Mr Linton's daughter began making enquiries to try to locate him. She noted his address was listed as The Salvation Army Cairns so she called them and left a message for him. In August 2023, Mr Linton's daughter managed to re-establish contact with her father by phone and they began to speak on the phone every Sunday. She was concerned about his mental and physical health at this time. In October 2023 Ms Linton managed to convince her father to return to Perth, but he asked for some time to prepare himself. Martine contacted the City East Mental Health Service on 28 November 2023 for advice on what support services he might need and booked him in to see a GP, in preparation for his return.[6]

8. Mr Linton's daughter flew to Cairns on 8 December 2023 and was reunited with her father at The Salvation Army in Cairns. She immediately noted that her father was having issues with his hearing, sight and balance, along with some obvious confusion and memory deficits, in addition to what she knew about his cardiac issues. He had minimal possessions, limited to a few clothes and an esky full of loose paperwork. Mr Linton flew home to Perth with his daughter the following day.[7]

9. Following his return to Perth on 9 December 2023, Mr Linton lived with his daughter and her family for approximately one week, during which time he became increasingly agitated, paranoid and delusional. He was reluctant to take his medications, thought people were stealing from him and conspiring against him and was suspicious of his relatives. Mr Linton saw a general practitioner in Mount Lawley on 12 December 2023 for a general health check and treatment for an ulcer on his left foot. Mr Linton was found to have high blood pressure, a raised cholesterol and poorly controlled diabetes, all of which would contribute to a raised cardiovascular risk. He was re-prescribed his previous medications. The doctor and Mr Linton's daughter also had concerns about Mr Linton's mental health as he was easily agitated when challenged about his delusions.[8]

10. Mr Linton's daughter had been helping her father gain access to Centrelink payments and apply for State Housing assistance, but when she tried to fill in some paperwork with him in relation to housing on 14 December 2023 he became very agitated. She contacted staff at the City East Mental Health Service for help that day. It was arranged that mental health staff would attend for a home visit, with police escort, the following day to assess Mr Linton. However, prior to this occurring, Ms Linton managed to persuade her father to attend hospital for assessment.[9]

[5] Exhibit 1, Tab 11, Tab 12 and Tab 13.
[6] Exhibit 1, Tab 10.
[7] Exhibit 1, Tab 10.
[8] Exhibit 1, Tab 10.
[9] Exhibit 1, Tab 10.

ROYAL PERTH HOSPITAL PRESENTATION

11. Mr Linton presented with his daughter to the Royal Perth Hospital (RPH) Emergency Department on the morning of 15 December 2023. His presenting problem was documented as an infected wound on his left foot, but it was also noted that his daughter had raised concerns regarding his mental health. Mr Linton's physical assessment recorded that his blood pressure was high and blood tests showed anaemia, poorly controlled diabetes, high cholesterol, renal impairment and a raised troponin level suggestive of a recent heart attack. He mentioned intermittent chest pain but denied it was from the heart and said it was from "his ribs."[10] An ECG was reported to show signs of his previous heart attack and a CT brain scan showed old infarcts (strokes) and changes in the cerebellum suggestive of chronic alcohol use. Mr Linton was admitted to the Acute Medical Unit (AMU) for treatment. Medical records indicate Mr Linton told doctors he had not been taking any of his prescribed medications after his heart attack in Queensland.[11]

12. At 9.30 pm on the evening of 15 December 2023, Mr Linton's troponin levels were noted to have increased but he denied any chest pain. The AMU Registrar discussed the case with the Cardiology Registrar, who reported he would review Mr Linton. Mr Linton did not complain of any chest pain and his observations remained stable in the meantime. He was also scheduled for non-urgent endocrine review.[12]

13. A request had also been made for psychiatric review, but on 16 December 2023 the psychiatric registrar advised there was no capacity to review Mr Linton that day. Mr Linton was eventually psychiatrically reviewed the following day, being 17 December 2023, by the Consultant-Liaison Psychiatry Team. Notes record Mr Linton was alert when reviewed and understood he was in hospital but was unable to elaborate comprehensively as to why. He was dismissive of his cardiac concerns and indicated he did not feel he had a mental illness. The impression was of untreated schizophrenia or possible psychotic depression, as well as some possible organic causes including uncontrolled diabetes and multiple heart attacks. He was detained under the *Mental Health Act 2014* for further management and care, with the plan to refer him for assessment to be admitted as an involuntary patient to the Mental Health Unit once he was medically cleared. He was commenced on the antipsychotic risperidone while still in the AMU.[13]

