JURISDICTION	:	CORONER'S COURT OF WESTERN AUSTRALIA
ACT	:	CORONERS ACT 1996
CORONER	:	PHILIP JOHN URQUHART, CORONER
HEARD	:	19 - 20 NOVEMBER 2024 and 16 DECEMBER 2024
DELIVERED	:	6 MARCH 2025
FILE NO/S	:	CORC 914 of 2021
DECEASED	:	NORRIS, JALEN HUNTER

Catchwords:

Nil

Legislation:

Nil

Counsel Appearing:
Mr J Tiller assisted the Coroner
Mr T Cummings (Slater & Gordon) appeared on behalf of the family
Ms C Lakewood (State Solicitor's Office) appeared on behalf of the Western Australian Police Force
Mr C Beetham (on instructions from DLA Piper) and Ms A Pull appeared on behalf of St John of God Health Care Incorporation, Dr Philip Brooks, Dr Claudine Cerda-Pavia, Brendan Hester and Christopher Goadby

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 ***Jalen Hunter NORRIS*** *with an inquest held at Perth Coroners Court, Central Law Courts, Court 85, 501 Hay Street, PERTH, on 19 - 20 November 2024 and 16 December 2024, find that the identity of the deceased person was* ***Jalen Hunter NORRIS*** *and that death occurred on 9 April 2021 at the Woodbridge train crossing, Devon Street, Woodbridge, from multiple injuries in the following circumstances:*

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LIST OF ABBREVIATIONS AND ACRONYMS

Abbreviation/Acronym	Meaning
the Act	*Mental Health Act 2014* (WA)
ADHD	Attention Deficit Hyperactivity Disorder
the ***Briginshaw*** principle	the accepted standard of proof a court is to apply when deciding if a matter adverse in nature has been proven on the balance of probabilities
BWC	Body Worn Camera
CAMHS	Child and Adolescent Mental Health Service
CCTV	closed-circuit television
the Court	the Coroners Court
CT scan	Computed Tomography scan
ED	Emergency Department
EDPLS	Emergency Department Psychiatric Liaison Service at SJOGMH
IAU	Internal Affairs Unit
mg	milligrams
the panel	the panel of experts that undertook the SAC1 investigation
the police station	Kiara Police Station
PLN	Psychiatric Liaison Nurse
PSOLIS	Psychiatric Services On-Line Information System
RMO	Resident Medical Officer
RPH	Royal Perth Hospital
SAC1	Security Assessment Code 1
SJOGMH	St John of God Midland Hospital
TAFE	Technical and Further Education
Ts	transcript from the inquest
WAPF	Western Australian Police Force
WAPOL	Western Australian Police

INTRODUCTION

"The belief that one's own view of reality is the only reality is the most dangerous of all delusions."
Paul Watzlawick - psychologist

1 The deceased (Jalen)[1] died shortly after 6.00 pm on 9 April 2021 when he was struck by a train at the crossing on Devon Street in Woodbridge. He was 23 years old.

2 On the afternoon of 9 April 2021, Jalen had been arrested by police and charged with several offences. Although Jalen had been served with the bail papers in connection with those charges shortly before his death, the prosecution notices for those charges had not been formally lodged with the Magistrates Court. Consequently, Jalen had not been lawfully released to bail from the custody of police.

3 Hence the Court determined that, immediately before his death, Jalen was a "*person held in care*" of the police within the meaning of section 22(1)(a) of the *Coroners Act 1996* (WA). Therefore, a coronial inquest into Jalen's death was mandatory, and was to include an investigation into the quality of the supervision, treatment and care of Jalen while in that care.[2]

4 I held an inquest into the death of Jalen on 19 - 20 November 2024 and 16 December 2024. Jalen's parents were amongst the family members who attended each day of the inquest.

5 In the order in which they testified, the following witnesses gave oral evidence at the inquest:[3]

i. Constable Russell Campbell (police officer attached to Kiara Police Station);

ii. Constable Rachel Hey (probationary police officer attached to Kiara Police Station);

iii. First Class Constable Shaun Hutt (police officer attached to Kiara Police Station);

iv. Constable Kim Axford (police officer attached to Kiara Police Station);

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[1] As the family had requested their relative be referred to as "Jalen" during the inquest, I will identify him in the same manner in this finding.

[2] *Coroners Act 1996* (WA) s 22(1)(a), s 25(3)

[3] Unless otherwise stated, the cited positions of these witnesses are the positions they held at the time of Jalen's death.

v. Detective Sergeant Michael Butcher (police officer attached to the Internal Affairs Unit);

vi. Brendan Hester (nurse at St John of God Midland Hospital);

vii. Dr Claudine Cerda-Pavia (resident medical officer at St John of God Midland Hospital);

viii. Christopher Goadby (current acting Nurse Director, Emergency Department and Clinical Operations, St John of God Midland Hospital);

ix. Dr Philip Brooks (consultant emergency physician at St John of God Midland Hospital); and

x. Dr Mark Hall (independent consultant forensic psychiatrist).

6 The documentary evidence at the inquest comprised of three volumes of the brief which were tendered as exhibit 1 at the inquest's commencement. During the course of the inquest, further exhibits were tendered and they were identified as exhibits 2A, 2B and 2C and exhibits 3 - 5.

7 The inquest focused on the quality of the supervision, treatment and care that Jalen received on 9 April 2021 by police officers from Kiara Police Station and health service providers at St John of God Midland Hospital (SJOGMH).

8 In making my findings, I have applied the standard of proof as set out in ***Briginshaw v Briginshaw*** (1938) 60 CLR 336. This standard of proof requires a consideration of the nature and gravity of the conduct when deciding whether a matter adverse in nature has been proven on the balance of probabilities (the ***Briginshaw*** principle).[4]

9 I am also mindful not to insert hindsight bias into my assessment of the actions taken by police officers and health service providers at SJOGMH who were responsible for Jalen's supervision, treatment and care. Hindsight bias is the tendency, after an event, to assume the event was more predictable or foreseeable than it actually was at the time.[5]

[4] ***Briginshaw v Briginshaw*** (1938) 60 CLR 336, 361-362 (Dixon J)

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

JALEN

Background [6]

10 Jalen was born on 12 February 1998 at Swan District Hospital. He had one older sister.

11 At primary school, Jalen was diagnosed with Attention Deficit Hyperactivity Disorder (ADHD). He was prescribed medication to treat his ADHD which he continued to take until he was in high school.

12 By Year 10, Jalen began to disengage from his schooling. Although he started Year 11, Jalen subsequently completed a bridging course which provided a gateway to attend TAFE (Technical and Further Education).

13 Although Jalen enjoyed swimming, his main passion was gaming. He later developed an interest in fitness and had his own weights and workout equipment at home. This interest led him to study for a Certificate III in Fitness at the North Metro TAFE with an aim to becoming a personal trainer. However, he left the course without completing it.

14 Jalen had held various casual employment positions since he was 14 years old.

Jalen's mental health history [7]

15 Jalen began struggling with his mental health as a youth. He was given various differential diagnoses that included atypical behavioural problems, Autism Spectrum Disorder, delusional disorder, depressive and anxiety disorders, and drug-induced psychosis.

16 Jalen had complained that he felt unfairly treated by his parents, who he thought were overly strict, punitive and critical of him. His self-harming behaviours began in 2012, when he cut and scratched himself with a compass and/or scissors when at school.

17 From about 2013, Jalen's mental health began to deteriorate. He disclosed that he felt suicidal because of the way things were at home.

18 In March 2015, Jalen was referred by his school to Youth Axis, part of the Child and Adolescence Mental Health Service (CAMHS) due to self-harming behaviour that had occurred over the preceding eight months. With respect to this behaviour, it was reported in February 2015 that Jalen

[6] Exhibit 1, Volume 1, Tab 7, Statement of Lynette Norris, dated 16 June 2021
[7] Exhibit 3, Report from Dr Mark Hall dated 19 November 2024

had intended to suicide at the Bayswater train station and an alert to that effect was placed on PSOLIS.[8] Jalen had counselling with Youth Access for two months and was diagnosed with post-traumatic stress disorder and adjustment disorder. A concern was also expressed that he might be at risk of psychosis.

19 Records indicate that from early 2016 (when he was 18 years old), Jalen began experimenting with illicit drugs; most notably cannabis, ecstasy, nitrous oxide and LSD. From those drugs, it was only cannabis that he appeared to use frequently.

20 In November 2016, a psychologist treating Jalen expressed concern he had a potential delusional disorder. Thereafter, Jalen had various admissions to the ED at SJOGMH which included the following.

21 On 21 May 2017, Jalen was taken by police to the ED at SJOGMH due to his low mood and suicidal ideation after an argument with his father. Jalen disclosed thoughts of jumping in front of a train and was referred to the ED mental health staff for further assessment. Following that assessment, it was determined that there was no evidence of a mental illness and no acute risk issues. Rather, Jalen was considered to be having an acute situational reaction to his homelessness. He subsequently arranged to stay with a friend.

