JURISDICTION	**:**	CORONER'S COURT OF WESTERN AUSTRALIA
ACT	**:**	CORONERS ACT 1996
CORONER	**:**	MICHAEL ANDREW GLIDDON JENKIN, CORONER
HEARD	**:**	15 - 16 APRIL 2025
DELIVERED	**:**	30 JUNE 2025
FILE NO/S	**:**	CORC 950 of 2023
DECEASED	**:**	PEEL, HOUSTON

Legislation:

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

Cases:

Briginshaw v Briginshaw (1938) 60 CLR 336

Counsel Appearing:

Mr D McDonald appeared to assist the coroner.

Mr G Scott (State Solicitor's Office) appeared for the South Metropolitan Health Service.

Mr J Cavanagh (Blumers Personal Injury Lawyers) appeared for Houston's family.

Mr D Rafferty (Eureka Lawyers) appeared for Mr A De Francesch, and Ms L Hackett.

Coroners Act 1996
(Section 26(1))

RECORD OF INVESTIGATION INTO DEATH

*I, Michael Andrew Gliddon Jenkin, Coroner, having investigated the death of **Houston PEEL** with an inquest held at Perth Coroners Court, Central Law Courts, Court 85, 501 Hay Street, Perth, on 15 - 16 March 2025, find that the identity of the deceased person was **Houston PEEL** and that death occurred on or about 30 March 2023 at Moitch Park, Robin Warren Drive, Murdoch, from ligature compression of the neck (hanging) in the following circumstances:*

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INTRODUCTION

1. Mr Houston Peel (Houston)[1] died on or about 30 March 2023 at Moitch Park, Murdoch from ligature compression of the neck. He was 29-years of age.[2,3,4,5,6]

2. Houston was brought to the emergency department (ED) at Fiona Stanley Hospital (FSH) by ambulance on 30 March 2023 at about 4.35 am. Houston's family had become concerned that he was exhibiting psychotic behaviour, and Houston had agreed to attend FSH to be assessed.

3. Houston was seen by a triage nurse and assigned a triage score of "3", meaning he was to be seen within 30 minutes. However, at the relevant time the ED was extremely busy. Although Houston was given some antipsychotic medication and later some paracetamol, he was not seen by a doctor before he left the ED at 8.52 am.

4. Houston did not answer his name when it was called at about 9.15 am, and at 10.47 am his medical record was marked "*did not wait*" and he was discharged from FSH. Houston did not contact his family after leaving the emergency department, and that evening his mother reported him to police as a missing person. Houston was discovered by his ex-partner, hanging in bushland opposite FSH on 13 April 2023.

5. I held an inquest into Houston's death on 15 - 16 April 2025 at Perth, which was attended by members of Houston's family, including his mother. The documentary evidence tendered at the inquest comprised one volume, and the following witnesses gave evidence:

a. Mr A De Francesch (Triage nurse and Shift Coordinator, FSH);[7]
b. Ms K Dedman (Registered nurse, FSH);[8]
c. Mr J Teruel, (Registered nurse, FSH);[9]

[1] At the request of his family, Mr Peel was referred to at the inquest and in this finding as "Houston"
[2] Exhibit 1, Vol. 1, Tab 1, P100 - Report of death form (19.06.24)
[3] Exhibit 1, Vol. 1, Tab 3, Life Extinct Form (13.04.23)
[4] Exhibit 1, Vol. 1, Tab 4, P92 - Identification of deceased person by visual means form 13.04.23
[5] Exhibit 1, Vol. 1, Tab 5.1, Supplementary Toxicology Report (31.12.24)
[6] Exhibit 1, Vol. 1, Tab 6.1, Supplementary Post Mortem Report (10.06.22)
[7] ts 15.04.25 (de Francesch), pp6-39
[8] ts 15.04.25 (Dedman), pp39-49
[9] ts 15.04.25 (Teruel), pp49-62

d. Ms L Hackett, (Nurse Unit Manager, FSH);[10]
e. Dr A Brett (Independent Consultant Forensic Psychiatrist);[11]
f. Dr C Taylor (Head of Emergency Medicine, FSH);[12] and
g. Dr M Monaghan (Area Director Clinical Services, SMHS).[13]

6. The inquest focused on the adequacy of Houston's triage assessment, the delay in his being assessed by a mental health professional, whether FSH complied with its "*Did Not Wait*" policy, and the appropriateness of FSH's practice of prescribing and dispensing psychotropic medication in the absence of a medical review.

7. In assessing Houston's treatment at FSH, I have been mindful not to insert any hindsight bias into my assessment of the acts or omissions of clinical staff. Hindsight bias is the tendency after an event, to assume that the event was more predictable or foreseeable than it actually was at the time.[14]

8. Further, in relation to deciding whether a finding which is adverse in nature is open on the available evidence, I have applied the standard of proof set out by the High Court of Australia in its decision in a case known as ***Briginshaw v Briginshaw***[15].

9. That case is authority for the proposition that when assessing the quality of the treatment and care Houston received at FSH, I must consider the nature and gravity of the relevant conduct when deciding whether a finding which is adverse in nature has been proven on the balance of probabilities.

[10] ts 15.04.25 (Hackett), pp62-89
[11] ts 15.04.25 (Brett), pp89-121
[12] ts 15.04.25 (Taylor), pp121-146
[13] ts 15.04.25 (Monaghan), pp146-156
[14] Dillon H and Hadley M, *The Australasian Coroner's Manual* (2015), p10
[15] (1938) 60 CLR 336, per Dixon J at pp361-362

HOUSTON

Background[16]

10. Houston was born in Zimbabwe on 16 April 1993, and was 29-years of age when he died on or about 30 March 2023. Houston had come to Australia about five years earlier, and was employed as a rigger with a mining company. Houston was single at the time of his death, but he and his ex-partner had a child together.

Medical history[17,18]

11. Houston does not appear to have had any chronic medical conditions and there are limited records from his GP. In June 2021, Houston was admitted to hospital after a fall whilst under the influence of alcohol. He sustained a laceration to his hand (which was sutured), and fractures to the pubic rami, and sacral/acetabular/femoral head fractures which were managed conservatively. He was discharged on 30 June 2021 and referred to rehabilitation services, and a clinical psychologist.[19]

12. On 22 November 2022, Houston saw his GP and complained of experiencing "*panic attacks*" four weeks previously whilst in Bali. The GP records do not record any specific treatment, but a urine screen was positive for Valium (diazepam). On 29 March 2023, Houston attended his GP clinic complaining of "*feeling faint after taking (a) whole packet of sleeping tablets to fall asleep*". Although Houston was to have been brought into the treatment room, it appears he left before being medically assessed.

13. On 20 March 2023, Houston and his ex-partner, their child and a male friend (Cedric) went to Bali for a holiday. On 27 March 2023, Houston presented to a medical clinic with a history of vomiting, dizziness, and malaise. Houston told clinic staff "*he had big meals*" the day before, and he was diagnosed with "*(suspected) Gastroenteritis/Acute Food poisoning*", and he was treated with intravenous fluids, and oral and intravenous anti-nausea medication.[20,21]

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[16] Exhibit 1, Vol. 1, Tab 2, Report - Coronial Investigator R Fyneman (26.06.24), p7
[17] Exhibit 1, Vol. 1, Tab 11, SAC1 Clinical Investigation Report (09.06.23), p3
[18] Exhibit 1, Vol. 1, Tab 12, Medical Records - Cannington Medical & Dental Centre
[19] Exhibit 1, Vol. 1, Tab 11, SAC1 Clinical Investigation Report (09.06.23), p3
[20] Exhibit 1, Vol. 1, Tab 2, Report - Coronial Investigator R Fyneman (26.06.24), p7
[21] Exhibit 1, Vol. 1, Tab 18, Medical Report - Bhakti Vedanta Medical, Bali (27.06.24)

EVENTS LEADING TO HOUSTON'S DEATH

Events of: 28 - 30 March 2023[22,23,24,25]

14. At about 6.30 pm on 28 March 2023, Houston's mother collected him from Perth Airport after his return from a holiday in Bali. Houston seemed fine, and he showed his mother some anti-nausea medication he had been given at a clinic in Bali. Houston had a light dinner and he and his family went to bed at about 10.30 pm.