14. While Mr Linton was still receiving treatment in the AMU, a resident medical officer consulted Cardiology Advanced Trainee Dr Cameron Walters about Mr Linton's case. Dr Walters was working in the cardiology ward at RPH at the time. Dr Walters did not review Mr Linton personally, but he discussed Mr Linton's case with the medical officer over the telephone. The medical officer provided a summary of Mr Linton's history and advised Mr Linton had elevated troponin levels on one assay, but with results within reference range on another assay. Dr Walters then reviewed the digital pathology results himself.[14]

[10] Exhibit 1, Tab 11, p. 77.
[11] Exhibit 1, Tab 11.
[12] Exhibit 1, Tab 11, p. 85.
[13] Exhibit 1, Tab 11 and Tab 13.
[14] Exhibit 1, Tab 14, T 24 - 25.

15. Dr Walters explained that troponin levels are significant because "they essentially define whether a patient is deemed to have suffered a myocardial injury,"[15] which is one of two features that when present together lead to a diagnosis of a heart attack or acute coronary syndrome. To diagnose a myocardial injury, a patient's troponin should be both elevated and show an acute change in absolute concentration. The elevation is usually accepted as at least one troponin reading being above the 99th percentile for the general population range and change in absolute concentration is determined by tracking a rise and fall in a patient's troponin over a period of time, usually hours. A change in troponin on its own does not mean there has been a heart attack, but it is an integral part of diagnosing a heart attack.[16]

16. However, Dr Walters also explained that there is a recognised issue with troponin assays, as they can be artificially elevated through interference from various sources, which can lead to false positives. In the troponin blood test, there are biochemical reasons why some people may have components of their blood that interfere with the assay used for testing troponin levels. To verify whether it is, in fact, an artifactual interference with the biochemical assay, repeating it on a different assay will usually overcome this form of interference.[17]

17. In Mr Linton's case, there were concerns the results reflected assay interference as the readings were not dynamic, so testing was done on different machines. The results were markedly different, which suggested Mr Linton's initial high troponin level readings were a 'false positive'.[18]

18. Considering the levels of troponin suggested no acute myocardial injury, along with the fact Mr Linton had no chest pain and had no other symptoms or ECG changes that suggested active ischaemia, Dr Walters concluded that Mr Linton "had stable coronary artery disease without any current cardiac symptoms. That is, he was not suffering acute myocardial injury."[19] In light of this conclusion, Dr Walters advised the medical officer that the high readings were false positives, although it seems the medical officer incorrectly noted this advice down as 'false negatives'.[20] Dr Walters recommended that Mr Linton receive ongoing secondary prevention therapies for his cardiac conditions, being to continue on bisoprolol, statin and aspirin therapy. None of the medications Dr Walters recommended have any meaningful interactions with commonly used psychiatric medications, so they would be expected to be safe to be taken together.[21]

19. Dr Walters stated that he considered Mr Linton's medium-term health depended on his mental health issues resolving, as it seemed his mental health issues were interfering with his compliance with his medications therapy and his agreement to undergo cardiac surgery. Dr Walters recalled recommending that Mr Linton be

[15] Exhibit 1, Tab 14 [12].
[16] T 24; Exhibit 1, Tab 14 [12].
[17] T 25; Exhibit 1, Tab 14..
[18] T 26 - 27; Exhibit 1, Tab 14.
[19] Exhibit 1, Tab 14.
[20] T 26 - 27; Exhibit 1, Tab 14.
[21] Exhibit 1, Tab 14.

connected with the cardiology outpatient clinic following resolution of his mental health issues.[22]

MENTAL HEALTH UNIT ADMISSION

20. Mr Linton was admitted to RPH's Mental Health Unit (MHU) on the evening of 21 December 2023 after being medically cleared. At that time, he had a degree of stability so emergency lifesaving was not required, although he would still benefit from cardiac intervention if and when consent could be obtained.[23]

21. Mr Linton was reviewed by Consultant Psychiatrist Dr Jai Nathani for the first time on 22 December 2023. During the review Mr Linton mentioned his belief in 'channelling' – that by having drops of another person's blood on his skin, the blood could seep in and he could absorb the blood and be revitalised. He also had unrealistic beliefs about the powers of the turmeric he was taking to prevent him contracting COVID. Dr Nathani telephoned and spoke to Mr Linton's daughter as part of his assessment process. She reported concerns with her father's memory. It was also noted that Mr Linton had not been taking his medications, which contributed to his overall poor health, due to his unusual beliefs. Dr Nathani determined Mr Linton clearly lacked capacity to make decisions about his medical care and treatment, so he determined Mr Linton should be made an involuntary patient under the Mental Health Act. He was placed on an inpatient treatment order Form 6A for a period of up to 21 days' duration.[24]