22 On 24 July 2017, Jalen threatened to throw himself in front of a car and stood in the middle of the road with his hands over his eyes. The driver of a car stopped and brought him to the ED at SJOGMH. Jalen was again referred to mental health staff and subsequently discharged home after a mental health assessment.

23 On 29 December 2017, Jalen was taken to the ED of SJOGMH by police after he had been found on a platform at Bassendean train station intending to jump onto the tracks. An assessment in the ED concluded he was experiencing a situational crisis and he was advised to see his GP for mental health follow-up.

24 On 4 December 2019, Jalen was taken to the ED at SJOGMH by police after he had expressed a belief that his Xbox and an open group Facebook page was telling him that he was going to be killed and his father wanted to kill him. At the ED, he presented in an extremely agitated and paranoid state, and he was not making sense. Jalen was detained for a further

[8] PSOLIS is an acronym for Psychiatric Services On-Line Information System which is the clinical information database for patients used by government health services in Western Australia.

assessment under the *Mental Health Act 2014* (WA). He remained in the ED and over the course of 24 hours he was given a substantial dose of olanzapine (an anti-psychotic medication).

25 When reviewed in the ED on 5 December 2019, Jalen was more settled and was considered to have experienced a resolving drug-induced psychosis with deferential diagnosis of being prodromal[9] for an underlying mental health illness such as schizophrenia. He was subsequently referred to the Midland Community Mental Health Service with a recommendation that he continue taking olanzapine.

26 During December 2019, Jalen maintained the unsubstantiated belief that his sister was dealing in drugs.

27 In 2020, Jalen engaged with a psychologist; however, by the end of the year he had subsequently disengaged with any mental health support. His psychology referral was later closed on 11 March 2021 due to non-engagement.

28 During late 2020 and early 2021, Jalen was in and out of his parents' home in Kiara for two to three days at a time. In January 2021, he left the family home to stay with an older woman. On 28 February 2021, Jalen's partner arrived from Queensland and stayed with him at this woman's residence. Jalen's partner noticed he was consistently smoking cannabis and that he was not regularly taking olanzapine.

29 In the weeks before his death, Jalen interacted with the same Facebook page he believed wanted to kill him. This would cause him to become stressed and agitated.

30 On 30 March 2021, Jalen and his partner left the woman's residence following an argument Jalen had with the woman. On 7 April 2021, after staying at a hostel, Jalen and his partner returned to live with his parents as they could no longer afford staying at the hostel. This was despite Jalen still harbouring paranoia about his parents and his sister. A boarder was also staying with Jalen's parents at the time.

[9] "Prodromal" is a medical term meaning to happen at the beginning of a medical condition when initial symptoms are experienced.

EVENTS LEADING TO JALEN'S DEATH [10]

31 On 8 April 2021, Jalen's partner noticed his mood was up and down and they had an argument about her going to the gym. Jalen had also organised to buy some cannabis. His partner had no contact with him until much later that day when he was talking about the same Facebook page referred to above, and how his sister was plotting his murder. Although they both went to a nearby McDonald's, Jalen's partner walked home and he drove off. Jalen did not return home until the morning of 9 April 2021.

32 Once home, Jalen continued his erratic and paranoid behaviour. He asked his partner to buy him a coffee and then broke up with her via a text message. After that, Jalen asked her to arrange a dental appointment and was then rude to the receptionist. He later accused his partner of being out to get him and taking his money, and repeated his accusation that his sister was plotting his murder.

33 Early in the afternoon an issue arose regarding Jalen's partner giving her mobile telephone number to his parents. Jalen was angered by this and said his parents could not be trusted, asserting to his partner that his parents would now be able to trace her. He therefore wanted the sim card from his partner's phone. When she refused to give it to him, Jalen snatched the mobile phone from her hand and used one of his workout weight plates to smash the phone on the floor. Jalen's reason for breaking the phone was to protect his partner.

34 The boarder was at home in another part of the house. She thought the noise she was hearing was physical violence by Jalen to his partner. The boarder subsequently contacted the police at about 12.40 pm.

Police attend the Kiara address [11]

35 At 12.52 pm, Constable Russell Campbell (Constable Campbell) and Probationary Constable Rachel Hey (Probationary Constable Hey) from Kiara Police Station (the police station) were dispatched to attend. They arrived at Jalen's parents' address at 12.55 pm. Jalen was outside at the front of the house and was spoken to by Constable Campbell, while Probationary Constable Hey spoke with Jalen's partner and the boarder.

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[10] Exhibit 1, Volume 1, Tab 2, Coronial Investigation Squad report dated 25 May 2022; Exhibit 1, Volume 1, Tab 13, Statement of Constable Russell Campbell dated 27 October 2021

[11] Exhibit 1, Volume 1, Tab 13, Statement of Constable Russell Campbell dated 27 October 2021; Statement of Probationary Constable Rachel Hey dated 19 January 2022; Exhibit 1 , Volume 2, Tab 2, St John Ambulance Patient Care Record

36 Jalen told Constable Campbell that he broke his partner's phone in order to protect her and because his parents were gang members, he could not have them knowing his partner's number. He maintained his sister was plotting a murder against him using gang members and that he had evidence on his phone to prove this threat. He showed Constable Campbell the Facebook page that he said his sister had created and explained the comments on the page were written by his sister and that she was also using it to sell drugs. He maintained all of the comments were making a reference to him.

37 At about 1.20 pm, Jalen was placed under arrest for criminal damage regarding the damage to his partner's mobile phone and was advised he would be taken to the police station. A search of Jalen before leaving his parents' address located a small amount of cannabis and he was told he would also be charged for possessing a prohibited drug. Jalen arrived at the police station at 1.38 pm.

38 Jalen was initially calm and compliant at the police station. When answering questions about his mental health he identified having ADHD and depression. However, when asked whether he had spoken about or attempted self-harm in the past five years, Jalen answered he had not.

39 After refusing to participate in an interview, Jalen was placed in a cell at the police station at 1.58 pm. Charges of criminal damage/destruction of property (relating to the mobile phone), possession of cannabis and unlawful damage (regarding damage to the floor caused by the weight plate) were entered for Jalen. Although these charges were recorded, the prosecution notices for them were not immediately lodged. Subsequently, there were no charge numbers allocated to the three charges by the Magistrates Court.

40 Probationary Constable Hey carried out several physical cell checks on Jalen at intervals of about 15 minutes. No observations were made of Jalen acting out of the ordinary during those checks.

41 However, at about 2.55 pm, a loud noise was heard from Jalen's cell. Footage from the CCTV camera inside the cell showed him deliberately striking his head against the glass door with force, and falling to the floor.

42 Police officers responded to the incident, and Jalen appeared dazed and subsequently unsteady on his feet. He was not responsive to questions and was taken from the cell and placed on a bench in the observation area while an ambulance was called.

43 While waiting for the ambulance, Jalen slid from the bench onto the floor and began displaying very unusual behaviour that included growling noises, dry retching and spitting. He resisted being placed into the recovery position by police and he was subsequently handcuffed.

44 At 3.09 pm, paramedics attended and Jalen was still exhibiting odd behaviour by spitting, yelling and kicking the cushions off the stretcher as he was lying on it. He refused to communicate with the paramedics and due to his behaviour, Jalen was given 5 mg of midazolam.[12] At 3.25 pm, the paramedics determined he could be safely transported by ambulance to the ED at SJOGMH.

Jalen attends the ED at SJOGMH [13]

45 The ambulance arrived at the ED at 3.44 pm. As he was still in police custody, two officers from the police station accompanied Jalen to the ED. One officer, Senior Constable Shaun Hutt (Senior Constable Hutt), went in the ambulance and the other officer, Constable Kim Axford (Constable Axford), followed the ambulance in a police vehicle. The police officers who had arrested Jalen did not attend as their shift had finished at 3.00 pm.

46 Once in the ED, Jalen was placed in a low-stimulation room at 3.58 pm. It was recorded Jalen was alert and speaking with police officers in a calm manner. Constable Axford completed a "Police Handover to ED" form at 4.03 pm, documenting that Jalen had struck his head on a glass panel at the police station and had an "*episode*" where he began dry retching.[14]

47 Shortly after arriving at the ED, Jalen was triaged. Included in the triage notes was that Jalen had presented with an "*altered mental state*" and that there had been "*deliberate self-harm whilst under police arrest*".[15] He was given a triage score of "3" which meant he ought to be seen within 30 minutes.

48 Between 4.11 pm and 4.28 pm, Senior Constable Hutt, with Constable Axford, served Jalen with bail papers in connection with the three charges from earlier that afternoon. This was recorded on Body Worn Camera (BWC) footage from both officers (the BWC footage). Due to the

[12] A sedative commonly given by paramedics to agitated patients before they are taken by ambulance to hospital.