15. Houston's mother (who is a mental health worker) spoke to Houston briefly at about 8.00 am the next morning. Houston said he had not slept well, and his mother suggested he sleep in her room and gave him some Restavit (doxylamine). At about 12.30 pm, Houston's younger brother reported that Houston was "*talking to himself*", but when his mother asked who he was talking to, Houston said: "*Nobody, I am just sorting things out in my head*".[26]

16. Later, Houston seemed to be agitated and was pacing and talking to himself. Houston's mother called his ex-partner and asked her to take Houston to his GP as she was concerned he was "*psychotic*". Although the ex-partner took Houston to his GP, when his name was called, he became agitated and left without being seen.

17. Houston's GP was concerned for his welfare and was under the impression Houston had taken "*a box of sleeping tablets*", and so the GP contacted police. Meanwhile, Houston had told his ex-partner he thought he could hear his friend Cedric's voice and that he needed to go to a Telstra store.

18. On the way to the store, Houston was talking to himself, saying "*It's ok, I'm now on my way to get my SIM card and phone and then I can transfer the money*". When the ex-partner asked what he was talking about, Houston said he was just talking to himself, and they drove to his house in Harrisdale, where they were met by police.[27]

[22] Exhibit 1, Vol. 1, Tab 8, Statement - Ms S Peel (01.08.23)
[23] Exhibit 1, Vol. 1, Tab 2, Report - Coronial Investigator R Fyneman (26.06.24)
[24] Exhibit 1, Vol. 1, Tab 8, Statement - Ms S Peel (01.08.23)
[25] Exhibit 1, Vol. 1, Tab 9, Statement - Ms S Geogeo (25.07.23)
[26] Exhibit 1, Vol. 1, Tab 8, Statement - Ms S Peel (01.08.23), paras 14-15
[27] Exhibit 1, Vol. 1, Tab 9, Statement - Ms S Geogeo (25.07.23), para 48

19. Police contacted Houston's mother and confirmed that Houston had only taken a single sleeping tablet, and not an entire box as the GP had assumed. Police told Houston's mother they had no concerns for Houston's welfare and left. At the Harrisdale home, Houston collected a phone charger, and removed the hard drive for the property's CCTV cameras. When his ex-partner asked him about the hard drive, Houston said: "*Now they're gonna know we've been here*".[28,29]

20. Houston and his ex-partner then drove back to his mother's apartment in South Perth, and at about 5.00 pm, she noticed Houston was pacing up and down and seemed agitated. Houston also appeared be having conversations with "*the voices*" and when his mother asked who he was talking to, Houston said: "*They want the money*".

21. Houston then started asking his mother to deposit money in his bank account, and over the course of the evening, he called several family members and friends asking for money. At about 3.00 am on 30 March 2023, Houston called his father (who was living in New Zealand) and asked for $50,000. Houston's father told Houston he didn't have that much money, and the phone call ended. In her statement, Houston's mother says this about this phone call and Houston's demeanour:

> Houston was cooperative and respectful in his responses to his dad during the conversation and after he hung up the phone call, Houston's demeanour changed and he suddenly became fearful and grabbed two kitchen knives, looking up at the air vents telling me to stay where I am as they are here to harm us, he stretched out his arm to stop me from going in front of him to protect me and himself, from people whom he felt were coming after him (Visual hallucinations).[30]

22. Despite reassurance, Houston continued to express concerns about his family's safety, and his family drove to his sister's house in Wilson. At about 3.15 am, Houston's mother called emergency services to request an ambulance due to her concerns about Houston's behaviour.

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[28] Exhibit 1, Vol. 1, Tab 8, Statement - Ms S Peel (01.08.23), paras 22-23
[29] Exhibit 1, Vol. 1, Tab 9, Statement - Ms S Geogeo (25.07.23), paras 57-58
[30] Exhibit 1, Vol. 1, Tab 8, Statement - Ms S Peel (01.08.23), para 34

23. Police attended and as Houston "*appeared calm*", police said they had no concerns for his welfare. However, Houston's mother explained that Houston's behaviour was out of character and that the family: "*[W]ere very concerned for our and his welfare as he was experiencing visual and auditory hallucinations*".[31]

24. Ambulance officers arrived just before 4.00 am, and the St John Ambulance (SJA) patient care record for this attendance includes the following notes relating to the officers' observations and assessments:

> (*Presenting Complaint*): patient's mum phoned SJA as this morning patient has called multiple family members demanding money, **talking to people who aren't there, telling him family they need to transfer him money or the people will get angry, dragged brother out of bed. Patient reports not sleeping since Sunday night**. Patient reports taking "*couple of dexamphetamine(s)*" and bag of "*coke*" in Bali ?8 days ago. [Emphasis added]
>
> (*History & Examination*): patient's family state this has happened twice before, not in last several months. Prior methamphetamine use- not for several months. Not under any MH team. Normally lives with friends/family, working in construction. Patient reports being in Bali for 1 week, reports having severe diarrhoea and vomiting and going to medical clinic receiving IV medication on Saturday/Sunday prior to flying back to Perth Monday.
>
> (*On Examination*) **Patient admits to hearing voices, none at present**. Denies feeling homicidal/suicidal at present. Dressed appropriately. [Emphasis added]
>
> (*Impression*): **?Psychosis** ?Cause[32] [Emphasis added]

25. As noted, Houston agreed to be taken to FSH for assessment, and he was transported there by ambulance alone. For reasons I will explain, whilst it is completely understandable that none of Houston's family went with him to FSH, with the benefit of hindsight, it is unfortunate he was unaccompanied.

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[31] Exhibit 1, Vol. 1, Tab 8, Statement - Ms S Peel (01.08.23), para 44
[32] Exhibit 1, Vol. 1, Tab 7.1, SJA Patient Care Record MEL22N2 (30.03.23), p2

Treatment at FSH: 30 March 2023[33,34,35,36,37,38,39,40,41,42,43,44,45,46,47]

26. When Houston arrived at FSH, ambulance officers provided a verbal handover to Mr De Francesch, a qualified triage nurse in the emergency department (ED). It appears that the written SJA patient care record I have referred to was not immediately available, and in his statement, Mr De Francesch says this about what he was told by an ambulance officer who transported Houston to FSH:

> I spoke with one of the paramedics and received the iSoBAR handover. I remember that during that handover, the paramedic told me that (Houston's) family had called an ambulance because they were concerned by his behaviour in asking them for money. I then asked (Houston) questions. (Houston) was compliant, friendly, well-kept, and not dishevelled. He was calm and very open when talking to me. He said to me that he had had difficulty sleeping.[48]

27. Mr De Francesch started his triage assessment of Houston at about 4.35 am, and says Houston said he was anxious about owing money to someone and showed him text messages where he was asking people for money. Mr De Francesch says Houston told him his family were worried about him because he was asking them for money, and they had called an ambulance as a result.

28. Houston disclosed using drugs on his recent holiday in Bali, and having had "*Bali belly*" and loose stools. He also said he had "*been hearing voices*" since his return from Bali, but did not describe "*command hallucinations*".[49]

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[33] Exhibit 1, Vol. 1, Tab 10, FSH Medical Records (30.03.23)
[34] Exhibit 1, Vol. 1, Tab 11, SAC1 Clinical Investigation Report (09.06.23)
[35] Exhibit 1, Vol. 1, Tab 19, Statement - Mr P Hammond (26.02.25)
[36] Exhibit 1, Vol. 1, Tab 20, Statement - Mr P Anzini (09.03.25)
[37] Exhibit 1, Vol. 1, Tab 21, Statement - Ms L Hackett (28.03.25) and ts 15.04.25 (Hackett), pp62-89
[38] Exhibit 1, Vol. 1, Tab 22, Statement - Dr C Taylor (27.03.25) and ts 15.04.25 (Taylor), pp121-146
[39] Exhibit 1, Vol. 1, Tab 23, Statement - Mr J Teruel (28.03.25) and ts 15.04.25 (Teruel), pp49-62
[40] Exhibit 1, Vol. 1, Tab 24, Statement - Mr A De Francesch (11.04.25) and ts 15.04.25 (De Francesch), pp7-39
[41] Exhibit 1, Vol. 1, Tab 25, Statement - Dr S Fu (17.03.25)
[42] Exhibit 1, Vol. 1, Tab 26, Letter - Dr M Monaghan (04.04.25) and ts 15.04.25 (Monaghan), pp146-156
[43] Exhibit 1, Vol. 1, Tab 26.1, Management of patients who do not wait after presenting to Emergency Department
[44] Exhibit 1, Vol. 1, Tab 27, Mental Health patient management Emergency Department policy
[45] Exhibit 1, Vol. 1, Tab 28, Statement - Ms K Dedman (31.03.25) and ts 15.04.25 (Dedman), pp39-49
[46] Exhibit 1, Vol. 1, Tab 17.1, Report - Dr A Brett (14.01.25) and ts 15.04.25 (Brett), pp62-121
[47] Exhibit 1, Vol. 1, Tab 17.2, Email - Dr A Brett to Mr D McDonald (08.04.25)
[48] Exhibit 1, Vol. 1, Tab 24, Statement - Mr A De Francesch (11.04.25), para 39
[49] Exhibit 1, Vol. 1, Tab 24, Statement - Mr A De Francesch (11.04.25), para 43

29. In his statement, Mr De Francesch said Houston did not appear to "*react to any hallucinations or unseen stimuli during the triage discussion*" and "*was not acting behaviourally disturbed*. Mr De Francesch also said Houston did not display "*any reg flags of psychosis*" such as "*grandiose delusions*" or "*stories which did not make sense*", and that Houston denied any thoughts of self-harm or plans.[50]

30. Mr De Francesch concluded his triage assessment at 4.43 am, and assigned Houston a triage score of "3", meaning that assessment and treatment should start within 30 minutes. However, at the relevant time, due to the extraordinarily high patient demand that the ED was experiencing, the wait time for patients with a triage score of 3 was about nine hours.