22. Dr Nathani stated that the priority of Mr Linton's admission in the MHU was to understand the causes of his poor capacity. Differential diagnoses included schizophrenia and bipolar affective disorder, but organic causes such as vascular dementia needed to be ruled out first. This was particularly so given Mr Linton's severe coronary artery disease and diabetic foot ulcer, which suggested the blood vessels in his brain might also be affected. Further, by the time he was seen by Dr Nathani, he had been on risperidone for some time with little improvement in his mental state, which suggested the condition might be something other than schizophrenia. Dr Nathani planned to treat Mr Linton's symptoms of psychosis to the point where he could consent to treatment of his heart conditions, or if that could not be achieved then assist his family to obtain guardianship orders to enable appropriate treatment decisions to be made in relation to his triple vessel coronary artery disease.[25]

23. Because of his suspicion that Mr Linton had vascular dementia, Dr Nathani prioritised the cognitive testing that is used to diagnose this condition. Mr Linton was seen by an occupational therapist on 22 December 2023 for a type of cognitive assessment that mainly tests for dementia. His score was well below the cut-off so the treating team began to make arrangements for a meeting with Mr Linton's children in early January to discuss the possibility of guardianship orders so consent

[22] Exhibit 1, Tab 14.
[23] T 10; Exhibit 1, Tab 13.
[24] T 10, 15, 20; Exhibit 1, Tab 13.
[25] T 8 - 11; Exhibit 1, Tab 13.

could then be obtained from a guardian for him to undergo the necessary heart surgery.[26]

24. In the meantime, Mr Linton was continuing on an antipsychotic (risperidone) and a mood stabiliser (sodium valproate) that he had been prescribed by the Consultant-Liaison Psychiatry Team. Neither of these medications interact with the medications Mr Linton was prescribed for his heart condition. Risperidone, along with other antipsychotic medications, does carry a risk of cardiac arrhythmia so the MHU team sought to minimise the risk by prescribing only one antipsychotic medication at a time and performing an ECG.[27]

25. Mr Linton's blood pressure had been high on his admission to the MHU, which had appropriately been escalated to a medical officer for review at that time.[28] His blood pressure readings were within normal range over the following days. Mr Linton was seen by the Resident Medical Officer (RMO) on the morning of his second day on the ward. The RMO contacted the hospital's Safety Afterhours for Everyone (SAFE) team, which responds to medical incidents across the hospital, to alert them to Mr Linton's presence in the MHU given he was a high-risk patient. The RMO also discussed Mr Linton with the Cardiology Registrar. It was noted that his routine ward admission ECG performed by the RMO appeared to be stable, with no acute changes since his first presentation to the hospital. In particular, Dr Nathani noted that the ECG did not show the kind of changes to heart rate or rhythm that are suggestion of a myocardial infarction (heart attack), ventricular fibrillation or ventricular tachycardia – the kinds of findings that are associated with mortality.[29]

26. Mr Linton also reported no chest pain, although this was less significant as Mr Linton had also felt no chest pain when he suffered a heart attack in Queensland. He had experienced dizziness/fainting on that previous occasion, and he did not report any similar symptoms, nor any nausea or sweatiness, which are also symptoms of a cardiac event. Mr Linton's vital signs continued to be monitored on the Adult Deterioration Detection System (ADDS) while in the MHU and nothing of significance was noted.[30]

27. As he was a diabetic with a history of poor glucose control, Mr Linton's blood glucose levels were monitored throughout his stay on the ward through finger-prick testing. After initially being mildly elevated, it had normalised by day two and generally remained well controlled. His diabetic foot ulcer also appeared to be healing well.[31]

28. On 23 December 2023, a medical officer in the MHU contacted the cardiology advanced trainee, Dr Walters, again in relation to Mr Linton's care. Dr Walters recalled he was contacted because of some differences between the ECG performed on Mr Linton's admission to hospital and the ECG performed when he was admitted

[26] T 13; Exhibit 1, Tab 10.
[27] Exhibit 1, Tab 10.
[28] T 13.
[29] T 15 - 16; Exhibit 1, Tab 10.
[30] T 13 - 14.
[31] T 15, 19; Exhibit 1, Tab 10.