[13] Exhibit 1, Volume 1, Tab 2, Coronial Investigation Squad Report dated 25 May 2022; Exhibit 3, Report of Dr Mark Hall dated 19 November 2024

[14] Exhibit 1, Volume 2, Tab 3.1, Police Handover to ED form

[15] Exhibit 1, Volume 2, Tab 3, Adult Emergency Department Record, p.1

nature of the alleged offending, standard Protective Bail Conditions were imposed. These conditions meant Jalen could not contact by any means, or approach within 100 metres of, his parents, his partner or the boarder. In addition, he was not permitted to be within 50 metres of his parents' address.[16]

49 It was clear from the time recorded on the BWC footage that Jalen signed these bail papers before the prosecution notices for the charges relating to the bail were lodged and approved for court at 4.39 pm. Consequently, Jalen's release to bail was not lawful as the charges to which they related were not formally in existence at the time the bail papers were signed.

50 Dr Claudine Cerda-Pavia (Dr Cerda-Pavia), a resident medical officer at the ED, was the first doctor to assess Jalen. Dr Cerda-Pavia recorded that Jalen was non-compliant with requests from hospital staff and declined to discuss his mental state or undergo a urine drug test. Dr Cerda-Pavia also recorded that Mr Norris had expressed concerns he had "*no safe place*" to go.[17] This would have been a reference to the terms of his bail conditions.

51 Jalen was then assessed by Dr Philip Brooks (Dr Brooks), the ED consultant physician. Dr Brooks noted Jalen declined to allow him to examine him, and that Jalen said he "*feels fine*" and wanted to leave. Jalen voiced no concerns regarding suicidal ideation or his mental health, and Dr Brooks noted that he appeared to be experiencing a "*situational crisis*" in that he was unable to return to his parents' house to get his belongings. Dr Brooks recorded that his examination of Jalen's mental state did not reveal evidence of "*a significant depressive illness nor any psychotic phenomena.*"[18]

52 After these assessments from the two doctors, arrangements were made for a social worker to see Jalen to discuss options for accommodation that night and for him to be provided with a meal.

Jalen leaves the ED at SJOGMH [19]

53 When hospital staff returned with a meal for Jalen, it was discovered he had left the ED. He had not taken his bail paperwork or any of his personal belongings, including his mobile phone. At the time, Jalen was barefooted

[16] Exhibit 1, Volume 1, Tab 16.2, Form 6 - Bail Undertaking form
[17] Exhibit 1, Volume 2, Tab 3.2, SJOGMH Progress Notes dated 9 April 2021
[18] Exhibit 1, Volume 2, Tab 3.2, SJOGMH Progress Notes dated 9 April 2021
[19] Exhibit 1, Volume 1, Tab 2, Coronial Investigation Squad Report dated 25 May 2022

and wearing a paper jumpsuit that had been provided to him at the police station.

54 At 5.09 pm, SJOGMH CCTV footage showed Jalen leaving the triage area of the ED by himself.

55 Shortly after this, Jalen's mother contacted SJOGMH and she was advised Jalen had left without his personal belongings. Jalen's mother was informed she should notify police for a welfare check, which she subsequently did.

56 At about 5.30 pm, members of the public reported Jalen to be behaving oddly near the Devon Street train crossing near Woodbridge train station. This was approximately 2 km west of SJOGMH.

57 Members of the public observed Jalen to be pacing back and forth by the train tracks. He then walked onto the tracks and sat down in front of an oncoming train, causing its driver to sound the horn several times. Jalen did not move from his position on the tracks and he was struck by the train at about 6.05 pm. Witnesses notified emergency services and an ambulance arrived shortly afterwards. Due to the injuries he had sustained, Jalen was certified life extinct at 6.35 pm on 9 April 2021.[20]

CAUSE AND MANNER OF DEATH [21]

Cause of death

58 Dr Jodi White (Dr White), a forensic pathologist, conducted an external post mortem examination and CT scan upon Jalen's body on 16 April 2021.

59 The examination found extensive soft tissue and bone injuries throughout Jalen's entire body.

60 A toxicological analysis of blood and urine samples from Jalen detected small amounts of alcohol in the blood (0.01%) and in the urine (0.013%). A very small amount of tetrahydrocannabinol was also detected, indicating previous cannabis use. No other illicit drugs were detected. In addition, midazolam and one of its metabolites were detected and I am satisfied this was from the dose administered to Jalen by the paramedics.

[20] Exhibit 1, Volume 1, Tab 4, Life Extinct Form dated 9 April 2021,

[21] Exhibit 1, Volume 1, Tabs 5 - 5.2, Supplementary Post Mortem Report dated 16 April 2021, Post Mortem Report dated 16 April 2021 and Interim Post Mortem Report dated 16 April 2021; Exhibit 1, Volume 1, Tab 6, Toxicology Report dated 18 June 2021

61 At the conclusion of Dr White's external post mortem examination, she expressed the opinion that the cause of death was multiple injuries.

62 I accept and adopt the opinion expressed by the forensic pathologist as to the cause of Jalen's death.

Manner of death

63 I am satisfied that in the lead-up to his death, Jalen was experiencing psychosis. I agree with Dr Hall's assessment that the cause of this psychosis cannot be determined with confidence as it may have been due to drug intoxication, temporary drug-induced psychosis or schizophrenia that had been aggravated by cannabis use.[22]

64 I am also satisfied that on 9 April 2021, Jalen had the delusional beliefs that one or more of his immediate family had planned to kill him, and that his partner was also in danger of being killed. On top of that was the anxiety and stress caused by his bail conditions that prevented him from returning to his parents' home and providing the protection to his partner that he believed she required.

65 Contrary to what he told Dr Brooks, I am satisfied that shortly after Jalen discharged himself from the ED at SJOGMH, he had formed an intention to end his life. Jalen implemented his long-held way to end his life by deliberately placing himself on train tracks in front of an oncoming train.

66 Accordingly, I find that death occurred by way of suicide.

THE CLINICAL INCIDENT INVESTIGATION (SAC1) REPORT [23]

67 Jalen's death was investigated through a Root Cause Analysis inquiry process. These internal inquiries by hospitals include cases where there is a clinical incident which has, or could have, caused serious harm or death to a patient that was attributable to the provision of health care (or lack thereof), rather than the patient's underlying illness. These clinical incidents are categorised as Severity Assessment Code 1 (SAC1).

68 The circumstances of Jalen's death were felt to full within SAC1 and consequently a clinical investigation was conducted into the care of Jalen by SJOGMH on 9 April 2021.

69 A SAC1 investigation report was prepared by a panel of experts (the panel). The panel comprised of a Chief Operating Officer, the Head of ED, a

[22] Exhibit 3, Report of Dr Mark Hall dated 19 November 2024, pp.14-15

[23] Exhibit 1, Volume 2, Tab 1, SAC1 Clinical Incident Investigation Report dated 21 May 2021

consultant psychiatrist, an ED nurse manager, a psychiatric liaison nurse and a risk officer.

70 After completing its investigation, the panel concluded: [24]

> ... that the RMO[25] had undertaken a thorough assessment of the patient on arrival. The patient disclosed no suicidal ideation and agreed to see a social worker and seek help regarding his social situation. The panel agreed the driver for suicide was more likely to be due to situation stressors; isolation from family and homelessness and agreed that if a mental health assessment had been undertaken, the outcome may have been unchanged as there was a high likelihood the patient would have been discharged (as he had on previous presentations) due to there being no indication of a mental health disorder.
>
> However, the panel identified several missed opportunities with communications that contributed to this patient leaving the [emergency] department without a firm discharge plan in place.

71 After citing these missed opportunities, the panel reported that it had "*identified the root cause to be due to miscommunication at multiple levels, both verbally and documented, that led to the consultant not having all the necessary information to consider a mental health referral.*"[26]

72 The panel made two recommendations to address the missed opportunities it had identified. The response to those recommendations are addressed later in this finding.

THE INVESTIGATION BY INTERNAL AFFAIRS UNIT

73 Given Jalen's interactions with police and the circumstances of his death, the Western Australia Police Force (WAPF) deemed the matter as a critical incident. Consequently, an Internal Affairs Unit (IAU) investigation examined the actions of the four police officers directly involved[27] to determine whether there had been any non-compliance with WAPF policies. The potential non-compliance with WAPF policies concerned whether there was a failure by any of these police officers to provide an adequate duty of care to Jalen.

74 At the completion of the IAU investigation, which involved a compulsory managerial interview with each of the four police officers, it was

[24] Exhibit 1, Volume 2, Tab 1, SAC1 Clinical Incident Investigation Report dated 21 May 2021, p.9
[25] Resident Medical Officer
[26] Exhibit 1, Volume 2, Tab 1, SAC1 Clinical Incident Investigation Report dated 21 May 2021, p.9
[27] Constable Campbell, Probationary Constable Hey, Senior Constable Hutt and Constable Axford.

determined there was no failure by any of the police officers to provide an adequate duty of care to Jalen.

ISSUES RAISED BY THE EVIDENCE

Should police have taken Jalen to hospital for a mental health assessment under the Mental Health Act 2014 (WA)

75 From the information available to me, it was evident police had arranged for an ambulance to take Jalen to hospital for a physical assessment of any injuries he had sustained from striking his head against the cell glass door. It was not for the purpose of a mental health assessment.