31. Mr De Francesch said that but for Houston's "*mildly elevated*" heart rate (which could have been due to dehydration caused by "*Bali belly*"), he would have given Houston a triage score of 4 (i.e.: assessment and treatment within one hour). Houston did not have a high respiratory rate, and Mr De Francesch's overall impression was that Houston was "*anxious, but friendly and cooperative*".[51]

32. Mr De Francesch said that on the basis of Houston's presentation and level of mental health symptoms, he "*strongly believed*" and was "*confident*" his triage score was "*correct*". Mr De Francesch noted that Houston was: "*cooperative, gave a coherent history, did not report thoughts of self-harm, said he was willing to wait and had walked in with the paramedics willingly*".[52]

33. In the nursing triage assessment form, Mr De Francesch noted:

> *Presenting History*: Drug/alcohol use - drug - recently returned from Bali, known previous meth (methylamphetamine) use, has had bizarre behaviour tonight, calling family requesting $50k. Nil thoughts of self-harm. Pupils extremely dilated. Has been hearing voices, recent Bali belly. hr (heart rate) 110, bp (blood pressure) 140/80.[53]

[50] Exhibit 1, Vol. 1, Tab 24, Statement - Mr A De Francesch (11.04.25), paras 43-47
[51] Exhibit 1, Vol. 1, Tab 24, Statement - Mr A De Francesch (11.04.25), paras 48-51
[52] Exhibit 1, Vol. 1, Tab 24, Statement - Mr A De Francesch (11.04.25), paras 51-52
[53] Exhibit 1, Vol. 1, Tab 10, FSH Adult Triage Nursing Assessment (4.34 am, 30.03.23)

34. As can be seen, key pieces of Houston's recent history were missing from both the SJA patient care record, and from the triage nursing assessment form. It appears that FSH staff were unaware that Houston had become fearful "*they*" were "*coming*" and had removed the hard drive from the CCTV at his home, as well as fetching kitchen knives whilst looking at air vents in his mother's apartment.

35. It also appears that Houston's mother's assessment that her son was exhibiting psychotic behaviour (which was also referred to in the SJA patient care record) was not before clinical staff at FSH. Had Houston been accompanied by a family member, it is at least possible that this additional information could have been conveyed to nursing staff.

36. As I will explain, Houston left the ED before he was medically assessed, and it is also possible that if he had been accompanied by a family member, he might have remained in the ED, although it is impossible to know if this would have been the case.

37. In making these observations, I want to make it clear that I am not making any negative comment on the actions of Houston's family. Houston was clearly a much loved family member, and his family were entitled to assume that he would receive appropriate assessment and care when he arrived at the ED. Houston's family were no doubt relieved when Houston agreed to go to FSH for assessment.

38. In referring to what might have occurred if Houston had been accompanied to FSH, the only point I wish to make is that collateral information from loved ones can be very important, especially in mental health presentations. In Houston's case, it is possible that additional information may have elevated the concerns of clinical staff at FSH, notwithstanding the fact that Houston did not appear to be exhibiting psychotic behaviour while he was in the ED.

39. At the inquest Mr De Francesch was asked whether his triage assessment would have been any different if he had been aware that Houston had been holding knives, and saying "*they're coming, they're coming*" while staring at air vents in his mother's home.[54]

[54] ts 15.04.25 (De Francesch), pp22-23

40. Mr De Francesch's response was:

> Having collateral information from family or friends always does help the triage process because we only have a short period of time to get as much information as we can and reflect against the criteria that we score against. **Again, if I had reassessed him at the time with all the extra collateral, I can't say for certain if the score would change**, but based on that incidence and the triage guidelines, you can still be an ATS 3 and have hallucinations, paranoia, delusions. That still fits that ATS 3 category and…again, at the time I triaged him, I did not have that collateral information.[55] [Emphasis added]

41. I accept that triage assessments are designed to be brief, and are primarily directed to assessing the urgency at which a person needs to be seen. Typically, triage nurses are not mental health professionals, and in the context of a busy ED a brief triage assessment does not allow space for a patient's mental state to be comprehensively assessed. It may also be the case that subtle signs or symptoms of mental illness may not be identified.

42. Key events after Houston's triage assessment are as follows:

a. *4.38 am*: at Mr De Francesch's request, Dr S Fu (an ED registrar) briefly reviewed Houston's notes, before she prescribed 10 mg of the antipsychotic medication, olanzapine. Mr De Francesch dispensed the medication to Houston who took it willingly. Mr De Francesch also told Houston to stay in the ED waiting room and wait for his name to be called;[56,57,58]

b. *5.08 am*: Houston was briefly assessed by Ms Dedman (a registered nurse in the ED) after complaining of neck and left sided chest pain. Houston's heart rate was noted as 101 beats per minute and his ADDS[59] score was "1", indicating his vital signs were within normal or near-normal limits. Houston was given "*analgesia*" (i.e. 1,000 mg of paracetamol);[60,61,62,63]

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[55] ts 15.04.25 (De Francesch), p23
[56] Exhibit 1, Vol. 1, Tab 25, Statement - Dr S Fu (17.03.25), paras 18-22
[57] Exhibit 1, Vol. 1, Tab 10, FSH Medication Chart (4.38 am, 30.03.23)
[58] Exhibit 1, Vol. 1, Tab 22-CT4, FSH EDIS entry (4.50 am, 31.03.23) and ts 15.04.25 (De Francesch), pp23-25
[59] ADDS is the abbreviation for Adult Deterioration Detection Score
[60] Exhibit 1, Vol. 1, Tab 28, Statement - Ms K Dedman (31.03.25), paras 16-30 and ts 15.04.25 (Dedman), pp39-49
[61] Exhibit 1, Vol. 1, Tab 10, FSH Continuation Notes (5.08 am, 30.03.23)
[62] Exhibit 1, Vol. 1, Tab 10, FSH Medication Chart (5.15 am, 30.03.23)
[63] Exhibit 1, Vol. 1, Tab 22-CT4, FSH EDIS entry (5.15 am, 31.03.23)

c. *7.15 am*: Houston approached Mr Teruel (a registered nurse in the ED) and showed him a piece of paper with the word "*Andy*" written on it. Houston said he was looking for "Andy" but Mr Teruel told him he didn't know what he meant. Mr Teruel did not think Houston was "*manic, agitated, panicked or acting otherwise unusually*" and that Houston seemed "*quite calm but confused*".[64] Mr Teruel made the following note in the ED electronic records system (EDIS): "*0715 (Houston) wandering in WR (waiting room) asking about "Andy". Knows that he is confused, has had olanzapine given*";[65]

d. *7.30 am*: Houston left the ED waiting room and walked to the main foyer of FSH, where he was approached by a security officer. The officer said Houston was "*acting skittish*", and "*said something like he was afraid*" but was "*mumbling and did not make complete* sense". Houston also said something about Bali, and the officer escorted him back to the ED and spoke briefly with Ms Hackett (Nurse Unit Manager in the ED) before leaving Houston in the ED.[66,67,68]

In an EDIS system entry at 7.30 am, Ms Hackett noted: "*found wandering confused near SMIS reception, they will bring him back to the WR (waiting room)*".[69] In her statement, Ms Hackett made the following observation about her use of the word "*confused*" in her EDIS entry:

> I do not recall if I wrote "*confused*" in the sense of being concerned about his ability to understand where he was, or confused about the way to get back to the ED from the concourse. I am aware that patients are easily lost when going to the concourse and returning, because the pathways between the main hospital and ED are a bit confusing.[70]

With great respect, given the statement from the security guard who says that Houston was "*mumbling and did not make complete* sense",[71] and Mr Teruel's evidence,[72,73] the observation in Ms Hackett's statement seems to be an unnecessary gloss on her EDIS system entry. In any case, there is no record of any assessment or other action being taken once Houston had been returned to the ED.