to the MHU. Dr Walters was sent the ECGs to review. He noted there were some changes on both ECGs of a degree of thickening to his left ventricle, consistent with his history of hypertension. Mr Linton's second ECG showed some subtle changes in the ST segment, where one phase of the cardiac cycle changes to another. His heart rate was also slightly faster. There can be a number of reasons for such differences and in Mr Linton's case, Dr Walters felt the changes could be attributable to the ECG lead being placed in a slightly different location, or his having a slightly higher heart rate.[32]

29. Dr Walters observed that these changes can also be associated with acute ischaemia where other physical symptoms are present. However, there was no information to suggest Mr Linton was experiencing chest pain, shortness of breath or any other somatic symptom. In the absence of any such symptoms, Dr Walters believed the changes were due to left ventricular hypertrophy (i.e. increased ventricular muscle mass), which might be as a consequence of his chronic health conditions, including hypertension.[33]

30. During the conversation, Dr Walters was also asked why Mr Linton's perindopril medication was ceased. Perindopril is an ACE inhibitor medication used to treat high blood pressure and heart failure. Although he was not part of Mr Linton's treating team and had not made the decision to cease that medication, Dr Walters made an educated guess that it was likely because of an elevated creatinine level in Mr Linton's pathology results. Elevated creatinine levels indicate the kidneys are not functioning as they should, and perindopril is a mild nephrotoxin (negatively affecting kidney function). While mildly elevated, Dr Walters reviewed Mr Linton's blood tests over the past week and determined that Mr Linton's creatinine was stable. Dr Walters advised that if they wished to restart it, it would be reasonable to do so, but that his urine, electrolytes and creatinine would need to continue to be monitored to ensure his kidneys did not get worse. Dr Walters was not contacted or consulted again in relation to Mr Linton's care.[34]

31. At the inquest, Dr Walters confirmed that based upon the information that he had reviewed at the time, on his admission to RPH Mr Linton appeared to have stable coronary artery disease without any current acute cardiac symptoms, on a known background of a past heart attack when he was in Queensland. Dr Walters commented that were it not for the troponin artefact from the previous event in Queensland, the picture would have looked quite different, but everything he was told at the time and the objective information he reviewed suggested Mr Linton was stable, although he remained at ongoing risk of another heart attack and absolutely needed cardiac follow-up once he was cooperative with receiving cardiac care. In the meantime, Mr Linton was on appropriate medical therapy, such as aspirin and statins, to try to reduce the risk of another heart attack.[35]

[32] T 30; Exhibit 1, Tab 14.
[33] Exhibit 1, Tab 14.
[34] T 31 - 32; Exhibit 1, Tab 14.
[35] T 29, 34.

EVENTS ON 30 DECEMBER 2023

32. On 30 December 2023 at 11.00 am, a nurse recorded Mr Linton had a low blood pressure reading of 90/60. This reading was escalated to the RMO. The low reading was of concern but it was noted that aside from the low BP reading he was asymptomatic, with all other vital signs within normal limits and no self-report of light-headedness or dizziness. In particular, given the low reading could have signalled he was going into cardiogenic shock, it was noted that Mr Linton's heart rate was normal, which was inconsistent with cardiogenic shock as in that instance the heart rate increases.[36]

33. Mr Linton had not been drinking much water that day and had a dry mouth, so it was thought he could be dehydrated, which can cause low blood pressure. It was decided to increase his fluid intake and continue to monitor him. A fluid balance chart was commenced and he was encouraged by staff to drink more fluids.[37]

34. Mr Linton had been placed on 30-minute observations as well. He was seen by a nurse at 1.00 pm, 1.30 pm and 2.00 pm and on each occasion he was resting in his bed. At 2.30 pm, when he was checked again, he was noted to be asleep in bed.[38]

35. When the next nursing check was performed at 3.00 pm, Mr Linton was found unconscious on the floor of the bathroom. A Code Blue was initiated and the Medical Emergency Team attended, but Mr Linton could not be revived. His death was confirmed at 3.53 pm.[39]

36. Dr Nathani was not on the ward that day but he was informed by the nurse in charge. Dr Nathani contacted Mr Linton's family to notify them of his death and given Mr Linton's status as an involuntary patient, the death was also reported to the Coroner. [40]