76 Section 156 and section 157 of the *Mental Health Act 2014* (WA) (the Act) authorises a police officer to arrange for a person to have a mental health assessment if certain conditions are met. The relevant provisions of section 156 of the Act states:

> (1) A police officer may apprehend a person if the officer reasonably suspects that the person –
>
> (a) has a mental illness; and
>
> (b) because of the metal illness, needs to be apprehended to –
>
> (i) protect the health or safety of the person or the safety of another person; or
>
> (ii) prevent the person causing, or continuing to cause, serious damage to property.
>
> ...
>
> (3) A police officer –
>
> (a) must, as soon as practicable after apprehending a person under subsection (1), arrange for the person to be assessed by a medical practitioner or authorised mental health practitioner for the purpose of deciding whether or not to refer to the person under section 26(2) or (3)(a) for an examination to be conducted by a psychiatrist ...

77 Section 157 of the Act covers the scenario if a person has been arrested. It states:

> (1) This section applies if –
>
> (a) a person is arrested by a police officer on suspicion of having committed an offence; and

(b) the police officer reasonably suspects that the person has a mental illness for which the person is in need of immediate treatment.

(2) The police officer must, as soon as practicable, arrange for the person to be assessed by a medical practitioner or authorised mental health practitioner for the purpose of deciding whether or not to refer the person under section 26(2) or (3)(a) for an examination to be conducted by a psychiatrist.

78 Section 6(1) of the Act defines when a person has a mental illness:

A person has a mental illness if the person has a condition that –

(a) is characterised by a disturbance of thought, mood, volition, perception, orientation or memory; and

(b) significantly impairs (temporarily or permanently) the person's judgment or behaviour.

79 The question that arose at the inquest was whether the provisions in section 156 and/or section 157 of the Act had been satisfied given Jalen's behaviour at his parents' house and then, after his arrest, at the police station.

80 Given Jalen was arrested shortly after police attended his parents' address, I am satisfied the provisions of section 157 of the Act had greater application to Jalen's set of circumstance than section 156.

81 At the inquest, Constable Campbell described Jalen as having "*heightened emotions*" at his parents' address.[28] Constable Campbell said he initially thought Jalen was paranoid. However, after Jalen showed him the Facebook page on his mobile phone, he considered that Jalen may have been telling the truth about his sister operating a gang and selling drugs.[29] Having watched the BWC footage of Jalen's conversations and behaviour in Constable Campbell's presence, I have some difficulty accepting this was a true reflection of Constable Campbell's state of mind at the relevant time.

82 Although Probationary Constable Hey recalled that Jalen was "*calm*" and "*compliant*",[30] it should be noted she did not interact with Jalen as much as Constable Campbell.

83 At the inquest, Constable Campbell said he only became concerned for Jalen's mental after he had self-harmed at the police station by hitting his

[28] Ts 19.11.24 (Constable Campbell), p.20
[29] Ts 19.11.24 (Constable Campbell), p.25
[30] Ts 19.11.24 (Probationary Constable Hey), p.49

head.[31] It was only then that Constable Campbell considered there was a need to get him to hospital for some help. I then asked Constable Campbell these questions: [32]

> But need some help at hospital, what, for a physical injury he might have incurred or his mental well-being or both? --- My first concern was because he was - he looked unconscious, so that was my first priority. And then, yes, I guess I imagine they - because it's self-harm, I imagine they would have assessed him at the hospital for that, but I'm- yes, I'm not too sure. So, yes, that - I just kind of assumed that would have come with it.
>
> What, so there would be an assessment of his mental well-being at the hospital? --- I thought so, yes.

84 I am satisfied this was a reasonable expectation for Constable Campbell (and the other police officers who interacted with Jalen) to have.

85 In the preparation of his report for the Court, Dr Hall was asked whether police should have taken Jalen to hospital for a mental health assessment during his arrest on 9 April 2021. Dr Hall provided this answer:[33]

> During the police attendance on 9 April 2021, Mr Norris was clearly mentally disturbed. Furthermore, he was deemed to pose sufficient risk to warrant protective bail conditions. Given those factors, invocation of s 156 of the *Mental Health Act 2014* was available to the officers and would have been preferable.

86 Dr Hall was taken to this part of his report by counsel assisting at the inquest and he provided the following clarifications:[34]

> It's difficult to say whether he should have [been taken to hospital for a mental health assessment]. Because the officers were not there for a welfare check in the first instance and so there was a complaint of criminal behaviour, criminal damage with circumstances of aggravation, potentially a family violence incident. ... So they left there [i.e. the parents' address] with a different sort of agenda. He wasn't floridly psychotic in the sense that he wasn't overly agitated and making any threats to hurt anybody or himself there and then. In fact, he was doing the opposite and trying to reassure people. So - and bearing in mind that officers would normally, when they were invoking section 156 of the *Mental Health Act* would sometimes be doing so with people more obviously unwell than he is. So taking all those things into account, it's difficult to say that they should have taken him on that occasion, but it's

[31] Ts 19.11.24 (Constable Campbell), p.35
[32] Ts 19.11.24 (Constable Campbell), p.35
[33] Exhibit 3, Report from Dr Mark Hall dated 19 November 2024, p.15
[34] Ts 16.12.24 (Dr Hall), p.270

> fair to say that that option was certainly available to them had they been in a position to turn [their] mind to that at the time.
>
> So, to be fair, to say that whilst it was, as you say, available or open to them, from your assessment, it wasn't a case where, clearly, the *Mental Health Act* should have been active in this case. Essentially there wasn't something that was immediately obvious so far as ---? --- That's right. It wasn't unequivocally clear that that should have happened.
>
> Yes. And so whilst there were, perhaps, obviously, with your benefit of Jalen's medical history as well, clear indicators … that are consistent with his history of mental health that, obviously, for the police present on that day without that information that the steps they took were reasonable in the circumstances? --- That's correct.

87 With respect to this matter, the Court also had a report from Commander Martin Haime (Commander Haime) from the Operations Support Portfolio at the WAPF. In that role, Commander Haime is responsible for overseeing policing divisions, including the Mental Health Division.

88 In his report, Commander Haime made the pertinent observation that: "*Police officers are first responders and are not equipped to identify specific mental health problems or diagnose particular conditions. Officers will respond based on the information and behaviour presented to them at a particular time.*"[35]

89 After reviewing the relevant material, Commander Haime stated:[36]

> … I am of the view that the circumstances of Mr Norris' behaviour would not support the officers invoking their powers under s 156 of the *Mental Health Act.* In my experiences as a police officer, behaviours similar to what Mr Norris showed is not uncommon amongst people WA Police deal with. Persons are apprehended under s 156 where they are exhibiting behaviours to such a degree that they clearly cannot remain safely in the community. In contrast, whilst he was at times upset at the situation generally and made some unusual and concerning comments, Mr Norris appeared lucid, compliant and appeared to understand all directions provided to him.
>
> For these reasons, I believe it was not appropriate for the officers to form the view that he was suffering a mental illness in such circumstances as to trigger his apprehension; having regard to the applicable legislation.

[35] Exhibit 4, Report from Commander Martin Haime to the Court dated 9 December 2024, p.3
[36] Exhibit 4, Report from Commander Martin Haime to the Court dated 9 December 2024, pp.3-4

> To do so, based on the records I have reviewed, would create a substantially lower and perhaps inappropriate threshold in the application of s 156 *Mental Health Act* than current operational practice and would result in a significant increase in individuals conveyed to hospital by police. …
>
> The application of s 156 does not necessarily guarantee that a person will be admitted to hospital to receive mental health care and treatment. Internal WA Police Force data indicates that of the cohort of individuals conveyed to hospital by officers under s 156 *Mental Health Act,* an estimated 77% are released by medical staff within three hours without being admitted to the facility.

90 Commander Haime also examined the application of section 157 of the Act to the circumstances that existed after Jalen's arrest. After noting that section 157(1)(b) of the Act requires a police officer to reasonably suspect that the person has a mental illness for which there is a need of "*immediate*" treatment, Commander Haime stated:[37]

> Based on the records I have reviewed, I am of the view that Mr Norris did not require "*immediate*" treatment for a mental illness. I consider it appropriate that after he physically injured himself in custody, the focus was to seek treatment for his physical injury whilst in custody.

91 Based on all the information available, particularly the views expressed by Dr Hall and Commander Haime, and being careful not to insert hindsight bias, I am satisfied the actions by police in not invoking section 156 or section 157 of the Act were appropriate.

92 In so finding, I have also noted the clear intent of the Act is for the care and treatment of persons with mental health issues to always be carried out in the least restrictive way.

Did police provide an adequate history of Jalen's behaviour to ED staff?

93 For the reasons set out below, I am satisfied medical staff at the ED did not receive an adequate history from police regarding what Jalen had said to the arresting officers prior to his attendance at SJOGMH. Given the circumstances responsible for that, I have categorised this as a "missed opportunity".