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[64] Exhibit 1, Vol. 1, Tab 23, Statement - Mr J Teruel (28.03.25), paras 26-30 and ts 15.03.25 (Teruel), pp53-55
[65] Exhibit 1, Vol. 1, Tab 22-CT4, FSH EDIS entry (7.15 am, 31.03.23)
[66] Exhibit 1, Vol. 1, Tab 20, Statement - Mr P Anzini (09.03.25)
[67] Exhibit 1, Vol. 1, Tab 11, SAC1 Clinical Investigation Report (09.06.23), p3
[68] Exhibit 1, Vol. 1, Tab 23, Statement - Mr J Teruel (28.03.25), paras 26-30 and ts 15.03.25 (Teruel), pp55-56
[69] Exhibit 1, Vol. 1, Tab 22-CT4, FSH EDIS entry (7.30 am, 31.03.23)
[70] Exhibit 1, Vol. 1, Tab 21, Statement - Ms L Hackett (28.03.25), para 37 and ts 15.03.25 (Hackett), pp75-77
[71] Exhibit 1, Vol. 1, Tab 20, Statement - Mr P Anzini (09.03.25)
[72] Exhibit 1, Vol. 1, Tab 23, Statement - Mr J Teruel (28.03.25), paras 26-30 and ts 15.03.25 (Teruel), pp53-55
[73] Exhibit 1, Vol. 1, Tab 22-CT4, FSH EDIS entry (7.15 am, 31.03.23)

However, in fairness, I note that in his statement, Mr Teruel says: "*I recall that sometime later (Houston) left the wait room and returned with a security guard. (Houston) did not seem distressed and went and sat back down using his phone*".[74]

e. *8.23 am*: CCTV footage shows that Houston walked out of the ED and was seen outside the triage entrance. He appeared "*calm and unagitated and was texting on his phone*";[75,76]

f. *8.52 am*: CCTV shows that Houston left the ED waiting room before walking across a road into an adjacent carpark and then out of the range of the CCTV camera. Houston did not return to the ED after this point;[77,78,79]

g. *9.15 am*: although Mr Teruel does not specifically recall calling Houston's name in the ED waiting room, he (Mr Teruel) accepted that he had done so, and he made the following note in EDIS: "*0915 Not in WR (waiting room) when called*".[80] Of course, Houston did not respond to this call because he had left the ED about 25 minutes earlier.[81,82] In his statement Mr Teruel said he was "*not particularly worried*" about Houston's presentation as Houston was "*calm and compliant*", and Mr Teruel also said that in his experience:

> [P]sychiatric presentations get up and disturb other patients. I have noticed patients with psychiatric presentation usually become anxious. seek attention often either by disturbing other patients or attempts to do something. These patients also often approach the triage often. They also usually will voice concerns to anyone, either at triage or to a family member who usually stays with them.[83]

h. *10.47 am*: a note in the ED medical records states: "*Not in WR (i.e.: waiting room) when called*". Following this entry, Houston was effectively "*discharged*" from the ED. Despite the fact that a Did Not Wait Policy (which was in place at the relevant time) required follow-up action, no such action was taken by any of the ED staff.[84,85,86,87]

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[74] Exhibit 1, Vol. 1, Tab 23, Statement - Mr J Teruel (28.03.25), para 32
[75] Exhibit 1, Vol. 1, Tab 11, SAC1 Clinical Investigation Report (09.06.23), p3
[76] Exhibit 1, Vol. 1, Tab 23, Statement - Mr J Teruel (28.03.25), para 33
[77] Exhibit 1, Vol. 1, Tab 11, SAC1 Clinical Investigation Report (09.06.23), p3
[78] Exhibit 1, Vol. 1, Tab 2, Report - Coronial Investigator R Fyneman (26.06.24), p4
[79] Exhibit 1, Vol. 1, Tab 23, Statement - Mr J Teruel (28.03.25), para 33
[80] Exhibit 1, Vol. 1, Tab 22-CT4, FSH EDIS entry (9.15 am, 31.03.23)
[81] Exhibit 1, Vol. 1, Tab 11, SAC1 Clinical Investigation Report (09.06.23), p3
[82] Exhibit 1, Vol. 1, Tab 2, Report - Coronial Investigator R Fyneman (26.06.24), p4
[83] Exhibit 1, Vol. 1, Tab 23, Statement - Mr J Teruel (28.03.25), para 34
[84] Exhibit 1, Vol. 1, Tab 10, FSH Continuation Notes (10.47 am, 30.03.23)
[85] Exhibit 1, Vol. 1, Tab 10, FSH Emergency Medicine Summary (30.03.23)
[86] Exhibit 1, Vol. 1, Tab 11, SAC1 Clinical Investigation Report (09.06.23), pp3-4
[87] At the inquest, Mr Teruel said one of the nurses in the ED should have called Houston: ts 15.04.25 (Teruel), p57

Houston is reported missing[88]

43. At 4.14 am on 30 March 2023, Houston's mother received a text message from Houston asking her to "*please keep checking*" on his ex-partner and their child, and she sent a text message at 4.37 am saying: "*I will, love you and get well*". At 4.52 am, Houston sent a text message to his mother saying: "*Thanks*", and at 7:48 am he sent what was to be his last text message to his mother, saying: "*Not bad. Just chilling here*".[89]

44. Houston's movements after he left the ED at about 8.52 am, are unknown, but after that time, he did not make any contact with his family or friends. Bank records show that at 10.24 am on 30 March 2023, Houston transferred a sum of money to "*Cedric*", who police established was a friend and work colleague who Houston had known for about 10 months.[90,91,92]

45. Cedric told police that during a recent trip to Bali with Houston (and Houston's ex-partner and their baby) Houston had lost his wallet and mobile phone. Cedric said he loaned Houston $2,000, which was repaid on 30 March 2023, and this was his last contact with Houston.[93,94]

46. At about 12.00 pm, Houston's mother began calling different hospitals to find out where he had been taken. When she called FSH, she was told that Houston had been "*discharged*" at 10.47 am. Houston's mother says she called FSH "*throughout the day hoping to get new or different information*", and also called "*a few friends*" but no one knew where Houston was.[95]

47. Houston's mother says his lack of contact was out of character and she "*knew something was not right*". She contacted police to request a welfare check at his home in Harrisdale, at about 6.00 pm, Houston mother contacted police to report Houston as a missing person.[96,97]

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[88] Exhibit 1, Vol. 1, Tab 2, Report - Coronial Investigator R Fyneman (26.06.24), pp2 & 4
[89] Exhibit 1, Vol. 1, Tab 8, Statement - Ms S Peel (01.08.23), para 53
[90] Exhibit 1, Vol. 1, Tab 16, WAPOL Running Sheet 1124 17889 (9.28 pm, 05.04.23, 3.43 pm, 12.04.23 & 7.45 am, 13 .04.23)
[91] Exhibit 1, Vol. 1, Tab 9, Statement - Ms S Geogeo (25.07.23), paras 82-83
[92] See also: Exhibit 1, Vol. 1, Tab 8, Statement - Ms S Peel (01.08.23), para 53
[93] Exhibit 1, Vol. 1, Tab 16, WAPOL Running Sheet 310323 1124 17889 (7.45 am, 13.04.23)
[94] See also: Exhibit 1, Vol. 1, Tab 9, Statement - Ms S Geogeo (25.07.23), paras 82-83
[95] Exhibit 1, Vol. 1, Tab 8, Statement - Ms S Peel (01.08.23), para 54-56
[96] Exhibit 1, Vol. 1, Tab 8, Statement - Ms S Peel (01.08.23), para 56-58
[97] Exhibit 1, Vol. 1, Tab 2, Report - Coronial Investigator R Fyneman (26.06.24), p2

Houston is found

48. Police were unable to locate Houston, and family members made several unsuccessful search efforts to find him. On 13 April 2023, Houston's ex-partner and his cousin were searching for him in the vicinity of FSH.[98,99,100,101]