CAUSE AND MANNER OF DEATH

37. Forensic Pathologist Dr Joe Ong made a post mortem examination on the body of Mr Linton on 8 January 2024. The examination showed hardening, thickening and narrowing of the vessels on the surface of the heart (coronary artery atherosclerosis); there was associated scarring of the heart muscle. There was evidence of medical intervention, including changes of cardiopulmonary resuscitation. Further investigations were performed, including microscopic examination of the heart muscle, which showed changes in keeping with a recent 'heart attack (acute myocardial infarction) and scarring of the heart muscle. The presence of coronary artery atherosclerosis with significant luminal narrowing was also confirmed. At the conclusion of all investigations, Dr Ong formed the opinion the cause of death was

[36] Exhibit 1, Tab 10 and Tab 11.
[37] T 18 - 19; Exhibit 1, Tab 13.
[38] Exhibit 1, Tab 11, p. 124.
[39] T 19; Exhibit 1, Tab 11 and Tab 13.
[40] Exhibit 1, Tab 13.

acute myocardial infarction in association with coronary artery atherosclerosis. Dr Ong expressed his opinion the death was due to natural causes.[41]

38. I accept and adopt Dr Ong's opinion as to the cause and manner of death.

TREATMENT, SUPERVISION AND CARE

39. Dr Nathani expressed the opinion the psychiatric team's clinical management or Mr Linton during the time on the MHU was very good, noting they were progressing the diagnostic testing for the suspicion of vascular dementia while treating his psychotic symptoms and preparing to discuss guardianship orders with his family. Dr Nathani noted the short timelines over which his assessments were undertaken conveys the sense of urgency in the team at the relevant time, with the aim to ensure Mr Linton's chronic heart conditions could be appropriately treated as swiftly as possible. Sadly, that was not able to be completed prior to his death.[42]

40. In terms of the management of Mr Linton's cardiac risk, it was relevant that he was not willing to consent to the necessary cardiac surgery at the time of his death, and Dr Walters gave evidence that it would have been challenging to facilitate cardiac follow-up while he was actively resisting cardiac care. Dr Walters observed that Mr Linton's highest risk time for another heart attack was immediately after the event in Cairns, and he had managed to get through that period without any significant adverse effects, but he carried a persistent risk from that time and even in the era of modern medicine, heart attacks are still frequently and commonly lethal. Dr Walters explained that the rates of survival for cardiac arrest are low, even when they occur in hospital, so even if he had been observed at the time of the cardiac event, it does not mean that he could have been saved.[43]

41. All of the evidence before me supported the conclusion Mr Linton's medical and psychiatric care while he was a patient at Royal Perth Hospital was reasonable and diligent, when viewed within the context of the challenging circumstances presented by his lack of insight into his cardiac condition due to his cognitive/psychiatric issues, which complicated his treatment plan and delayed recommended treatment.

CONCLUSION

42. Mr Linton had poorly controlled diabetes and severe coronary artery disease in December 2023, on the background of a previous heart attack when he was living in Cairns. Unfortunately, he also had mental health issues and cognitive decline that led him to often be non-compliant with his medications and he was a smoker. All of these factors placed him at a high risk of another heart attack and sudden death.

43. Mr Linton's daughter, Martine, had made every effort to support and care for her father once she became aware of his parlous situation. She brought him home to

[41] Exhibit 1, Tab 5.
[42] Exhibit 1, Tab 13.
[43] T 33 - 35.

Perth and cared for him in her home for a brief period before she brought him to Royal Perth Hospital as she recognised he needed psychiatric and medical help. Unfortunately, due to his psychiatric issues, he refused life-saving coronary bypass surgery, which complicated his medical care. Once the medical team were satisfied Mr Linton's cardiac symptoms were stable and he had been placed on appropriate medical therapy, he was transferred as an involuntary patient to the psychiatric unit so that his mental state could be properly assessed and, if necessary, guardianship orders sought that would allow a guardian to provide the necessary consent for Mr Linton to undergo cardiac surgery. Sadly, while that was still in progress, Mr Linton suffered an acute heart attack and went into cardiac arrest. Emergency resuscitation efforts were unsuccessful and he died at the hospital on 30 December 2023.

44. I am satisfied Mr Linton's care was reasonable and appropriate while he was being held as an involuntary patient and I make no adverse comments or recommendations in this case.

I certify that the preceding paragraph(s) comprise the reasons for decision of the Coroner's Court of Western Australia.

ACTING STATE CORONER S H Linton

5 DECEMBER 2025