94 One of those circumstances concerned the timing of when the shift ended for Jalen's arresting officers. The shift for Constable Campbell and

[37] Exhibit 4, Report from Commander Martin Haime to the Court dated 9 December 2024, p.4

Probationary Constable Hey finished at 3.00 pm. Usually there would be a handover from those officers to the officers starting their shift at 3.00 pm.

95 For Jalen's matter, those two officers were First Class Constable Shaun Hutt (Constable Hutt) and Constable Kim Axford (Constable Axford). However, the handover was interrupted by Jalen striking his head against the cell door. As Constable Hutt explained at the inquest:[38]

> Generally it [the handover] would tell you everything that has happened and where they were at that particular point in the investigation, but we didn't really get a chance for much of a handover at that point because of what happened in the cell.

96 It was therefore not surprising to hear Constable Axford say that she had not been told anything about what Jalen had said to police at his parents' address.[39]

97 As Jalen was under arrest and accompanied by police when he was taken to the ED at SJOGMH, police were required to complete a form from the hospital titled "Police Handover to ED". In this instance, Constable Axford filled out the form. In the box titled "Narrative (incident, circumstances, threats made)", Constable Axford wrote: "*Patient was in custody. Self-inflicted hit to head on glass panel. Had an 'episode' where he began dry retching. Ambulance called.*"[40]

98 Constable Axford explained that she wrote the word "episode" because she "*wasn't entirely sure how to articulate the bizarre behaviour*" Jalen had demonstrated after he had struck his head.[41]

99 At the inquest, Constable Axford said that she also spoke to nursing staff at the ED and provided further details regarding how Jalen was behaving following the head strike.[42]

100 Unfortunately, no information was provided by police to ED staff regarding what Jalen had said to police at or about the time of his arrest which would have indicated he may have been experiencing a paranoid and/or delusional episode. As Dr Hall noted:[43]

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[38] Ts 19.11.24 (Constable Hutt), p.72
[39] Ts 20.11.24 (Constable Axford), p.121
[40] Exhibit 1, Volume 2, Tab 3.1, Police Handover to ED form
[41] Exhibit 1, Volume 1, Tab 16, Statement of Constable Kim Axford dated 20 January 2022, p.7
[42] Ts 19.11.24 (Constable Axford), p.109
[43] Exhibit 3, Report from Dr Mark Hall dated 19 November 2024, pp.15-16

> It was clear from the "Police Handover to ED" form, although incomplete, that Mr Norris was there for the assessment of a potential medical episode related to head injury. What is not made clear on the form is the extent to which he had exhibited mental disturbance prior to the head injury. The officer that completed the handover form was not present at the time of his arrest when he was expressing delusional ideas.
>
> ...
>
> Overall, it was in the change from police custody to hospital care that the significant mental health aspects of Mr Norris' initial presentation were lost in terms of handover.

101 Nevertheless, some information regarding Jalen's behaviour earlier that afternoon was received by the triage nurse, Brendan Hester (Mr Hester). He recorded Jalen had made "*delusional comments*" and was "*paranoid about family*".[44] This information, however, was obtained from Jalen and not the police. As Mr Hester explained:[45]

> I recall Jalen telling me something to the effect that "*my family don't want me*" and that his "*family were drug dealers*". He was mumbling and not making eye contact with me. His comments about his family are what I recalled as "*delusional comments/paranoid about family*" on the triage form.

102 Mr Hester had also recorded "*?THC use recent*",[46] which meant that Jalen may have recently used cannabis. Mr Hester advised he had received this information from either the police or the paramedics.[47]

103 Although police did not provide relevant information to medical staff at SJOGMH regarding Jalen's comments to Constable Campbell, I am satisfied that the circumstances in which that occurred do not warrant an adverse finding being made. Rather, it was a missed opportunity.

Should police have passed onto ED staff comments made by Jalen during his bail service process?

104 As already outlined above, Constable Hutt and Constable Axford served Jalen with his bail papers at the ED of SJOGMH. BWC footage recorded what Jalen and the police officers said during this process. Segments of this footage were played at the inquest and subsequently tendered as exhibits.[48]

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[44] Exhibit 1, Volume 2, Tab 3, Adult Emergency Department Record, p.1
[45] Exhibit 1, Volume 1, Tab 22, Statement of Brendan Hester dated 20 November 2024, p.2
[46] Exhibit 1, Volume 2, Tab 3, Adult Emergency Department Record, p.1
[47] Ts 20.11.24 (Mr Hester), p.168
[48] Exhibit 2A, BWC footage from 6 mins to 8 mins 20 secs; Exhibit 2B, BWC footage from 16 mins 30 secs to 17 mins 30 secs

105 During the bail process, Constable Hutt explained that the Protective Bail Conditions could remain until everything was finalised and dealt with, and mentioned that could be six to 12 months if Jalen pleaded not guilty. It is clear from the BWC footage that Jalen became anxious when he was informed of this potential delay.

106 He subsequently asked the police officers: "*What if this gang gets to her [his partner] before me? What if they kill her?*" Constable Hutt responded by saying that he did not know what had happened today. Jalen continues with his questioning, asking, "*Where's her protection? What if someone kills my girlfriend? Who do I complain to because I know someone's going to?*" Constable Hutt replied: "*That sounds very far-fetched*" and when Jalen again asked: "*What if someone kills my girlfriend?*", Constable Hutt said police would investigate. Constable Axford added that if Jalen's partner had any concerns then she could come to the police.[49]

107 Those comments did not allay Jalen's anxiety and it was clear he was very stressed about the welfare of his partner. Although Jalen genuinely held these concerns, I am satisfied they were clearly a result of his paranoia. Given his comment that what Jalen was saying sounded "*very far-fetched*", I am satisfied Constable Hutt did not take Jalen's concerns seriously.

108 About eight minutes later, Jalen made further statements that I am satisfied were also due to his paranoia. He told Constable Hutt and Constable Axford that he and his partner "*truly believe*" that Jalen's parents are "*trying to incriminate me and lock me up.*"[50] He then said:[51]

> If I die one day, if I die - commit suicide or die, my girlfriend, my ex, my best friend, all my gang members, they'll definitely point the finger at my parents saying: "*They caused this to happen; they played with his mental health to the point that this happened.*"

109 Neither Constable Hutt nor Constable Axford asked any questions of Jalen regarding these comments. Constable Hutt responded by saying "*Alright*", and simply asked Jalen to finish signing the bail papers.[52] Neither police officer told any ED staff at SJOGMH what Jalen had said to them regarding his belief his partner would be killed or his mentioning of suicide. The question arose at the inquest whether they should have.[53]

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[49] Exhibit 2A, BWC footage from 6 mins to 8 mins 20 secs

[50] Exhibit 2B, BWC footage from 16 mins 30 secs to 17 mins 30 secs

[51] Exhibit 2B, BWC footage from 16 mins 30 secs to 17 mins 30 secs

[52] Exhibit 2B, BWC footage from 16 mins 30 secs to 17 mins 30 secs

[53] Constable Hutt had also mentioned an earlier occasion in the ED when Jalen had spoken about killing himself. This took place when only he was with Jalen and it was not recorded on BWC. It arose when Jalen

110 Regarding Jalen's concerns that his partner was going to be killed, Constable Hutt said that he did not consider at the time Jalen had "*a mental health issue*".[54] When he was asked why that was the case, Constable Hutt answered:[55]

> We're more sort of trained - we don't get training in mental health, as such. We're more sort of - when we go to jobs, people threaten to kill themselves, or stating that they want to kill themselves. I'm not trained to put little bits and pieces of that sort of stuff together to get a mental profile of somebody.

111 At the inquest, Constable Hutt agreed he did not think that at the time when they were made, Jalen's concerns regarding his partner were justified.[56] A short time later I asked these questions to Constable Hutt:[57]

> So, Senior Constable, he has now mentioned suicide twice to you in your presence.[58] And I'm just grappling with, that now being the case, that he is making far-fetched allegations to you, that there has already been that self-harm incident in the cell, and, as Mr Tiller says, it's painting a picture of someone that has some … current mental health issues. Would you accept that? --- Yes.
>
> And I'm just trying to work out why this wasn't brought to the attention of someone at the hospital? --- Because I still believe at the time, and I still believe that at that point in time, he had - it wasn't going through his mind that he was going to kill himself.
>
> …
>
> But did you now think … that this is information that somebody who is better trained than you could take on-board in making their own assessment as to whether there was a danger of him self-harming? Would you accept that? --- I can see the point, yes.
>
> …
>
> So, as I understand your evidence then, Senior Constable, you've decided, "Well, my assessment of this situation is that he's not going to act on those comments he has made about suicide, so therefore it's not necessary to bring that to the attention of hospital staff"? --- Yes, your Honour.
>
> Is that essentially it? --- Yes.