49. At about 11.15 am, Houston's ex-partner discovered him hanging from a tree in bushland (Moitch Park) opposite FSH. Houston was obviously deceased, and there was a rope around his neck that was tied to a tree branch.[102,103,104,105,106]

50. Police officers attended the scene and confirmed that Houston was deceased.[107,108,109,110,111]

51. Following an investigation, police concluded there was no evidence of criminality, or of the involvement of another person or persons in relation to Houston's death.[112,113]

[98] Exhibit 1, Vol. 1, Tab 16, WAPOL Running Sheet 310323 1124 17889
[99] Exhibit 1, Vol. 1, Tab 2, Report - Coronial Investigator R Fyneman (26.06.24), pp2-3
[100] Exhibit 1, Vol. 1, Tab 8, Statement - Ms S Peel (01.08.23), paras 59-63
[101] Exhibit 1, Vol. 1, Tab 9, Statement - Ms S Geogeo (25.07.23), paras 85-93
[102] Exhibit 1, Vol. 1, Tab 2, Report - Coronial Investigator R Fyneman (26.06.24), pp2-4
[103] Exhibit 1, Vol. 1, Tab 2.1, Memorandum - Const. S Grover (08.10.24)
[104] Exhibit 1, Vol. 1, Tab 2.2, Memorandum - Const. D Hallam (07.09.23)
[105] Exhibit 1, Vol. 1, Tab 8, Statement - Ms S Peel (01.08.23), paras 60-63
[106] Exhibit 1, Vol. 1, Tab 9, Statement - Ms S Geogeo (25.07.23), paras 87-93
[107] Exhibit 1, Vol. 1, Tab 14, Scene photographs of the area where Houston's body was found
[108] Exhibit 1, Vol. 1, Tab 3, Life Extinct Form (13.04.23)
[109] Exhibit 1, Vol. 1, Tab 6.1, Supplementary Post Mortem Report (10.06.24)
[110] Exhibit 1, Vol. 1, Tab 4, P92 - Identification of deceased person by visual means form 13.04.23
[111] Exhibit 1, Vol. 1, Tab 2, Report - Coronial Investigator R Fyneman (26.06.24), pp3-4 & 8-9
[112] Exhibit 1, Vol. 1, Tab 2.1, Memorandum - Const. S Grover (08.10.24)
[113] Exhibit 1, Vol. 1, Tab 2.2, Memorandum - Const. D Hallam (07.09.23)

CAUSE AND MANNER OF DEATH[114,115,116]

52. A forensic pathologist (Dr J White) conducted an external post mortem examination of Houston's body on 19 April 2023 at the State Mortuary, and reviewed CT scans. Dr White noted advanced post mortem changes, and an evident mark to Houston's neck which was consistent with the ligature that had accompanied his body.

53. Toxicological analysis detected therapeutic levels of several medications in Houston's system, namely: doxylamine (an insomnia medication) and olanzapine (an atypical antipsychotic), along with diphenhydramine (an antihistamine), ondansetron (an anti-nausea medication), and paracetamol. Alcohol and other common drugs were not detected.[117,118]

54. At the conclusion of her external post mortem examination, Dr White expressed the opinion that the cause of Houston's death was ligature compression of the neck (hanging).

55. I respectfully adopt Dr White's opinion as my finding as to the cause of Houston's death.

56. Further, on the basis of the available evidence including the circumstances of how his body was located, I find that the manner of Houston's death was suicide.[119,120,121,122]

[114] Exhibit 1, Vol. 1, Tab 6.1, Supplementary Post Mortem Report (10.06.24)
[115] Exhibit 1, Vol. 1, Tab 6, Post Mortem Report (19.04.23)
[116] See also: Exhibit 1, Vol. 1, Tab 2, Report - Coronial Investigator R Fyneman (26.06.24), pp8-9
[117] Exhibit 1, Vol. 1, Tab 5, Report - ChemCentre Toxicology (01.12.23)
[118] Exhibit 1, Vol. 1, Tab 5.1, Supplementary Report - ChemCentre Toxicology (31.12.24)
[119] Exhibit 1, Vol. 1, Tab 14, Scene photographs of the area Houston's body was found
[120] Exhibit 1, Vol. 1, Tab 3, Life Extinct Form (13.04.23)
[121] Exhibit 1, Vol. 1, Tab 6.1, Supplementary Post Mortem Report (10.06.24)
[122] Exhibit 1, Vol. 1, Tab 4, P92 - Identification of deceased person by visual means form 13.04.23

SAC1 REVIEW

Overview

57. Following Houston's death, a clinical incident investigation (SAC1) was conducted by a panel consisting of clinical, policy and consumer representatives. The panel: "*convened to discuss the patient's presentation and management, and the events preceding the clinical incident*". The SAC1 concluded that on the basis of Houston's presentation in the ED, there was no basis to detain him under the *Mental Health Act 2014* as an involuntary patient. However, the SAC1 identified two issues which I have summarised below.[123]

Significant delay in Emergency Department[124]

58. The panel noted that the 7.30 am FSH census for 30 March 2023, showed there were 67 patients in the ED. Of those, 14 patients had not been seen, and there was a seven hour waiting time for medical review. I accept the unfortunate truth that inordinate and unacceptable waiting times are common place in emergency departments across Western Australia.

59. In her statement, the Head of Emergency Medicine at FSH (Dr Taylor) made the following observations about waiting times in the ED at FSH:

> In my view, the longer wait times are a result of the limited capacity of the hospital. In essence, the ED can only see so many patients at one time and ED overcrowding is common across Australia and internationally. This is a complex multifactorial issue where demand for ED care exceeds the available capacity leading to long waits to be seen. These issues include 'patient surge' in presentation and acuity, constraints on internal throughput and boarding of admitted patients awaiting inpatient admission to the hospital.[125]

60. Dr Taylor also noted the systemic gap in treatment options for patients who require "*subacute assessment and care*", and that patients presenting to the ED have become more medically complex.[126]

[123] Exhibit 1, Vol. 1, Tab 11, SAC1 Clinical Investigation Report (09.06.23), pp3-4
[124] Exhibit 1, Vol. 1, Tab 11, SAC1 Clinical Investigation Report (09.06.23), p4
[125] Exhibit 1, Vol. 1, Tab 22, Statement - Dr C Taylor (27.03.25), para 21 and ts 15.04.24 Taylor), pp122-126
[126] Exhibit 1, Vol. 1, Tab 22, Statement - Dr C Taylor (27.03.25), paras 22-24

61. The SAC1 noted the lengthy waiting times in the ED at the relevant time, and identified this as a "*potentially lost opportunity*" noting:

> The panel conceded ED waiting times were consistently longer during the night and overnight/early morning patient presentations for ATS of 3-5 were regularly faced with lengthy waits. The panel acknowledged (Houston) demonstrated help seeking behaviour and appeared to be willing to engage with assessment of his symptoms. **The panel concluded the wait time of 5 hours was prolonged, (and) may have contributed to the patient leaving the department without review and was a potentially lost opportunity to have intervened with clinical assessment and referral to appropriate mental health services.**[127,128] [Emphasis added]

62. However, the panel declined to make any recommendation about this issue on the basis that a South Metropolitan Health Service (SMHS) project was "*in progress to address issues with timely access to care within the ED*".[129]

Did Not Wait policy

63. At the relevant time, FSH had a "Did Not Wait" policy (DNW Policy) in place that was designed to address the situation where a patient leaves the ED (as Houston did) without being medically reviewed. Under that policy, follow up was required for patients assessed as being at either "*moderate*" or "*high*" risk.[130]

64. Moderate risk patients include those "*presenting with mental health concerns*", and under the DNW policy, where a patient in this category did not wait to be seen, a triage nurse "*or other identified staff member*" was required to contact the patient during "*business hours*" and "*encourage them to return for assessment*". Where the patient could not be contacted, the DNW policy provided that the patient's GP "*should be contacted and informed*".[131]

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[127] Exhibit 1, Vol. 1, Tab 11, SAC1 Clinical Investigation Report (09.06.23), p4
[128] At the inquest, several FSH witnesses agreed with this assessment, see for example: 15.04.25 (Teruel), pp61-62
[129] Exhibit 1, Vol. 1, Tab 11, SAC1 Clinical Investigation Report (09.06.23), p10
[130] Exhibit 1, Vol. 1, Tab 22-CT3, Management & Review of Did Not Wait Patients that Present to ED, p3
[131] Exhibit 1, Vol. 1, Tab 22-CT3, Management & Review of Did Not Wait Patients that Present to ED, p4