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was talking about how he would like to become a police officer and had said this interaction with police had ruined any chance of that. As Constable Hutt recounted: "*He then made a flippant comment saying something like 'I may as well go kill myself'.*": Exhibit 1, Volume 1, Tab 15, Statement of Constable Shaun Hutt dated 20 January 2022, p.5

[54] Ts 19.11.24 (Constable Hutt), p.86

[55] Ts 19.11.24 (Constable Hut), pp.86-87

[56] Ts 19.11.24 (Constable Hutt), p.86

[57] Ts 19.11.24 (Constable Hutt), pp.88-89

[58] For details of the other occasion, see footnote 53.

> Now, again, upon reflection and with the benefit of hindsight, would you accept that that was a mistake that you made? --- In hindsight, it's probably something that should have been handed over, given the circumstances of what happened afterwards. But at the time, yes, I also believed it didn't need to be, otherwise I would have.

112 Constable Axford was also asked at the inquest whether Jalen's comments that if he died or suicided ought to have been passed onto ED staff. Constable Axford said that was not necessary as she took those remarks by Jalen "*as a flippant comment*".[59]

113 At the inquest, Dr Brooks was asked what his response would be if he had been advised by police that Jalen had mentioned suicide in their presence. Dr Brooks answered:[60]

> If a patient is expressing suicidal ideation regardless of the context, because people say those sorts of things for a variety of different reasons. But on the surface of it, the right thing to do is to explore it and ensure that you know, there is nothing serious underpinning it, and of course often there is. And, you know, in the emergency department we see people in mental health crisis often and suicidal ideation is a common presentation. And we take it seriously. And so if people express suicidal ideation, even if the context of something grievous happening socially, whatever that may be, it is always something that we factor into our assessments. Or at least I do. My practice is to factor that into an assessment.
>
> So if it was brought to your attention, it would have been something you would have been addressing directly or looking to address directly with Dr Cerda-Pavia and with Jalen? --- And with Jalen. Absolutely.
>
> In addition to this, in the course of speaking with police officers not only in the low stimulation room but also, at the time of his arrest, Jalen had repeatedly expressed concerns that his partner was going to be murdered. If you were advised of those kind of comments, what would be your response? --- It would be to undertake some questioning to try and flesh that out and find out what that represented. Was that a genuine belief or was it not? Yes. So I would just further investigate it.
>
> ...
>
> So, Doctor, what would have been these further investigations? What would have been involved if you had received this sort of information? --- Probably less investigations and more just historical inquiry as to, you know, what Jalen meant by what he was saying. And almost certainly a deeper dive into any mental health records. Mental health records for patients aren't immediately available, they're on a sort of, separate

[59] Ts 19.11.4 (Constable Axford), p.110
[60] Ts 16.12.24 (Dr Brooks), pp.257-258

> database that the emergency staff never had ready access to. So, what my practice is, is to contact the mental health team that are in embedded in the ED[61] and ask them to look on that database, which is referred to as PSOLIS.
>
> Yes? --- Get them to look at PSOLIS and get me some background.

114 Dr Cerda-Pavia gave similar evidence at the inquest.[62]

115 For the preparation of his report for the Court, Dr Hall was asked whether police should have notified hospital staff of the remarks Jalen made concerning suicide when he was being served his bail papers. Dr Hall answered:[63]

> It is regrettable that Mr Norris' remark about committing suicide that was made during the serving of his bail papers was not communicated to hospital staff. Notification of such a remark, particularly with health practitioners on hand in a hospital setting, would be good practice.

116 Dr Hall qualified that answer at the inquest, stating it was a speculating remark by Jalen that was "*really driven by his ongoing belief that his parents were dangerous people to him and to his girlfriend*", and that it lacked "*authenticity in terms of suicidality.*"[64] He added that Jalen then became future focused as he spoke to the police officers about having to get his belongings from his parents' house. Dr Hall concluded: "*So I think if I were in the sergeant's shoes,*[65] *I would not have interpreted that as a genuine expression of suicidal ideation.*"[66]

117 Being mindful not to insert hindsight bias, I am satisfied to the required standard, that the concerns Jalen had expressed to Constable Hutt and Constable Axford during the bail process that his partner would be killed by a gang and his comments about suicide should have been forwarded onto ED staff. I accept Dr Hall's qualifications in his evidence at the inquest I have cited above; including his observation there was no genuine expression of suicidal ideation. However, what Jalen had said to the two police officers demonstrated he was most likely having some disordered thought processes that were delusional in nature. I am satisfied that a police officer, particularly one with Constable Hutt's experience, ought to have been able to ascertain that. In those circumstances, it should have been

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[61] i.e. the ED Psychiatric Liaison Service.
[62] Ts 20.11.24 (Dr Cerda-Pavia), pp.212-215
[63] Exhibit 3, Report from Dr Mark Hall dated 19 November 2024, p.16
[64] Ts 16.12.24 (Dr Mark Hall), p.273
[65] Dr Hall is referring to Constable Hutt.
[66] Ts 16.12.24 (Dr Mark Hall), p.273

evident this information may be useful to the doctors who were going to assess Jalen shortly after those comments were made.

118 As Constable Axford had only completed her probation seven months prior to this incident and as Constable Hutt had seven years more experience than Constable Axford and was an acting Sergeant at the time,[67] I find it was incumbent upon Constable Hutt to convey this information onto ED staff or advise Constable Axford to do so. As he did not, it was a missed opportunity of some significance as both doctors who assessed Jalen testified they would have undertaken further inquiries if they had been given this information.

Whether ED medical staff should have sought a mental health assessment for Jalen

119 Despite my finding that the actions by police to not refer Jalen for a mental health assessment were appropriate, a separate question arose as to whether such an assessment by the ED Psychiatric Liaison Service (EDPLS) ought to have been arranged by ED medical staff once Jalen was in the ED.

120 This question was addressed by Dr Hall in his report: [68]

> Given the recent self-harm (by way of head injury), referral for mental health assessment was warranted, even assuming that was the extent of information available to the ED staff. However, the Adult Emergency Department Record time-stamped 1615, records that the "presenting history" was "delusional comments/paranoid about family", which strengthened the case for referral for a psychiatric opinion. The extent to which that notation was heeded by the RMO and ED consultant is unknown. Even without that information, there was evidence of lability, poor eye contact, anxiety, paranoia, and Mr Norris being uncooperative in terms of refusing to give the nurse his name, refusing to change into a gown, refusing to be examined and refusing to discuss his mental health.

121 At the inquest, Dr Cerda-Pavia confirmed that prior to her seeing Jalen, she would have seen the triage notes prepared by Mr Hester.[69] However, she could not recall whether she had the "Police Handover to ED" form or the records from the paramedics who had taken Jalen to SJOGMH.[70] Dr Cerda-Pavia also confirmed that she would have read previous records of Jalen's presentations to the ED at SJOGMH as she had recorded in the progress notes that his previous medical history was "*numerous*

[67] Exhibit 5, Email from Inspector Jason Fogliani to the SSO dated 16 December 2024
[68] Exhibit 3, Report from Dr Mark Hall dated 19 November 2024, pp.17-18
[69] Ts 20.11.24 (Dr Cerda-Pavia), p.193
[70] Ts 20.11.24 (Dr Cerda-Pavia), p.193

presentations, suspicion of drug use, social issues with family, [possible] violence."[71]

122 In her statement to the Court, Dr Cerda-Pavia said: [72]

> The notes by the triage nurse also record "delusional comments/ paranoid about family". Reviewing my notes, it seems to be it was my impression at the time that Mr Norris appeared paranoid in that he showed poor rapport, engagement, and eye contact, and was focused on not having somewhere to stay because of an order preventing him from returning home. But, in the time I spent with Mr Norris, I did not observe any delusional comments or signs of psychosis or agitation.

123 At the inquest, Dr Cerda-Pavia was shown the contents of the Adult Emergency Department Record when Jalen presented to the ED on 4 December 2019. This document recorded that Jalen had called triple zero twice and was "*concerned father wants to kill him and police were being bribed*" and that he "*appeared paranoid, having paranoid delusions.*"[73] Dr Cerda-Pavia agreed that if she had read that on 9 April 2021, she would have gone straight to the Psychiatric Liaison Nurse (PLN) who is part of the EDPLS.[74] On the face of it, that evidence supports Dr Hall's observation that "*inadequate attention was given to prior medical and psychiatric history.*"[75]

124 However, balanced against that was other evidence I had heard in two areas. The first was from Mr Hester who said that when Jalen presented to the ED it was during a peak period.[76] The second, and more important area, was the evidence from Dr Cerda-Pavia that she had seen an entry in the WebPAS system[77] that the PLN had asked for a urinary drug screen for Jalen.[78]

125 This entry was made at 4.20 pm (before Dr Cerda-Pavia's assessment of Jalen)[79] and provided some reassurance for Dr Cerda-Pavia that the PLN had looked at Jalen's records on PSOLIS.[80] Unfortunately that reassurance was, as Dr Cerda-Pavia described, "*a false sense of security*"[81] as no full