65. Under the DNW policy, "*high risk*" patients included those who presented with "*altered mental state immediately prior to going missing e.g. confused, delirious or cognitively impaired*. For these patients, the DNW Policy required "*the medical lead to immediately attempt contact with the patient via mobile phone to encourage them to return*". Where this contact failed, the patient's next-of-kin or carer was to be contacted, escalation to "*senior staff*" was to occur, and the medical lead was to consider the necessity of involving the police and/or a social worker.[132]

66. In this case, Houston should certainly have been assessed as being at moderate risk, and it is arguable that he could have been assessed as a high risk patient on the basis of his "*confusion*". In this regard, I refer to the entry in the EDIS system made by Mr Teruel at 7.15 am on 30 March 2023, which I referred to earlier.[133]

67. Regardless of whether Houston was assessed as being at moderate or high risk, either way in accordance with the DNW Policy, he should have been followed up when he left the ED, and he was not. However, at the relevant time, there were two key several impediments to follow up action being taken, as the SAC1 noted:

> **The senior ED representatives on the panel expressed their unfamiliarity with the policy (i.e.: the DNW policy), confirmed it was not utilised in everyday clinical practice, and were concerned it was not deliverable within current resources.**[134] [Emphasis added]
>
> The panel agreed there were circumstances in which patients who DNW (i.e.: did not wait) (or their next of kin) should be contacted to encourage return to the ED for assessment however were unable to determine for this event whether the intervention would been timely enough to alter the patient outcome. The panel concluded there was opportunity to review the current DNW policy with involvement from key stakeholders, to ensure appropriate patient follow up can be operationalised and embedded within the department.[135]

[132] Exhibit 1, Vol. 1, Tab 22-CT3, Management & Review of Did Not Wait Patients that Present to ED, p5
[133] Exhibit 1, Vol. 1, Tab 22-CT4, FSH EDIS entry (7.15 am, 31.03.23)
[134] See for example: ts 15.04.25 (Hackett), pp77-80
[135] Exhibit 1, Vol. 1, Tab 11, SAC1 Clinical Investigation Report (09.06.23), p4

68. At the inquest, clinical staff either said they were unaware of the DNW policy, or that the policy was undeliverable.[136,137,138,139] Since Houston's death, the DNW Policy has been updated (the Updated DNW Policy).[140] In his report, SMHS's Area Director for Clinical Services (Dr Monaghan) noted that:

> The DNW Policy in effect at the time of Mr Peel's death presented two key challenges for FSH ED staff: the complexity of the risk assessment process as well as the expectations for follow-up within an ED that is the busiest in Western Australia and consistently operates in a demanding environment often beyond its capacity. The challenges would mean that the ED would not have been able to reliably make contact with patients who DNW in a clinically useful way.[141]

69. Dr Monaghan said that the previous policy did not account for the high number of ED patients who did not wait to be seen, or provide "*adequately clear guidance*" for identifying high risk patients. Further, the previous policy did not provide a procedure to enable a triage nurse to flag a concern about a possible departure "*even if the patient was triaged as lower acuity*". As for the Updated DNW Policy, Dr Monaghan noted that:

> The revised policy attempts to address these issues by refining the list of high-risk patient cohorts should they DNW and aligning this list more appropriately with information available to the triage staff at the time.
>
> As part of this policy update, Fiona Stanley Hospital is incorporating into the triage form a "check box" for the triage nurse to select if the person is considered a high risk in accordance with the updated DNW Policy. If this box is selected in the triage form, and the patient does not wait for assessment, staff will escalate the patient record to a senior clinician to make a decision around any necessary follow-up.[142]

[136] Exhibit 1, Vol. 1, Tab 21, Statement - Ms L Hackett (28.03.25) and ts 15.04.25 (Hackett), pp62-89
[137] Exhibit 1, Vol. 1, Tab 22, Statement - Dr C Taylor (27.03.25) and ts 15.04.25 (Taylor), pp121-146
[138] Exhibit 1, Vol. 1, Tab 24, Statement - Mr A De Francesch (11.04.25) and ts 15.04.25 (De Francesch), pp6-39
[139] Exhibit 1, Vol. 1, Tab 25, Statement - Dr S Fu (17.03.25)
[140] Exhibit 1, Vol. 1, Tab 26.1, Management & Review of patients that Did Not Wait after presenting to ED (04.04.25)
[141] Exhibit 1, Vol. 1, Tab 26, Report - Dr M Monaghan (04.04.25), p2 and see also: ts 14.04.25 (Monaghan), pp146-166
[142] Exhibit 1, Vol. 1, Tab 26, Report - Dr M Monaghan (04.04.25), p2

70. Although the Updated DNW policy is designed to address the types of concerns being expressed by several witnesses at the inquest,[143] the issue of the efficient dissemination of relevant policies remains. Part of the problem relates to the staggering number of policies that staff are expected to be across. In his report, Dr Monaghan said:

> There are approximately 1000 policies over SMHS and Fiona Stanley Hospital. In general, policies are reviewed and updated every 3 years unless they are risk rated as requiring more frequent review. Policies are reviewed to ensure compliance with laws and regulations, best-practice approaches, to respond to emerging issues, and to reflect technological and clinical advancements. Following review, policies are updated and then approved for release by the relevant executive committee. SMHS Policies are considered by our Area Executive Group (AEG). Once a policy is approved, the updated policy is republished with relevant stakeholder groups notified of the same.[144]

71. The current method of disseminating polices is to email them to staff. This is problematic not just because of the numbers of policies which must be distributed, but also because in the context of ever increasing patient loads (especially in the ED), staff have limited time to read and digest the content of these policies. The other issue is that because of the nature of presentations to the ED, clinical staff in this department must be familiar with a broader range of policies.

72. I accept that policies are an important part of establishing clear guidelines for clinical and other staff at FSH. However, the fact that at the inquest, a number of key clinical staff in the ED were unaware of the Updated DNW Policy (supposedly distributed two weeks earlier) highlights the fact that the current system of policy distribution requires attention.[145]

73. I have recommended that junior and senior medical, nursing and allied health staff be consulted with a view to developing a more streamlined system to ensure that staff are made aware of policies applicable to their area(s) of clinical responsibility.

[143] Exhibit 1, Vol. 1, Tab 26.1, Management & Review of patients that Did Not Wait after presenting to ED (04.04.25)
[144] Exhibit 1, Vol. 1, Tab 26, Report - Dr M Monaghan (04.04.25), p1
[145] See: ts 15.04.25 (De Francesch), pp29-34; ts 15.04.25 (Hackett), p85 and ts 15.04.25 (Taylor), pp133-135

OTHER ISSUES RAISED BY THE EVIDENCE

Prescription of olanzapine

74. As noted, Houston was given 10 mg of olanzapine at about 4.38 am on 30 March 2023 after it had been prescribed to him by Dr Fu. In her statement Dr Fu says this about her use of this medication:

> Olanzapine is a regularly prescribed antipsychotic and has a broad range of uses. While olanzapine is in the drug class 'antipsychotic', the prescription of olanzapine does not suggest the doctor has diagnosed the patient as having a psychotic episode. Olanzapine is used for anxiety and can assist with hallucinations regardless of the cause of that hallucination (i.e. whether it has an organic or psychiatric cause, or is caused by substance use or withdrawal). Olanzapine can also be used for agitation or delirium, and is often prescribed where the patient reports that the anxiety, or hallucinations, or similar symptoms, are not their first episode, or that they are prescribed olanzapine elsewhere and have found it to be effective.[146]

75. In her statement, Dr Taylor confirmed that it is common practice for patients like Houston to be given olanzapine, noting:

> I note that, on the paper file, (Houston) is recorded as having received Olanzapine shortly following his triage. This is practice commonly occurs to provide symptom relief for a patient who has expressed a recent history of disordered thoughts (such as auditory hallucinations or recent bizarre behaviour). Olanzapine is an oral antipsychotic which can be effective irrespective of the aetiology of disordered thoughts. As it has a favourable safety profile and is effective for these kinds of symptoms, Olanzapine can reasonably be prescribed before an in-person assessment by a doctor and based on the information relayed by a triage nurse.[147]

76. Although the SAC1 did refer to Houston being given olanzapine, it did not address the fact that Dr Fu had not reviewed Houston before she had prescribed this medication to him.[148]

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[146] Exhibit 1, Vol. 1, Tab 25, Statement - Dr S Fu (17.03.25), para 19
[147] Exhibit 1, Vol. 1, Tab 22, Statement - Dr C Taylor (27.03.25), para 50 and ts 15.04.25 (Taylor), pp128-132
[148] Exhibit 1, Vol. 1, Tab 11, SAC1 Clinical Investigation Report (09.06.23)

77. Instead, the SAC1 noted:

> The panel discussed the prescription and administration of Olanzapine at the time of triage and agreed this was an appropriate pharmaceutical intervention given the known long wait time until medical review and the patient's acutely psychotic behaviour.[149]

78. In her statement, Dr Fu said she did not recall Houston's case or whether she had met him, although it was possible that she had. However, Dr Fu also said her "*usual practice*" was to review a patient's medical record and "*prescribe olanzapine without meeting the patient*". In Houston's case, Dr Fu said she would have been comfortable prescribing olanzapine after reviewing his triage notes to assist in making Houston's wait for a medical review "*more comfortable*".[150]

79. Notwithstanding the fact that dispensing olanzapine to patients presenting to the ED with a recent history of disordered thoughts, auditory hallucinations and/or bizarre behaviour, I have **grave** concerns about the practice of prescribing psychotropic medication to patients without some form of prior medical review.