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[71] Ts 20.11.24 (Dr Cerda-Pavia), p.195; Exhibit 1, Volume 2, Tab 3.2, Progress Notes, p.1
[72] Exhibit 1, Volume 1, Tab 20, Statement of Dr Claudine Cerda-Pavia dated 30 November 2024, p.2
[73] Exhibit 1, Volume 2, Tab 6, Adult Emergency Department Record, p.1
[74] Ts 20.11.24 (Dr Cerda-Pavia), p.211
[75] Exhibit 3, Report of Dr Mark Hall dated 19 November 2024, p.17
[76] Ts 20.11.24 (Mr Hester), p.183
[77] The system that provides information for the healthcare of patients.
[78] Ts 20.11.24 (Dr Cerda-Pavia), pp.217-218
[79] Exhibit 1, Volume 2, Tab 1, SAC1 Clinical Incident Investigation Report dated 21 May 2021, p.8
[80] Ts 20.11.24 (Dr Cerda-Pavia), p.217
[81] Ts 20.11.24 (Dr Cerda-Pavia), p.218

review of PSOLIS had been undertaken. That was because the PLN had assumed Jalen would be referred to the EDPLS and the urinary drug screen was simply requested in the interim.[82]

126 In his statement to the Court, Dr Brooks noted the outcome of his examination of Jalen included the following:[83]

> A mental state examination revealed no evidence of a significant depressive illness, no suicidal ideation, no psychotic phenomena, no axis 1 diagnosis (a category of mental health and substance abuse disorders including schizophrenia and mood/anxiety/eating/sleeping disorders), and that he was future focused.
>
> ...
>
> My impression of Mr Norris was that he was in a situational crisis. He could not return to his home because of the police order/violence restraining order that I understood was in place. He was receptive to the assistance of a social worker to resolve this issue.

127 At the inquest, counsel assisting asked Dr Brooks whether he would have done anything differently now in terms of his involvement with Jalen. Dr Brooks answered: [84]

> I've reflected on this case a lot, the outcome of which is unfathomably tragic. And so I have thought long and hard whether or not there was anything I did or did not do - anything that I could have done at the time, that I would have done differently, that would have potentially had an impact on the outcome. And with the information that I had at the time, if I was given that information again, I would probably come to the same conclusion.

128 At the inquest, Dr Hall confirmed what he had said in his report; namely, that a referral for a mental health assessment was warranted:[85]

> I think the only thing that is regrettable is that the observations of the resident medical officer that Jalen was paranoid and I think there were a couple of other things there about his unusual eye contact and his reluctance to engage, I think it's just regrettable that some of those observations didn't translate into a referral to the Psychiatric Liaison Nurse.

129 In his closing submissions at the inquest, Mr Beetham conceded there was a missed opportunity by SJOGMH to refer Jalen for a mental health

[82] Exhibit 1, Volume 2, Tab 1, SAC1 Clinical Incident Investigation Report dated 21 May 2021, p.11
[83] Exhibit 1, Volume 1, Tab 21, Statement of Dr Philip Brooks dated 8 November 2024, pp.2-3
[84] Ts 16.12.24 (Dr Brooks), p.262
[85] Ts 16.12.24 (Dr Hall), p.276

assessment. In making that concession, which I consider was appropriate, Mr Beetham submitted that this opportunity was "*an organisational missed opportunity*", and that it was not a "*missed opportunity referable to any specific person*".[86]

130 I accept those submissions from Mr Beetham. Accordingly, I am satisfied to the required standard that there was a missed opportunity by SJOGMH to refer Jalen for a mental health assessment. This missed opportunity was organisational in nature and does not refer to a particular person or persons.

131 I also accept these observations from Dr Hall regarding the likely outcome had a mental health assessment of Jalen been undertaken by a member of the EDPLS:[87]

> However, even if a mental health assessment had been undertaken, *and* had that assessment yielded evidence of significant paranoid ideation, had Mr Norris then guaranteed his safety and agreed to have treatment and speak with a social worker, it is likely that the same disposition would have occurred. That is, Mr Norris would still have been discharged from the emergency department rather than admitted to a mental health unit.

132 At the inquest, Dr Hall provided further evidence with respect to this, stating that, "*in my experience, it's not uncommon for people who present in the way that Jalen did to not reach that threshold for admission to hospital.*"[88]

133 In addition, I accept this analysis by Dr Hall as it relates to those ED staff who interacted with Jalen on 9 April 2021:[89]

> Although opportunities for treatment and support were missed, both in the past and closer to his death, and although information regarding his paranoia was not effectively communicated between police and health staff, each person that interacted with Mr Norris did not take unreasonable actions in the context of what they knew and what they observed, nor were any contemporaneous assessments or actions obviously flawed nor patently inappropriate.

Whether Jalen ought to have been permitted to leave the ED by himself

134 As I have already referred to, Jalen left the ED by himself and without his personal belongings, barefooted and wearing a disposable jumpsuit that had earlier been provided to him by police. On the face of it, it could be asked

[86] Ts 16.12.24 (closing submissions of Mr Beetham), pp.304-305
[87] Exhibit 3, Report of Dr Mark Hall dated 19 November 2024, p.19
[88] Ts 16.12.24 (Dr Hall), p.276
[89] Exhibit 3, Report of Dr Mark Hall dated 19 November 2024, p.19

how was that allowed to happen? However, given the information I have received, I am satisfied there was nothing ED staff at SJOGMH could have lawfully done to prevent him from leaving.

135 Shortly after Dr Brooks' assessment of him, Jalen said to ED nursing staff that he wanted to leave. However, as recorded by a registered nurse, he "*was easily directed back into cubicle by security until confirmation no duty of care*[90]*[was]in place*".[91] Dr Brooks was subsequently consulted and he advised that as Jalen did not fall within the hospital's duty of care, he was able to leave the ED if he wanted.[92] As Dr Brooks had determined Jalen was experiencing a "situational crisis" (and not an acute mental health episode that may cause a serious injury to Jalen or another person), I am satisfied that was appropriate. Nor had Jalen's Glasgow Coma Scale indicated a need for him to be kept under medical supervision following his head strike. As Mr Hester said at the inquest, Jalen's score of 15 out of 15 meant he was "*a conscious, alert, orientated person*".[93]

136 In addition, the decision by Jalen to leave the ED was unexpected as far as Dr Cerda-Pavia and Dr Brooks were concerned. At the completion of their assessments, he had agreed to wait in order to see a social worker to assist him with short term accommodation and to be provided with a meal that he had requested.

137 A short time after Dr Brooks advised nursing staff Jalen was able to leave if he wanted to,[94] Jalen left the ED with security showing him the way to the exit.[95]

138 Even if Jalen had been referred to the EDPLS for a mental health assessment, it would not have prevented him from leaving SJOGMH. As Dr Hall explained when he was asked the following question:[96]

> Even if you're referred to the psychiatric liaison team, that also wouldn't necessarily guarantee that he would be prevented from leaving the hospital or put on forms or anything like that if he attempted to leave, would that

[90] A hospital would be able to detain a patient against their will under its duty of care obligations if it was required in order to prevent the patient from behaving in a way that was likely to result in serious physical injury to the patient or to another person.
[91] Exhibit 1, Volume 2, Tab 3.2, Progress Notes
[92] Exhibit 1, Volume 2, Tab 3.2, Progress Notes
[93] Ts 20.11.24 (Mr Hester), p.166
[94] One estimate was 5-10 minutes later: Exhibit 1, Volume 2, Tab 1, SAC1 Clinical Incident Investigation report dated 21 May 2021, p.8
[95] Exhibit 1, Volume 2, Tab 3.2, Progress Notes
[96] Ts 16.12.24 (Dr Hall), p.276

> be fair to say? --- Exactly. It wouldn't have - it would not have resulted necessarily in him being placed on forms under the Mental Health Act.

139 Unfortunately, patients discharging themselves from an ED is not an uncommon occurrence. As Dr Brooks said at the inquest:[97]

> I mean, some people just do not want to be in the emergency department nor sometimes in the company of the police. And so they would sort of, you know, bolt at an early opportunity just because they don't want to be in the hospital or in the situation that they find themselves in. If somebody were to, you know, leave their possessions ... it raises some concern about the urgency with which they ... are wanting to get out or something, you know, extremely pressing or something that had an extremely high priority they might want to leave for.

Was Dr Cerda-Pavia's response to the telephone call from Jalen's mother appropriate?

140 Shortly after Jalen had left the ED, his mother called SJOGMH and asked to speak to the doctor who had seen Jalen. Jalen's mother eventually spoke to Dr Cerda-Pavia who advised her that Jalen had left the hospital without taking his personal property, his keys or his phone.[98] As recounted by Jalen's mother:[99]

> I was very agitated at this stage, and asked why he had been allowed to leave without having a psychiatric evaluation. I was told Jalen had presented as calm and had refused an x-ray for his head injury. He had also refused a drug test and to see a social worker.[100]
>
> Jalen did agree to have some food but when staff returned with food, Jalen had left.
>
> ...
>
> Dr Corrine [sic] suggested I call police and request a welfare check if I was concerned for his safety.

141 Dr Cerda-Pavia's notes of this conversation are very similar:[101]

> Lynette rung and was very distressed her son had not been admitted to Mental Health due to his "schizophrenia".
>
> Stating Jalen is not safe as he has "low IQ" (no formal diagnosis) and [is] vulnerable on the streets.

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[97] Ts 16.12.24 (Dr Brooks), p.252

[98] Exhibit 1, Volume 1, Tab 7, Statement of Lynette Norris dated 16 June 2021, p.9

[99] Exhibit 1, Volume 1, Tab 7, Statement of Lynette Norris dated 16 June 2021, p.10

[100] Although Jalen refused a drug test, I am satisfied on all the information available that contrary to his mother's recollection of what she was told, he did agree to see a social worker.

[101] Exhibit 1, Volume 2, Tab 3.2, Progress Notes

> I explained that Jalen had been brought in by police for medical clearance post self-harm, and that there were no concerning signs during his time that indicated mental health concerns.
>
> Explained to Lynette that if she had concerns for well-being, to notify WAPOL for welfare check.

142 I am satisfied that Dr Cerda-Pavia's response to Jalen's mother's concerns was appropriate, including her suggestion that Jalen's mother call the police for a welfare check. I note that in making this finding there were no submissions to the contrary from the interested parties at the inquest.

CHANGES AND IMPROVEMENTS SINCE JALEN'S DEATH [102]

143 As would be expected of all hospitals, SJOGMH should always be on the pathway of continual improvements with respect to the treatment and care of patients who require its services.

144 Given there is ordinarily a gap of some duration between the date of the death the subject of the coronial investigation and the inquest's date, those entities connected to the death will often implement changes that are designed to improve practices and procedures before the inquest is heard.

145 In addition, when the death occurs in a hospital setting, a SAC1 investigation is usually completed well before the inquest is commenced and will frequently make recommendations designed to create improvements. The SAC1 investigation in relation to Jalen's death made two recommendations which have already been implemented.

"Police Handover to ED" form

146 The SAC1 investigation noted the following with respect to the "Police Handover to ED" form: [103]

> There was no clear plan on the Police Handover Form indicating:
>
> - The reason for presentation to ED
> - The patient's custody status
> - Plan if discharged from ED

[102] Exhibit 1, Volume 2, Tab 1, SAC1 Clinical Incident Investigation report dated 21 May 2021; Exhibit 1, Volume 1, Tab 23, Letter from Chris Goadby to counsel assisting dated 14 November 2024

[103] Exhibit 1, Volume 2, Tab 1, SAC1 Clinical Incident Investigation report dated 21 May 2021, p.15

147 It was recommended that: "*Police Handover Form to be completed by police and checked by the Triage Nurse to ensure completeness/ accuracy.*"[104]

148 The form that was in use in April 2021 was the same version that the ED had introduced in December 2019 in consultation with police. This consultation was done for the purpose of addressing deficiencies in the oral handovers that had previously taken place between police and SJOGMH.

149 Also in December 2019, Royal Perth Hospital (RPH) commenced a trial of a revamped "Police Handover to ED" form it had developed with the WAPF. This form was designed to capture additional information for each patient brought into the ED at RPH and specifically, to address violence and aggression towards RPH staff.

150 This improved form was subsequently implemented in January 2023 as a state-wide "Police Handover to ED" form and is now in place at SJOGMH.

151 The Court was provided with a copy of this form.[105] It is clear to me that this form contains far more information than the one that had been in use in April 2021. I also note that this form must be completed by a hospital staff member in the presence of police.

Mandating a PSOLIS check

152 The SAC1 investigation recommended: "*Mandating a PSOLIS check for patients presenting with any of the following complaints (as per the Mental Health Presentation to ED procedure); altered mental state, anxiety, deliberate self-harm, overdose/poisoning, psychiatric disorder, suicidal.*"[106]

153 In accordance with this recommendation, SJOGMH implemented a modified procedure for mental health presentations to the ED. As Christopher Goadby, acting Nurse Director, Emergency Department and Clinical Operations, SJOGMH, explained in his letter to the Court:[107]

> This procedure ensures that all patients triaged with a mental health presentation are referred to the ED Psychiatric Liaison Service (PLS). Mental health presentations are defined to include altered mental state,

[104] Exhibit 1, Volume 2, Tab 1, SAC1 Clinical Incident Investigation report dated 21 May 2021, p.15
[105] Exhibit 1, Volume 1, Tab 23.4, Statewide Emergency Department WA Police Handover
[106] Exhibit 1, Volume 2, Tab 1, SAC1 Clinical Incident Investigation Report dated 21 May 2021, p.16
[107] Exhibit 1, Volume 1, Tab 23, Letter from Chris Goadby to counsel assisting dated 14 November 2024, p.4

> anxiety, deliberate self-harm, overdose/poisoning, psychiatric disorder, and suicidal.

154 When this procedure is engaged, the EDPLS reviews PSOLIS and documents the completion of the PSOLIS check in the patient's medical records. This documentation is now done through the recently introduced electronic progress notes.[108]

155 Posters educating ED staff about when and how to request a PSOLIS check have been placed around the ED and each triage nurse at SJOGMH is required to attend training regarding PSOLIS checks.[109]

156 These changes are welcomed. Had they been in place at the time of Jalen's last presentation to the ED then the "Police Handover to ED" form would have been more comprehensive and a PSOLIS check would have been requested at the outset.

157 I commend the WAPF for the introduction of the improved state-wide "Police Handover to ED" form, and SJOGMH for the introduction of the mandated PSOLIS check.

158 In light of these two changes, I have not considered there is a need for me to make any further recommendations arising from the circumstances of Jalen's death.

CONCLUSION

159 This inquest involved a tragic case as it dealt with the death of a deeply troubled young man.

160 Dr Hall, a respected and experienced consultant psychiatrist, diagnosed Jalen in this way:[110]

> I do believe that Jalen was suffering from a mental illness. The precise diagnosis is difficult to know without having the opportunity to interview him, but it was, I believe, one of the psychotic disorders. So that's a broader umbrella term that incorporates a number of conditions, such as schizophrenia or delusional disorder, drug-induced psychosis, schizoaffective disorder, and the main way in which his illness was manifested was paranoid delusions.

161 I am satisfied Jalen was experiencing paranoid delusions on the afternoon of 9 April 2021. This led to police attending his parents' address, and he

[108] Exhibit 1, Volume 1, Tab 23, Letter from Chris Goadby to counsel assisting dated 14 November 2024, p.5
[109] Exhibit 1, Volume 1, Tab 23, Letter from Chris Goadby to counsel assisting dated 14 November 2024, p.5
[110] Ts 16.12.24 (Dr Hall), p.269

was subsequently arrested and taken into custody. After being placed in a cell at the police station, Jalen deliberately self-harmed by striking his head against the glass cell door. With two accompanying police officers, he was taken by ambulance to the ED at SJOGMH.

162 The more senior of those two police officers missed an opportunity to provide ED staff with comments Jalen had made regarding his delusional belief his partner was going to be murdered by a gang and that if he was going to die by suicide, it would be his parents' fault.

163 Unfortunately, due to what I found was an organisational missed opportunity, Jalen was not recommended for a mental health assessment to be performed by the EDPLS. A resident medical officer and consultant emergency physician formed the view he was experiencing a situational crisis. Consequently, as he was a voluntary patient at the ED, Jalen could not be prevented from discharging himself; which he did, less than 90 minutes after his presentation.

164 Although he had denied any thoughts of self-harm or suicidal ideation to doctors at the ED, within an hour of leaving SJOGMH, Jalen had walked to a train crossing and sat on the tracks in front of an oncoming train.

165 Since Jalen's death, changes have been made state-wide to the form that is completed by police when handing over a person in custody to an ED. SJOGMH has also made changes to its procedures which will ensure that patients attending the ED with mental health issues like Jalen had, will have a mandated check of their on-line psychiatric records by the PLN.

166 I have accepted Dr Hall's observation that, "*whilst Mr Norris' most recent encounter with police and health services highlights areas for improvement in processes, I am also of the opinion that his death would not necessarily been prevented had anything been done differently on 9 April 2021.*" [111]

167 All too frequently, the Court encounters cases in which a young person's life and the lives of their loved ones are devastated by the scourge of a mental health condition involving psychosis and/or paranoid delusions. Sadly, Jalen's death must now be added to that lengthy list.

168 Jalen's mother told the Court:[112]

[111] Exhibit 3, Report of Dr Mark Hall dated 19 November 2024, p.20

[112] Exhibit 1, Volume 1, Tab 7, Statement of Lynette Norris dated 16 June 2021, p.12

> Jalen was a much loved son, brother, nephew and grandson and his death has taken a huge toll on our family and affected our family profoundly. We are broken but determined to get to the bottom of what happened.

169 I hope the inquest process and my finding has assisted Jalen's family to find the answers they were seeking.

170 As I did at the conclusion of the inquest, I extend my sincere condolences to the family of Jalen.

PJ Urquhart
Coroner
6 March 2025