80. On 8 April 2025, Mr D McDonald (Counsel Assisting) wrote to Dr Brett (who assessed Houston's care and provided a report to the Court) asking his view about this practice, and Dr Brett's response was:

> I agree with the broad statement of how olanzapine can be used. I can understand pragmatically (Dr Fu's) statement, however, I believe that it is bad practice. The patient should know what they are being prescribed and why they are being prescribed it. I do not believe that people should be prescribed medication without being seen. It also makes diagnostic assessment harder if people have been medicated.[151]

81. At the inquest, Dr Brett expressed concern about the practice of administering antipsychotic medication prior to a comprehensive mental health assessment.

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[149] Exhibit 1, Vol. 1, Tab 11, SAC1 Clinical Investigation Report (09.06.23), p4
[150] Exhibit 1, Vol. 1, Tab 25, Statement - Dr S Fu (17.03.25), paras 18 & 20
[151] Exhibit 1, Vol. 1, Tab 17.3, Email - Dr A Brett to Mr D McDonald (08.04.25) and ts 15.04.25 (Brett), pp97-99

82. Dr Brett said that whilst this practice was understandable in the context of a busy emergency department, especially when it is known that the relevant patient will have an extended wait before a medical review, prescribing antipsychotic medication in these circumstances without a comprehensive mental health assessment, can interfere with the accuracy of any subsequent assessment and there may be a risk of adverse interactions with the patient's other prescribed medication.[152]

83. Dr Brett also said that he considered the situation might be different if antipsychotic medication was prescribed by a physician who had not seen the patient, where there had first been a comprehensive psychiatric triage by a mental health clinician, such as a psychiatric liaison nurse.[153]

84. I have recommended that the appropriateness of the current practice of prescribing psychotropic medications to patients without those patients first being reviewed by a doctor, be reviewed.

Triage of mental health presentations

85. At the time Houston presented to the ED, the typical roster was two triage nurses and one "*wait room*" nurse. Since that time, the standard roster has been increased to three triage nurses and three "*wait room*" nurses. This increase in staff is clearly welcome, but the current triage system remains problematic, at least in so far as patients with mental health concerns is concerned.[154,155]

86. In her statement, Dr Taylor explained that persons may present with apparently psychiatric symptoms that may in fact have an organic cause. By way of just one example, Dr Taylor noted:

> For example, apparent psychiatric symptoms may be a result of overdose, acute drug intoxication, alterations of electrolytes (such as low sodium), abnormalities of thyroid hormones, infections of the central nervous system, epilepsy, brain tumours and (although less likely) traumatic brain injuries.[156]

[152] ts 15.04.25 (Brett), pp97-98 & 101-102
[153] ts 15.04.25 (Brett), p97
[154] Exhibit 1, Vol. 1, Tab 23, Statement - Mr J Teruel (28.03.25), para 39 and ts 15.04.25 (De Francesch), p14
[155] ts 15.04.25 (De Francesch), pp14 & 19-21
[156] Exhibit 1, Vol. 1, Tab 22, Statement - Dr C Taylor (27.03.25), para 31 and ts 15.04.25 (Taylor), pp140-144

87. Dr Taylor also noted that a patient with an established mental health diagnosis who presents to the ED with features consistent with that diagnosis "*may be more quickly referred for an ED psychiatric review*", but they would still require a medical review first.[157]

88. However, Dr Taylor also said that in her professional view as an emergency medicine physician:

> [I]t would not be usual practice to refer a patient with a potential organic cause for their presentation for a psychiatric assessment without first assessing and treating any underlying organic issue, which may be missed and left untreated. Where a patient is apparently presenting with psychiatric symptoms, the appropriate approach is to first undertake a medical assessment to identify the appropriate care pathway. Once the organic causes have been excluded, the medical team can decide as to the appropriate next steps.[158]

89. Whilst I do not seek to cavil with the views of an experienced emergency medical physician such as Dr Taylor, the fact remains that current system for dealing with patients presenting to the ED with mental health issues (where a medical review is required before any mental assessment is conducted) is patently unacceptable.

90. I have recommended that consideration be given to employing mental health clinicians, and mental health peer workers to work in the ED waiting room with the aim of providing support to mental health patients who are waiting for the required medical review.

91. In my view this recommendation is particularly appropriate given that the evidence before me is that on 30 March 2023, the longest wait time for a patient in the ED was 11.5 hours. Whilst ED wait times have improved marginally since then in January 2025, only 12.9% of patients with a Triage score of "3" were being seen within the required 30 minute window, and it appears there is little hope scope for any immediate improvement on this statistic.[159,160]

[157] Exhibit 1, Vol. 1, Tab 22, Statement - Dr C Taylor (27.03.25), para 37
[158] Exhibit 1, Vol. 1, Tab 22, Statement - Dr C Taylor (27.03.25), para 35
[159] Exhibit 1, Vol. 1, Tab 21, Statement - Ms L Hackett (28.03.25), para 41
[160] Exhibit 1, Vol. 1, Tab 22, Statement - Dr C Taylor (27.03.25), para 20 and ts 15.04.25 (Taylor), pp122 & 124

92. Whilst there are protocols in place to escalate a patient's triage score if their condition deteriorates, the current system leaves that responsibility to wait room nurses, who are not trained in conducting either triage, or mental health assessments.[161]

93. I have therefore recommended that options for a more streamlined process be explored, so that once a patient presenting to the ED with mental health issues has been triaged, they can be reviewed by mental health clinicians, and where appropriate offered treatment, at a much earlier stage.

94. I have also suggested that alternative models of care for mental health patients presenting to an emergency department be examined to determine whether any of models might be appropriate at FSH.

QUALITY OF SUPERVISION, TREATMENT AND CARE

95. I acknowledge the extraordinary pressures which medical, nursing, and allied-health professionals working in emergency departments in Western Australia face on a daily basis. I also accept that inadequate facilities, insufficient staffing levels, and inflexibility in responding to increasing levels of patient acuity continue to hamper the efforts of these dedicated individuals who are clearly seeking to provide a quality service to health consumers.

96. I also acknowledge that many of these issues are systemic and of long-standing, and that the resources (both human and financial) available to address the patently obvious deficiencies in the health system in Western Australia are limited. I also accept that suicide is impossible to predict, and that a person's suicidality (and therefore their risk of suicide) can fluctuate, often on very short timeframes.

97. Nevertheless, in my view, with the benefit of hindsight there were missed opportunities where Houston's care could, and should have been improved.

[161] See: ts 15.04.25 (Dedman), p42 and ts 15.04.25 (Teruel), pp50-52

98. I acknowledge that patients routinely leave the ED for a variety of reasons, however, the fact that Houston was not reviewed when he was returned to the ED in a "*confused*" state is particularly unfortunate.

99. I also accept that the ED has physical limitations and that there are difficulties in providing more therapeutic waiting spaces for patients presenting with mental health issues. Nevertheless, I have recommended that efforts be made to provide a more therapeutically appropriate waiting area.

100. I am also concerned that the current practice of triaging patients with mental health issues is cumbersome and inflexible. The present requirement is that patients presenting with mental health issues must be "medically cleared" before they can be assessed by mental health clinicians. Whilst there are understandable reasons why this is so, the inordinate waiting times for a medical review means that mental health patients are obliged to "*grin and bear it*" in a waiting room that is busy, noisy, and clearly untherapeutic.

101. I have recommended that consideration be given to developing a more streamlined process so that once a patient presenting with mental health concerns had been triaged, they can be reviewed by mental health clinicians, and where appropriate, offered treatment at a much earlier stage. I have also recommended that alternative models of care (e.g.: South Australia's Urgent Mental Health Care Centre) may be useful in addressing the lengthy delays in these patients being assessed.

102. I also note that when it was found that Houston had left the ED without being reviewed by a doctor, no action was taken to follow him up. This is deeply regrettable, and contrary to any reasonable reading of the Did Not Wait policy that was in place at the time.

103. The circumstances which led Houston to take his life can never be known. Although Houston presented with possible psychotic symptoms, his mental state was never assessed because he left the ED before this could occur. The delay in him being called for a medical assessment was in the order of five hours, which is completely unacceptable, particularly in the case of a patient with mental health concerns who was waiting in the ED alone.

104. After carefully reviewing the available evidence, I have concluded that the care and treatment Houston was provided in the ED was suboptimal, and that he should have been the subject of a medical and mental health review at an earlier stage. However, on the basis of the evidence before me, and with due regard to the Briginshaw principle and the issue of hindsight bias, I have been unable to make any finding, to the relevant standard, that any action or inaction on the part of FSH caused Houston's death.

RECOMMENDATIONS

105. In view of the observations I have made in this finding, I make the following recommendations:

Recommendation No. 1

South Metropolitan Health Service (SMHS) should examine ways to improve the treatment and care provided to people presenting at the Fiona Stanley Hospital (FSH) emergency department (ED) with mental health issues by considering measures including, but not limited to:

a. providing a therapeutically appropriate waiting area;

b. employing mental health clinicians and mental health peer workers to work in the ED waiting room at FSH with the aim of providing support to mental health patients awaiting medical review;

c. developing a streamlined process so that once mental health patients have been triaged, they can be reviewed by mental health clinicians, and where appropriate, offered treatment at a much earlier stage; and

d. considering whether agencies such as South Australia's Urgent Mental Health Care Centre provide a model of care which could be offered by SMHS, whether at FSH or elsewhere.

Recommendation No. 2

South Metropolitan Health Service (SMHS) should review the appropriateness of prescribing psychotropic medications to patients presenting to the Fiona Stanley Hospital emergency department with mental health symptoms, without those patients first being reviewed by a doctor.

Recommendation No. 3

South Metropolitan Health Service (SMHS) should consider whether the current system of disseminating Fiona Stanley Hospital (FSH) policies, and SMHS policies to staff at FSH could be improved by filtering or curating the lists of policies being disseminated.

The assessment of whether the current system can be improved (and if so how) should include consultation with staff representatives (including junior and senior medical, nursing and allied health staff) with a view to developing a more streamlined system which ensures that staff are made aware of policies applicable to their area (or areas) of clinical responsibility.

Response to Recommendations

106. At my request, Mr McDonald (Counsel Assisting) sent a draft of my recommendations to all counsel by way of an email on 17 April 2025.[162] Feedback (if any) was requested no later than the close of business on 16 May 2025.

107. As at the date of publishing this finding, no feedback has been received from Mr Rafferty (counsel for both Mr De Francesch and Ms Hackett). By way of an email dated 15 May 2025, Mr G Scott (counsel for SMHS) advised his clients that SMHS's response to the draft recommendations was as follows:[163]

[162] Email - Mr D McDonald to Mr J Cavanagh, Mr D Rafferty, and Mr G Scott (17.04.25)
[163] SMHS response to Recommendations attached to Email - Mr G Scott to Mr D McDonald (15.05.25)

a. *Response to Recommendation 1:* SMHS advised that it is committed to improving the care and treatment of mental health patients, including access to services, and that:

> As the redevelopment of the (mental health) services at Fremantle Hospital continues, including the opening of an additional 40 beds in 2026, Fiona Stanley Fremantle Hospitals Group (within SMHS) are examining the feasibility of redesigning the triage area at the Alma Street Centre (at Fremantle Hospital) into a Mental Health Crisis Centre.[164]

SMHS also advised that if this plan could be achieved, then this would divert a significant number of patients presenting to emergency departments, including at FSH. However, SMHS also advised that:

> It is not currently proposed to attempt to develop a waiting area for (mental health) patients within the existing (emergency department) at FSH. To do so would require either a building extension, which would take a considerable period of time and resources, or diverting a section of the waiting area exclusively for MH patients and reduce the available space for the remainder of the patients accessing the department. The current view is that expanding the triage area within the Mental Health Service at Fremantle Hospital is the preferred option. Any of these options also require a significant expansion of human resources and this also poses not insignificant problems.[165]

SMHS also advised that consideration was being given to ways of increasing mental health "*in reach*" into the emergency department at FSH, so as to provide additional support to patients with "*primary mental health concerns*".

SMHS also advised that consideration is being given to exploring whether: "*a focussed cohort of patients with known mental health presentations*" can be referred directly from triage to emergency department mental health clinicians.[166]

[164] SMHS response to Recommendations attached to Email - Mr G Scott to Mr D McDonald (15.05.25), p1
[165] SMHS response to Recommendations attached to Email - Mr G Scott to Mr D McDonald (15.05.25), p1
[166] SMHS response to Recommendations attached to Email - Mr G Scott to Mr D McDonald (15.05.25), p2

Whilst I acknowledge that the proposed redesign of the triage area at the Alma Street Centre at Fremantle Hospital may be an appropriate solution and has the potential to "*divert a significant number of patients*" presenting to FSH with mental health issues, I consider that paragraph (a) of this recommendation is appropriate as drafted.

I also note that in as many words, SHMS appears to be supportive paragraphs (b) and (c) of Recommendation 1.

b. *Response to Recommendation 2:* SMHS advised that this recommendation is supported, and that:

> The Head of Emergency Department at FSH will recommend Medical Staff within the ED conduct a brief assessment of a patient before prescribing psychotropic medications. ED staff will also consult with the ED Mental Health team to seek input regarding other options that may be of assistance.[167]

c. *Response to Recommendation 3:* this recommendation is supported and SMHS advised it: "*will undertake a review of these processes and consider any ways in which the process can be improved*".[168]

108. By way of an email dated 16 May 2025, Mr Cavanagh (counsel for Houston's family) forwarded submissions on behalf of the family in which he advised that all of the recommendations I have proposed were accepted.

109. Houston's family also invited me to consider some additional recommendations. However, after careful review I have decided not to adopt these suggestions. In my view, the recommendations which I have proposed are appropriate, and open on the available evidence.[169]

[167] SMHS response to Recommendations attached to Email - Mr G Scott to Mr D McDonald (15.05.25), p2
[168] SMHS response to Recommendations attached to Email - Mr G Scott to Mr D McDonald (15.05.25), p2
[169] Houston's family's submissions attached to an Email - Mr J Cavanagh to Mr D McDonald (16.05.25)

CONCLUSION

110. Houston was a much loved family member who was only 29-years of age when he died from ligature compression of the neck at Moitch Park in Murdoch on or about 30 March 2023, after leaving FSH (where he had been waiting to be assessed) earlier that day.

111. After carefully reviewing the available evidence, I concluded that aspects of Houston's assessment and treatment whilst he was at FSH were inadequate, and that with the benefit of hindsight, there were missed opportunities where Houston's care could and should have been enhanced.

112. In arriving at these conclusions, I acknowledge the significant difficulties that emergency department staff at FSH face in managing the extraordinary number of patients it receives, many of whom present with mental health issues.

113. On the basis of my assessment of the available evidence, I have made three recommendations which I hope will enhance the treatment provided to patients with mental health issues who attend the emergency department at FHS.

114. The death of a loved one is always a sad occasion, but Houston was only 29 years old at the time he died. The death of such a young man, and in such truly awful circumstances, is almost an unfathomable tragedy. I simply cannot imagine the grief and sadness that Houston's death has caused his family and loved ones.

115. It is a common misconception that at some point after a loved one's death there is "*closure*". However, those who have experienced profound loss know this is not the case. The void left by the loved one's death does not get filled, nor do feelings of grief and sadness disappear.

116. However, with the passage of time, it may be that the sense of loss becomes a little easier to bear. Memories of happier times can emerge and these memories may help to deaden the ache. It is my sincere hope that Houston's family and friends may have this experience.

117. Finally, as I did at the conclusion of the inquest, I wish to again convey to Houston's family and loved ones, on behalf of the Court, my very sincere condolences for their terrible loss.

MAG Jenkin
Coroner
30 June 2025